Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.25pm on Wednesday 27 July 2022

Boardroom, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE

(The meeting is also available via MS Teams)

No.	Time		Action	Presenter
1.	2.00 – 2.05pm	**Welcome and Apologies**	Information	Chair
2.	2.05-2.07pm	Declarations of Interests	Information	Chair
3.	2.07 – 2.09pm	Minutes of the meeting held on 1 July 2022	Approval	Chair
4.	2.09 – 2.11pm	Action Log Matters Arising	Discussion	Chair
		Business Items		
5.	2.11 - 2.15pm	Questions from members of the public	Discussion	Chair
6.	2.15 – 2.30pm	Patient Story – We can move	Discussion	Tracey Cox Will Chapman
7.	2.30-2.40pm	Chief Executive Officer report	Discussion	Mary Hutton
8.	2.40 – 3.20pm	Integrated Finance, Performance, Quality and Workforce report	Discussion	Cath Leech Mark Walkingshaw Marion Andrews Evans Tracey Cox
9.	3.20pm	Integrated Care Partnership	Discussion	Mary Hutton
		Items for decision		
10.	3.20 – 3.55pm	Clinical Programme Approach: • Clinical Programme Approach Overview Urgent and Emergency Care Update	Approval	Gemma Artz / Sarah Scott

		• Frailty Strategy		Sian Cole & Dr Alan Gwynn
11.	3.55 – 4.10pm	Community Mental Health Team (CMHT) Delegation	Approval	Karl Gluck/Angela Potter
		Information items		
12.	4.10 – 4.15pm	EPRR Transition to ICB		Marion Andrews-Evans/Andy Ewens
13.	4.15 – 4.20pm	Chair's verbal report on the People Committee meeting held on 14 July 2022		
14.	4.20pm – 4.25pm	Chair's verbal report on the Audit Committee meeting held on 14t July 2022		
15.	4.25pm – 4.30pm	**Any Other Business**		
		Time and date of the next meeting: 2.00pm – 5.00pm 28 September 2022, Boardroom, Sanger House.		

Withdrawal of the press and public

That under the provision of Section 1, sub-section 2 of the public bodies admission to meetings act 1960, the public may be excluded for such a period as the Board is in Committee on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Verbal

Verbal and to be recorded in minutes.

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Gloucestershire Integrated Care Board Meeting

9.30am- 11.00pm on Friday 1 July 2022

Boardroom and Virtually at Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE

Members Present	Initial	Non-Executive Directors – Committee Chairs
Dame Gill Morgan	GM	ICB Chair
Mary Hutton	MH	Chief Executive Officer
Julie Soutter	JS	Non-Executive Director
Colin Greaves (CG)	CG	Non-Executive Director
Prof. Jane Cummings	JC	Non-Executive Director
Prof. Jo Coast	JC	Non-Executive Director
Dr Marion Andrew-Evans	MAE	Chief Nursing Officer
Cath Leech	CL	Chief Finance Officer
Ellen Rule	ER	Deputy Chief Executive / Director of Strategy & Innovation
Prof. Sarah Scott	SS	Executive Director of Adult Social Care & Public Heath, Gloucestershire County Council (GCC)
Claire Radley *(deputising for Deborah Lee)*	CR	Director for People and OD, Gloucestershire Hospitals NHS Foundation Trust (GHFT)
Sandra Betney *(deputising for Paul Roberts)*	SB	Deputy Chief Executive and Director of Finance - Gloucestershire Health & Care NHS Foundation Trust (GHC NHSFT)

Name	Initials	Participants

Deborah Evans	DE	Chair, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Cllr. Carole Allaway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council (GCC)
Andy Dempsey *(deputising for Chris Spencer)*	AD	Director of Partnerships & Strategy, Gloucestershire County Council (GCC)
Pete Bungard	PB	Chief Executive, Gloucestershire County Council (GCC)
Martin Holloway	MHo	Senior Independent Director, South Western Ambulance Service (SWAST)
Rachel Pearce	RP	Director of Commissioning, SW NHS England & Improvement (SW NHSE/I)
Mark Walkingshaw	MW	Director of Operational Planning & Performance, (GICB)
Kim Forey	KF	Director of Integration (GICB)
Helen Goodey	HG	Director of Primary Care & Place (GICB)
Paul Atkinson	PA	Chief Clinical Information Officer (GICB)

In attendance		
Elizabeth O'Mahoney	EOM	Regional Director, SW NHS England & Improvement (SW NHSE/I)
Dr Charles Sharp -	CS	Consultant in Respiratory Medicine, Gloucestershire Hospitals NHS Foundation Trust (GHFT)
Matt Lennard	ML	Chief Officer, Voluntary & Community Sector Alliance (VCSA), Gloucestershire
Christina Gradowski	CGi	Associate Director of Corporate Affairs (GICB)
Lauren Peachey	LP	Corporate Governance Manager (GICB)
Sophie Hopkins	SH	Communications Officer (GICB)

1	**Welcome and Apologies - Chair**
1.1	Apologies were noted from Dr Jo Bayley, Dr Andy Seymour, Ingrid Barker, Chris Spencer, Tracey Cox, Siobhan Farmer, Mark Branton, Deborah Lee, Graham Russell, Nikki Richardson, Clive Lewis, Paul Roberts, and Robert Graves.
1.2	The Chair confirmed that the Board of the ICB was quorate.
1.3	The Chair, GM, warmly welcomed the members, participants and attendees to the first Board meeting of the Gloucestershire Integrated Care Board (ICB). GM explained that at this first board meeting of the newly established Gloucestershire ICB there was a requirement to approve a number of key governance documents. Thereafter board meetings would concentrate on the strategic priorities and plans of the ICB and Integrated Care System (ICS).
1.4	GM explained that the next Board meeting of the Gloucestershire Integrated Care Board would be held on the 27th of July 2022.
2	**Launch of the Integrated Care Board (ICB)/Integrated Care System (ICS)**
2.1	GM expressed sincere gratitude to everybody who had been on the journey to progress the transition from the Clinical Commissioning Group to an Integrated Care Board. GM stated that an enormous amount of work had been undertaken by CCG staff and system partners to enable a legal and safe transition from the CCG into the ICB, with minimal barriers. Thus, bringing the ICB into the well-established position it finds itself in today. She commended both staff and partners for their continued enthusiasm and commitment to the vision and values of the ICB / ICS to improve services for the population of Gloucestershire.
2.2	GM summarised four key priorities for the Gloucestershire system: • to continue to work collaboratively with system partners, building on the learning from Covid-19, • to tackle the challenges for urgent and emergency care, including the ambulance handover issues, which were at the heart of senior discussions every day,

	• to continue to reduce the backlog of elective care in hospitals and in the community, and • to continue to invest and support Primary Care to effectively manage an increasing and demanding workload. In parallel with this work the system would focus on tackling long-term inequalities.
2.3	GM explained that the ICB working with partner organisations, will emphasise the longer-term approach in supporting the county council and district councils in making Gloucestershire a really good place to live and work, while tackling long-term inequalities. Working collaboratively, the ICB would deliver the health service components to make Gloucestershire a great place to live.
2.4	GM highlighted the positive and constructive relationship with Gloucestershire County Council, who had agreed to lead the Gloucestershire Health and wellbeing Partnership (Integrated Care Partnership committee.)
2.5	GM highlighted that there was a new plan around digital services, which will examine how to utilise digital opportunities to the maximum potential, enabling people to be supported in their own homes more effectively. The ICS was also progressing transformative work including clinical pathways which will achieve good outcomes for the population of Gloucestershire.
2.6	GM explained that the ICS would look to identify opportunities within estates and find solutions that will enable more people to remain safely and comfortably at home for as long as possible. She explained that change needed to be tackled collectively and stated that the vision for the future needed to encompass a supported, trained and dedicated workforce.
2.7	GM highlighted that the ICB had a good starting point in terms of the collaborative partnership that had developed amongst system partners. She added that the Non-Executive Directors who have been appointed to the ICB brought an immense wealth of experience, expertise as well as new perspectives; and she commended the ICS partners for their dedication and commitment.

2.8	EOM thanked the Board for the opportunity to highlight her hopes and aspirations for the ICB/ICS, summarising that the system would continue to accelerate the level of ambition, urgency, and the transformation agenda in Gloucestershire. EOM commended the rate of progress in Gloucestershire, which was second to none, while encouraging the system to accelerate its improvement agenda.
2.9	EOM encouraged the continual development of a multi-faceted local strategy which responded to urgent health needs as well as focusing on developing health care in the long-term.
2.10	EOM highlighted her hopes and aspirations for partners of the ICB to collectively accept their own responsibilities as members of the ICS, to support and enable this Board in terms of a positive culture and behaviours, building on the strong foundations already created and embedded.
2.11	EOM commented that the Region would support the ICB to continue to be exemplars around Population Health Management and care, while also tackling the inequalities agenda, along with some of the broader social and economic issues. EOM asked that the ICB share best practice with the Regional team to enable shared learning across the south-west.
2.12	GM introduced Matt Lennard (ML) from the Voluntary and Community Sector Alliance (VCSA). ML explained that the VCSA was the independent voice for the 5,500 organisations of the voluntary and community sector in Gloucestershire. The VSCA had, over the past year, informed voluntary and community organisations and groups across the county about ICS developments. The VCSA had been developing and coordinating the structures, systems and governance that will enable the VCSA to actively engage with the ICS in the immediate and long-term. ML spoke about the response from the VCSA being that of enthusiasm, engagement, interest and commitment to collaborative partnership working.
2.13	ML explained his hopes for the ICS. He would like to build upon the trust already established between the ICS and the voluntary and community sector, the health and care system, communities, and individuals that live in those communities. He stressed the importance of all partners and members of the ICS being seen as equal strategic partners.

2.14	GM introduced and welcomed Charlie Sharp (CS) from Gloucestershire Hospitals NHS Foundation Trust. CS spoke about his hopes and aspirations for the ICB. CS stated that there was an opportunity to build and improve patient-centred care along an integrated pathway where organisational boundaries were invisible to the patient. Specialist expertise should be available to the patient be that in the hospital, in the community or even in their own homes in the most appropriate way possible.
2.15	CS introduced himself as a consultant who was very involved with the development and improvement of clinical pathways. He stated that he was heartened to hear the positive feedback from partners about the ICB/ICS and the willingness of all partners to work collaboratively to improve population and patient health. He stated that moving forward there was a need to be brave around progressing innovative opportunities and embracing new models of care; this would require different attitudes to risk that would support new models of care, requiring an ambitious mindset. CS acknowledged how the system had responded to Covid in a positive and proportionate way by balancing different risks. There was a need to build upon this positive work.
2.16	CS explained that he hoped the system would begin to move away from the NHS as a "sickness service" and take on the role of health advocates for a more equitable health service and society, recognising that any advocacy undertaken upstream, would have benefits further downstream, in future years to come.
2.17	CS considered that the system should embody the Marmot principles; • respond and tackle inequalities, • apply shared learning, using skills from all settings, irrespective of professional groups, • drive forward a prevention agenda, using data sensibly, sharing data appropriately and having a continuous shared patient record. He concluded that the ICB / ICS had a massive opportunity to improve the health and wellbeing of local people.
2.18	GM informed the meeting that the ICB had appointed 14 clinicians to lead on specific programmes of work across the system. This would provide a real clinical drive to the improvement agenda. GM informed

	the Board that Charlie Sharp will be leading the work around population health management.
2.19	MH informed the Board that unfortunately Nikki Richardson, from Healthwatch Gloucestershire was unable to attend the meeting but wanted to share her hopes and aspirations for the ICB / ICS with the Board. MH read out the following statement: "Healthwatch Gloucestershire welcomes the new ICS, which provides an excellent opportunity to make health and care services in Gloucestershire even more focused on and engaged with patients and carers. Providing joined up services across the county that reach into all communities, and that include all stakeholders will provide the opportunity to create a healthier Gloucestershire and we look forward to working with partners to realise this ambition"
	GM confirmed that Healthwatch will attend the Board meetings of the ICB twice a year, to share their perspective of local health and care services.
2.20	Four short films showcased the work of the ICS and demonstrated the collaborative work undertaken between system partners including: • Frailty services; • Mental Health Practitioners in Primary Care; • The Park Homes Insulation Project, and • The School Streets Scheme (part of Greener Gloucestershire).
2.27	A video was shared from Ed Argar, MP, and Minister for State of Health of the UK, where he presented his hopes and ambitious for Gloucestershire ICB / ICS.
3	**Board Appointments**
3.1	GM informed board members that a pre-meeting had taken place at 9.00am on 1st July to formally appoint the members of the ICB Board. GM explained that the meeting formally appointed the unitary board members; this included the Non-Executive Directors, the Executives and

	partner members of the Board. The meeting also approved the ICB committee chairs and participants who were invited to each meeting.
3.2	**RESOLUTION: The Board noted the appointments to the Unitary Board; including the Non-Executive Directors, Executives, Partner Members, ICB Committee Chairs and Participants.**
4	**Questions from members of the public**
4.1	There were no questions from members of the public.
	Governance Matters for Approval
5	**Declarations of Interest**
5.1	GM explained that future Board meetings would include a published Declarations of Interest Register for Board members.
6	**Gloucestershire ICB Constitution (including the nominations and appointments process)**
6.1	MH explained that there had been a number of iterations of the ICB Constitution with partner involvement in its development. The Constitution and the Standing Orders had been through a rigorous process and had been approved by NHSEI. A number of Statutory Duties had been inherited from the CCG and a robust Governance process was needed to be put in place to ensure those Statutory Duties were met. Any variation to the Constitution would require approval by the Board followed by NHSEI approval. These requirements were set out in the Constitution.
6.2	**RESOLUTION: The Board received and approved the ICB Constitution**
7	**ICB Committee Terms of Reference (ToRs)**
7.1	MH explained that a large amount of work had been undertaken on the Terms of Reference for the ICB Committees. The chairs of the committees had been agreed. The committees were due to begin meeting this July.

7.2	MH explained that the Terms of Reference for the Remuneration Committee had been further updated in terms of setting out quoracy for the committee.
7.3	MH explained that the Terms of Reference for the System Resources Committee had been further updated to specify that the Non-Executive Director should 'ideally' hold a finance qualification with regard to s.4.3.1 of the ToR.
7.4	**RESOLUTION: The Board approved the ICB committee Terms of Reference:** • **Audit Committee** • **People Committee** • **Quality Committee** • **Primary Care & Direct Commissioning Committee** • **Remuneration Committee** • **System Resources Committee**
8	**Appointment of Conflicts of Interests Guardian**
8.1	GM explained that a Conflicts of Interest Guardian needed to be formally appointed by the Board. It was proposed that Julie Soutter, Non-Executive Director, Chair of the Audit Committee was appointed the ICB Conflicts of Interests Guardian.
8.2	**RESOLUTION: The Board approved Julie Soutter as the ICB Conflicts of Interest Guardian.**
9	**Scheme of Reservation and Delegation, Standing Financial Instructions and Detailed Scheme of Delegation**
9.1	CL informed the Board that the Scheme of Reservation and Delegation, the Standing Financial Instructions and Detailed Scheme of Delegation, were based on national templates and related to national guidance. These documents had been through a number of reviews with system partners. It was proposed that the Detailed Scheme of Delegation was reviewed during August and September; this will be taken to the Audit Committee prior to coming back to the Board, with any updates should this be necessary.

9.2	**<u>RESOLUTION</u>: The Board approved the:** • **Scheme of Reservation and Delegation,** • **Standing Financial Instructions and** • **Detailed Scheme of Delegation.**
10	**ICB Governance policies**
10.1	MH explained that these key governance policies had been submitted to NHSEI as part of the Governance Handbook in May 2022. The Standards of Business Conduct Policy included the Conflicts of Interest Policy and Gifts and Hospitality Policy. The Standards of Business Conduct Policy will be reviewed when further national guidance was received.
10.2	MH stated that the Counter Fraud, Bribery and Corruption Policy and the Health and Safety Policy have been updated to reflect the new statutory organisation, the ICB. The changes made to the policies, at this point in time were minimal.
10.3	It was also noted that there were 127 policies that the ICB had inherited from the CCG, with a process agreed for reviewing all these policies. They will be checked for validity, possible merger, and reduction. They will be taken to the relevant committee over the next six months to be reviewed and subsequently approved.
10.3	**<u>RESOLUTION</u>: The Board approved the ICB** • **Standards of Business Conduct Policy including Conflicts of Interest and Gifts and Hospitality Policies,** • **Counter Fraud, Bribery and Corruption Policy, and** • **Health and Safety Policy.**
11	**Establishing the Gloucestershire Health and Wellbeing Partnership (the Integrated Care Partnership) - CEO**
11.1	MH highlighted the importance of the Gloucestershire Health and Wellbeing Partnership. It was planned to take this proposal to the Health and Wellbeing Board on 19th July where they will look at the founding membership, the operating model, and Terms of Reference.

11.2	MH confirmed that this Partnership was referred to as the Gloucestershire Health and Wellbeing Partnership and will be jointly established by the ICB and Gloucestershire County Council. It was proposed that Mary Hutton and Councillor Carole Allaway-Martin were given the mandate to convene the partnership on behalf of the system.
11.3	SS commented that she welcomed the creation of the partnership stating that this will be a committee of the county council. There would be additional governance arrangements to work through, as such this might impact on the timeline for the formal start of the partnership, although meetings could take place in shadow form.
11.4	The Board was asked by the Chair to approve Councillor Carole Allaway-Martin as Chair of the Gloucestershire Health and Wellbeing Partnership and Mary Hutton, to be founding members and to work together to convene this partnership through the mechanisms discussed.
11.5	**RESOLUTION: The Board approved the appointment of Councillor Carole Allaway-Martin as Chair of the Gloucestershire Health and Wellbeing Partnership, and Mary Hutton to be founding members of this partnership.**
12.	**Operational Plan 2022/2023 - Director of Planning & Performance**
12.1	MW addressed the Operational Plan, stating that the plan was not new and that it had gone through a number of iterations. The purpose of this paper was to formally ask the Board to accept the Operational Plan which was submitted on 20th June 2022 to NHSEI as the agreed System Operational Plan for 2022/2023.
12.2	MW thanked all partners and teams across the system for all their work on the Plan. There had been various iterations and some constructive challenge and testing of this Plan during the process. There had been positive support and constructive challenge from NHSEI colleagues and subject matter experts had also scrutinised the Plan.
12.3	It was noted that the Plan sought to continue to invest in hospital and specialist services and also mental health, community, and primary care preventative services, including those included in the films shown today. It also sought to balance the tension between responding to the very real challenge around elective recovery while responding to the urgent and emergency care pressures currently being experienced.

12.4	MW stated that the Plan had required difficult decisions to be made and had required a degree of flexibility from all partners, working through this together. It was noted that our health and care system was still within the post pandemic recovery period and the Plan remained focussed on addressing some of the backlogs and pressures which had built up during that time.
12.5	The Plan committed to making strong progress in cancer performance, reducing long waits for planned treatment, hospital discharges and ambulance handover delays. There was a commitment to address some of the drivers of the pressures currently facing the health and social care system, by continuing to focus on prevention, self-care and alternatives to hospital-based services, as well as developing new community-based capacity within Gloucestershire.
12.6	MW stated that there was a need to re-confirm our commitment to continue to be a top performing system by reducing long waits for planned care services. It was noted that Gloucestershire was currently only one of three systems in the Southwest planning to achieve full levels of elective activity over the 104% target set nationally against 2019/2020 levels.
12.7	MW addressed the key risks summarised in section 3 of the Plan these included ongoing pressures related to urgent and emergency care and how this impacted upon elective recovery. It was noted that there were many pressures within mental and physical health services, and some overarching workforce pressures, across the whole system that needed to be closely monitored and mitigated together as a system.
12.8	MW therefore requested that the Board accept the 20 June 2022 submission of the System Operational Plan for 2022/23.
13	**Financial Plan 2022/2023 - Chief Finance Officer**
13.1	CL addressed the financial element of the System Operational Plan. System partners had worked very closely to ensure that the system as a whole presented a break even Plan rather than focus solely on individual organisations.
13.2	CL explained that there was a balanced Plan for each organisation within the system and the system as a whole, however this was dependent

	upon delivering the cashable savings in order to deliver that balanced Plan.
13.3	The system was also dependent upon receipt of the Elective Recovery Funding (ERF) monies, c£15m. Elective capacity was protected which was essential to that overall position.
13.4	There were a number of other risks associated with the Plan, one of which was very high inflation. Ongoing demand pressures existed throughout the whole system in a number of areas which were impacting on the ability to deliver elective activity. CL stated that it was essential that close system working continued, with everyone working around a strong governance framework to deliver a balanced financial position.
13.5	The next part of the work would be to look at the underlying position for the system as a whole to help inform the development of the Operational Plan for the next two to five years, in order to move back towards being a financially sustainable system.
13.6	DE extended her thanks to all staff and system partners who had undertaken an enormous amount of work to enable a smooth transition from the CCG to the the ICB. She also acknowledged the intensity of the work being conducted around the urgent and emergency care pathway. DE thanked GM for responding to the concerns of GHFT about the waits in emergency care. It was noted that Professor Jane Cummings would be leading a piece of work around this issue, which was gratefully acknowledged.
13.7	DE asked if the systemwide action plan for urgent and emergency care (where the contribution of every partner had been quantified) was now available. MHo also asked for some further clarity around risk reporting.
13.8	MH informed the Board that there was a systemwide action plan with quantified inputs but the plan was yet to be agreed, as some further work was needed. Leads had been identified for each of the projects for this plan and people were actively working on delivering the plan. There was some more work to be completed around resourcing and the development of an Organisational Development Plan.
13.9	GM stated that there would be a substantive item, on Urgent and Emergency Care (UEC) at a future board meeting. A number of pieces of work had been commissioned, internally and externally, which would

	be brought together into one plan. The outputs of this work would be shared with board members. It was also important to note that senior level meetings were being held between the health sector and the county council to ensure that work commissioned was shared, joined, and owned.
13.10	**ACTION: An Urgent and Emergency Care report to be made available at a future board meeting**
13.11	GM stated that it was important to address system risks, because the risks associated with UEC resided not only in the hospital but also in primary care, the community trust, in social care and in domiciliary care. It was therefore about understanding the system as a whole rather than any one component of it.
13.2	JC confirmed that there was a meeting in July to progress this work. It was clear that this would be a system-wide view of the risks and JC will be speaking to the different organisations across the system to clarify how to approach this. This would be work in real time and would be shared with ICS partners.
13.3	PB stated that a one system governance approach was needed. He noted that there were several problems related to urgent and emergency care which had not been resolved and were longstanding, not least workforce. The situation regarding workforce was a major concern and this would increase due to demographic changes over the next 20 years. As such there needed to be a different approach to the care economy. PB considered that partner engagement in the long term vision, was the only way the system would be able to change outcomes.
13.4	GM concurred with PB, noting that new innovative ideas were needed in health and care to tackle such issues, such as driving digital technologies and information to better support people.
13.5	**RESOLUTION: The Board approved the submission of the 20th June 2022 of the Operational Plan and Financial Plan 2022/23**
14.	**ICB Budget 2022/23 - Chief Finance Officer**
14.1	CL explained that this was the formal ICB Budget for the organisation. It was split into two parts: three months for the CCG and nine months for the ICB giving a total for 2022/23. Risks to the system were highlighted

	in the previous paper and remain pertinent to the ICB itself. It should be noted that the total resource allocation for Gloucestershire was over £1b. Delivery was dependent upon ERF efficiencies and included pre-commitments noted in Section 3.1.
14.2	GM acknowledged that the Directors of Finance within the ICS were working collaboratively and effectively on the financial challenges facing the system. GM stated that effective financial management was the tool and mechanism which facilitated the outcomes the system wanted to achieve.
14.3	**RESOLUTION: The Board approved the updated ICB Budget for 2022/23**
13.	**Any Other Business - Chair**
13.1	No other business was raised.
14.	**Closing Remarks - Chair**
14.1	GM thanked all those present for attending the first meeting of the ICB. GM thanked the partner members, non-executive directors and the executives and also the participant members for their time. GM stated that it was her hope that working together with a shared vision and purpose would ensure the delivery of better services and outcomes to Gloucestershire citizens.
15.	**The meeting closed at 11.00 am.**
16.	**Time and date of the next meeting** **2.00pm – 5.00pm Wednesday 27th July 2022, Boardroom, Sanger House**

Agenda Item 4

Action Log

27 July 2022

Minute Ref, & Date	Description	Response	Action owner	Due	Status
01.07.2022 Min 13.10	An Urgent and Emergency Care report to be made available at a future board meeting	A report on urgent and emergency care will come to the 28 September public board meeting	ER	28 Sep. 2022	Open

Questions and answers will be read out by the Chair at the meeting

Patient Story will be presented by Tracy Cox and Will Chapman.

Agenda Item 7

Integrated Care Board Meeting
27 July 2022

Report Title	**Chief Executive Report**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
	X				
Route to this meeting	The updates given in this report have also been shared with the Health Overview and Scrutiny Committee.				
Executive Summary	This report summarises key achievements and significant updates by the Chief Executive Officer of NHS Gloucestershire to the Integrated Care Board. This report will be provided on a bi-monthly basis to public meetings of the ICB.				

Key Issues to note	This report covers the following topics
	• **Integrated Care Board including clinical leadership roles**
	• **Covid 19 update**
	  ○ Covid-19 levels
	  ○ Vaccinations
	  ○ Post-Covid syndrome (long covid) service.
	• **Elective recovery, clinical programmes and schemes**
	  ○ Elective recovery
	  ○ Diagnostic hub
	  ○ Supporting people living with cancer
	  ○ Eye health
	  ○ Mental health and wellbeing
	  ○ Children's social prescribing schemes.
	• **Campaigns, initiatives and awareness**
	  ○ Fit for the Future engagement
	  ○ New volunteering website
	  ○ Supporting people waiting for care.
	• **Primary care and place**
	  ○ Primary Care Networks (PCNs)
	  ○ Integrated Locality Partnerships (ILPs) and population health management
	  ○ Workforce development and support
	  ○ Estates – new Cheltenham health centre.				

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Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The report includes a number of different services, schemes and initiatives with associated risks included on the project / implementation plans. The risk associated with not producing a CEO report that summarises key programmes is relatively small, as there would be other mechanisms to communicate with partners and stakeholders. (4x1) 4 (4x1) 4 (residual meaning accepted risk)			
Management of Conflicts of Interest	There are no conflicts of interests associated with the production of this report.			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource	X	**Buildings**	X
Financial Impact	The schemes and initiatives included in this report will have associated financial plans that have been approved.			
Regulatory and Legal Issues (including NHS Constitution)	Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act)			
Impact on Health Inequalities	Key programmes and schemes are designed to have an impact on reducing health inequalities and creating services and initiatives that are inclusive and meet people with protected characteristics needs such as the vaccination programme, mental health and wellbeing and children's social prescribing etc.			
Impact on Equality and Diversity	The Fit for the Future Scheme has a comprehensive Equality Assessment undertaken as do the clinical programmes and schemes that have been designed.			
Impact on Sustainable Development	n/a			
Patient and Public Involvement	The Fit for the Future engagement work seeks to involve patients and the public in developing and improving services.			
Recommendation	The Committee/Board (delete as appropriate) is requested to: • Note the Chief Executive Officer report.			
Sponsoring Director	Mary Hutton, ICB Chief Executive Officer			

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

NHS Gloucestershire Integrated Care Board (ICB)
Chief Executive Officer Report

July 2022

1.	**Introduction**
1.1	This report summarises key achievements and significant updates by the Chief Executive Officer of NHS Gloucestershire to the Integrated Care Board. This report will be provided on a bi-monthly basis to public meetings of the ICB.
2.	**Establishment of NHS Gloucestershire Integrated Care Board (ICB)**
2.1	NHS Gloucestershire Integrated Care Board (ICB) successfully launched on 1st July 2022, with the closure of Gloucestershire Clinical Commissioning Group (CCG). While there were many achievements of the CCG, the ICB will take forward the development and delivery of health and care services for residents in Gloucestershire. Significant work is underway in areas such as urgent and emergency care to tackle pressures that exist across the system, recognising the importance of all partners coming together in contributing to this work. The ICB will of course sit alongside both the Health and Wellbeing Board and Integrated Care Partnership (ICP) that will be important in helping us to deliver our health and wellbeing ambitions as well as tackle health inequalities across Gloucestershire.
2.2	**Clinical and Care Professional Leadership**
2.2.1	One of the key areas for the Integrated Care System will be ensuring that we have a strong clinical and care voice in how we improve health and care in Gloucestershire. Over the last few months work has been undertaken with a range of health and care professionals to explore what works and what opportunities are available to strengthen and develop clinical and care leadership in Gloucestershire. As part of this work the ICB has recruited a team of clinical leads for key clinical programmes (see appendix 1).
3.	**Covid -19 update**
3.1	**Covid-19 Levels**
	Due to guidance changing from 1st April, reporting of COVID case levels should be treated with caution due to changes in testing arrangements. The ONS infection survey (https://www.ons.gov.uk) provides a good indication of COVID prevalence within the community. There have been continued increases in Covid cases seen across all English regions with the South-West one of the highest regions (behind London and North-West) at 4.1% of the population. Levels within Gloucestershire have also increased with the ONS infection survey for period 23rd June to 30th June showing 5.1% of the population testing positive for COVID (please note that these are modelled percentages and should be treated with some caution due to the degree of uncertainty in ONS modelled sub-regional estimates).

3.2	As at 6th July 2022, Gloucestershire Hospitals NHS Foundation Trust had admitted 111 patients in the last 7 days with 87 patients in hospital on that specific day. Daily admissions have continued to show an increase from a low base at the start of June 2022 (source: https://coronavirus.data.gov.uk/).
3.3	**Vaccination update**
3.3.1	Vaccination rollout continues and by the end of May Gloucestershire had delivered over one and a half million vaccinations since the programme started in December 2020. Whilst GP led services in the county have been carrying out the majority of community vaccinations at the eleven Primary Care Network vaccination sites, health and care professionals from hospital and community services have also been providing vaccinations in other settings such as care homes, pharmacies, staff hubs, the Gloucestershire Royal Hospital JabVan, schools and various mobile 'pop-up' sites.
3.3.2	As at Wednesday 6th July, based on the national COVID dashboard (https://coronavirus.data.gov.uk/) the breakdown of people receiving a first, second and booster/3rd dose vaccine is as follows:

	Gloucestershire	South-West
1st Dose	88.3%	86.5%
2nd Dose	84.9%	83%
Booster or 3rd Dose	72.3%	69.3%

3.4	**Post-COVID Syndrome (Long COVID) Service**
3.4.1	A key part of COVID recovery is supporting those people with post-COVID symptoms. A Post-COVID Syndrome Service is currently provided by Gloucestershire Health and Care NHS Foundation Trust and aims to meet rehabilitation needs of patients and support them to pre-COVID health and wellbeing levels. Eligible patients can be referred by their GP with the service providing individual and group care to teach strategies to manage fatigue, stress, sleep, breathlessness, vocational rehabilitation, nutrition, brain-fog and dysautonomia.
4.	**Elective recovery, clinical programmes and schemes**
4.1	**Elective Recovery update**
4.1.1	The Gloucestershire system continues to make strong progress in reducing the number of patients who have been waiting the longest for their planned surgery. However, in common with other parts of the country, there continues to be a significant backlog of patients to work through and this will continue to be our focus during 2022/23. Within our plan for this year, we have committed to work together as a system to deliver levels of activity above 2019/20 levels (for both our NHS and independent sector providers). The new integrated Performance Report (item 8) covers key performance across finance, activity, quality and workforce in detail.
4.2	**Diagnostics Hubs**
4.2.1	*Diagnostics: Recovery and Renewal* was released in October 2020 and detailed a national strategy for diagnostics with 24 recommendations. Central to these recommendations is the premise that diagnostics need to double over the next 5 years to make England

	comparable with the rest of the world. One of the ways to increase diagnostic capacity is the creation of Community Diagnostic Hubs.
4.2.2	Community Diagnostics Hubs will be developed over the next 2 – 5 years with some early adopters in 2021/22. Gloucestershire has expressed an interest in becoming an early adopter site. Community Diagnostic Hubs will deliver additional, digitally connected, diagnostic capacity in England, providing patients with a coordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways.
4.3	**Supporting people living with Cancer**
4.3.1	Our work on supporting people with cancer seeks to support early diagnosis and the delivery of high quality cancer services that deliver personalised care and support to patients. Gloucestershire has seen a 10% increase in the number of patients treated for cancer in 2021/22 compared to 2020/21 with 96.7% of patients receiving their first treatment within 31 days of diagnosis.
4.4	**Eye Health**
4.4.1	This Clinical Programme Group is working to prevent avoidable sight loss and to reduce the consequences of sight loss. Vision Care for Homeless People opened its new clinic in Gloucester at the end of April 2022 providing eye tests, eye care and glasses to homeless people in Gloucester. It is run by volunteers and outcome data is now being captured and will be reported over the next few months. In addition, a new community ophthalmic link has gone live in the first community optometry practice with further rollout being planned. This is enabling community optometrists to have access to previous secondary care data and images, allowing people to be supported in the community.
5.	**Mental health (MH) and Wellbeing**

5.1	There is ongoing positive joint working between Mental Health/Public Mental Health Commissioning via the MH and Wellbeing group including, the development and monitoring of a central dashboard to aid a system-wide response. The dashboard includes:
	• Mental Health Acute Trust (Gloucestershire Health and Care NHS Foundation Trust – GHC).
	  ○ Referrals and admissions to key teams.
	• Early intervention/open access provision (Gloucestershire County Council – GCC)
	  ○ Qwell
	  ○ Kooth
	  ○ Self-harm helpline.
	• Voluntary Care Sector (VCS)
	  ○ Community Advice, Links & Mental Health Support Service (CALMHS)
	  ○ Teens in Crisis (TIC+)
	• Community Wellbeing Service.

6.	**Children's social prescribing schemes**
6.1	The NHS and its partners in Gloucestershire are trialling one of the first children and young people's social prescribing schemes to reduce the build-up of mental health problems following the COVID-19 pandemic. More than 50 children are now getting tailored care to help prevent long term mental health problems as part of the Gloucestershire scheme. They are being proactively contacted and offered a 6-week face-to-face course on mental health resilience including personalised support with issues such as anxiety or educational difficulties.
6.2	The scheme also includes general topics such as the importance of going outside, appropriate relationships, having fun, healthy eating, managing emotions, friends and family. For parents it can help with parenting skills, routines and boundaries.
7.	**Campaigns, initiatives, and awareness**
7.	**Fit for the Future 2 (FFTF2) Engagement**
7.1	Fit for the Future 2 is part of the One Gloucestershire vision, focusing on the medium and long-term future of some of our health services. Building on our Fit for the Future consultation during 2020/2021, we are involving local people and communities in exploring ideas for how several other services could develop in the future as part of FFTF2. This time the conversation about some of these services is broader, covering both: • the continued development of the 'Centres of Excellence' approach at Cheltenham General and Gloucestershire Royal Hospitals, including inpatient care (where you need to stay in hospital for a while, including overnight) • the wider journey of care for people who need services or support - in their own home, in their GP surgery or in the community. The FFTF2 specialist services are: benign gynaecology, diabetes and endocrinology, frailty services, non-interventional cardiology, respiratory and stroke services.
7.2	The Fit for the Future 2 Engagement commenced on 17 May 2022 and will continue over the summer. A comprehensive range of engagement opportunities have been undertaken to date. Activities have included the following: • ***Get Involved in Gloucestershire*** online participation platform project https://getinvolved.glos.nhs.uk/fit-for-the-future-2 • Information Bus Tour to city/town centres and supermarkets • Engagement Booklet (including Easy Read) • Online and Freepost Surveys – deadline extended to 31 July 2022 • Dedicated staff information, including a weekly briefing focussing on each service, and Live Staff Forums. • Facebook Live: opportunities to join online lunchtime discussions with people working in the FFTF2 specialist services.
8.	**New Volunteering Website**
8.1	**GoVolunteerGlos.org** launched on 1 June 2022 during national Volunteers Week. This a countywide initiative linking volunteers to a wide range of available opportunities. This online service will cover all different types of volunteering, including health and care. We

	know that the benefits that volunteering can bring to improving people's mental and physical health. The launch of the website has been widely shared across Gloucestershire.
9.	**Supporting people waiting for care**
9.1	A Customer Care Hub at Gloucestershire Hospitals NHS Foundation Trust. This includes a contact number and a 'My Planned Care' website to support both practices and patients. The website is easy to navigate and looks at current waiting lists by specialty to give an average of how long people have waited on both the admitted and non-admitted waiting lists as well as the average wait time for a first outpatient appointment. In time, the website will also provide some information for patients on what to do while waiting for various conditions and treatments. More information can be found here Gloucestershire Hospitals NHS Foundation Trust – My Planned Care NHS.
10.	**Primary Care & Place**
10.1	**Primary Care Networks**
10.1.2	Whilst the focus of our Primary Care Networks has continued to be delivery of the COVID vaccination programme and delivery of primary care services, PCN development continues apace. The PCN Additional Roles Reimbursement (ARR) scheme has been uplifted as planned for 2021/22, with full details now released of three additional roles: paramedic, mental health practitioner and advanced practitioner.
10.1.3	The PCN Investment and Impact Fund (IIF) indicators relating to flu vaccination, Learning Disability health checks and social prescribing have been carried forward from 2020/21, although with some increased expectations and/or targets with another very large flu campaign ahead of this winter.
10.1.4	A further target relating to standardising appointments across primary care for all our practices is an in-year target. A considerable set of further indicators could be introduced in October 2022, again subject to the COVID situation at that time, and therefore we are mindful of the potential burden that could be created for our practices and PCNs as we head into winter this year.
10.2	**Integrated Locality Partnerships & Population Health Management**
10.2.1	Structured support is provided to Integrated Locality Partnerships (ILP) working groups to progress identified priorities to impact population cohorts utilising a Population Health Management (PHM) approach. The rising risk of poor mental health outcomes for children and young people especially as a result of Covid-19 lockdown restrictions have been identified in Cheltenham, the Forest of Dean, Gloucester city, Stroud and Berkeley Vale and Tewkesbury. Health inequalities remain a particular focus in Gloucester city.
10.2.2	ILPs across the county have prepared bids to access the NHS Charities Together Stage Two Community Partnership Grants funding. These Locality project proposals, led in most cases by PCN Clinical Directors, have been developed in collaboration with other system partners.
10.2.3	We are in the process of finalising the draft PHM Development Programme case studies and roadmap with drafts out to comment with system partners and NHSE/I colleagues. Both products will support our PHM system development alongside our operational PHM toolkit products and templates for consistency. Three of the six PHM Champion roles in the county have been recruited, to further support the spread across the Integrated Care

	System. Each PHM Champion will provide clinical leadership to one or more ILP priority working group, working alongside partners to make measurable impact to population health and wellbeing.
10.3	**Workforce support and development**
10.3.1	The inaugural year of The Spark programme took place in 2020/21. It provides early career GPs with a programme of evening educational sessions, mentoring, peer support groups, life coaching, the opportunity to apply for a funded fellowship to support a Clinical Professional Development (CPD) project and shadowing opportunities. Thirty-one early career GPs took part; feedback on the sessions has been excellent. Six individuals were successful in their applications for a funded Fellowship for one session a week for twelve months and all six commenced their projects in March 2021 with a range of both clinical and academic/educational topics.
10.3.2	Discussions continue around implementation of Additional Role Reimbursement (ARR) roles within Primary Care with a key focus on engagement of Paramedics, Mental Health First Contact Practitioners, Trainee Nurse Associates and Advanced Clinical Practitioners, noting more recent interest in Dieticians and Health and Wellbeing coaches. The Primary Care Training Hub is in the process of developing an educational programme to increase understanding of these roles in order to support PCN's with accurate assessment of workforce requirements. .
10.3.4	We were successful in our bid to NHSE for funding to develop a GP Flexible Pool for the county. Gloucestershire is working with regional leads to understand their interpretations of requirements for a GP Flexible Pool. A number of different solutions are being developed across the region, with a key focus on delivering an enhanced level of support for locums including peer support and mentoring. A full options appraisal including use of some of the funding to purchase a dynamic digital solution to enable ease of posting and booking shifts is being developed.
10.4	**Estates - New Cheltenham health centre**
10.4.1	The Wilson Health Centre, located on Prestbury Road in Cheltenham, is now home to three busy GP surgeries: Berkeley Place Surgery, Prestbury Park Medica and Royal Crescent Surgery. It brings a transformation to GP services, allowing the practices to expand their services to meet the ever-increasing health and care needs of their patients.
10.4.2	The new premises have been built to modern, environmentally friendly specifications and include more consulting and treatment rooms than were possible in the three old premises, which the practices had outgrown. This will enable the practices to offer additional services to patients and the local community, including support from nurses, paramedics and pharmacists, as well as an onsite pharmacy, dental services, rooms to rent and more. The practices will also be able to share resources, work more flexibly and offer extended opening times to patients. While simultaneously allowing significantly more doctors, nurses and other health care professionals to receive training.
11.	**Recommendation**
11.1	The Board is asked to note the report.

Appendix 1

Appointment	Areas of Work
Dr Caroline Bennett	Diabetes, Planned Care (Diagnostics and Pathology) and Cancer
Dr Richard Bulbulia	Clinical Research
Dr Alan Gwynn	Renal, Frailty, Population Health Management and Clinical Research
Dr Emma Le Roux	Planned Care (such as Dermatology, Gynaecology)
Dr Hein Le Roux	Quality Improvement
Dr Helen Makins	Outpatients
Dr Graham Mennie	Circulatory and Cardiovascular Disease (CVD)
Dr Will Miles	Medicines Optimisation and Prescribing
Dr Jon Mutimer	Musculoskeletal & Rheumatology
Dr Faye Noble	Urgent Care / System Flow
Dr Charles Sharp	Prevention and Population Health Management Inequalities
Dr Mala Ubhi	Health Inequalities, Mental Health and Learning Disabilities and Autism
Dr Marie Wheeler	Children and Young People
Dr Martin Ansell	Mental Health (Adult & Children) (Secondary Care)

Agenda Item 8

Integrated Care Board Meeting

27 July 2022

Report Title	**Integrated Performance Report**					
Purpose	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting						
	ICB Internal	**Date**	**System Partner**	**Date**		
	ICB Operational Executive	18.07.2022	ICS Strategic Executive	21.07.2022		
Executive Summary	This is the first Integrated Performance Report for NHS Gloucestershire ICB. The report brings together information from four areas – performance, finance, quality and workforce to help us assess our progress in delivering health and care across Gloucestershire. The report provides: • An assurance page from each of the ICB Committees relating to their relevant part of the Integrated Performance Report (at present this is provided from the People Committee and will be added as Committees start to meet) • A headline summary from Performance, Finance, Quality and Workforce on key areas for discussion					

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- An appendix providing supporting information from each of the four Quadrants. The performance section of the report is aligned to our ICS transformation programmes so that we can more readily assess the impact that our work is having and help us understand where additional focus may be needed.

This is the first report and it will evolve. A summary has been provided below of development plans for the report and headline timescales.

In addition to this report, the intention is to provide an outcomes-based report (in collaboration with Gloucestershire County Council) on longer-term outcome measures and work to address health inequalities across Gloucestershire and within localities. This will be produced at least annually.

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Report area	By end Q2 (Sept)	By end Q3 (Dec)	By end Q4 (Mar)
To incorporate **ICB Committee assurance** pages	Completed		
Performance a). To incorporate all relevant national measures from oversight framework c). To incorporate profiled targets / benchmarking / value changes into dashboard b). To incorporate other key local measures across	Across 50% of metrics	Across 100% of metrics	Reviewed by all programmes

	transformation programmes			
	Quality a). Quality Groups (Safety, Experience, Effectiveness) set up to enable discussion and reporting flow b). NHSE to have reviewed the Quality Toolkit to enable better data flows c). To be able to confidently give full assurance across all Quality metrics for the ICS.	Setup	Completed	Completed
	Workforce a). To develop new workforce metrics b). To incorporate measures into dashboard – design of the report to be aligned with the performance section		Completed	Completed
	Finance a). Further trend analysis / graphical representation of certain financial metrics		Completed	

The report will also be used to inform review and assurance arrangements with local NHS Providers and with NHS England as part of the Oversight Framework.

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Key Issues to note	Areas of key exceptions have been included at the front of the Integrated Performance Report based around the areas of Performance, Quality, Workforce and Finance.			
Key Risks:	Areas of both risk against the Board Assurance Framework (BAF) as well as Transformation Programme related risks are reported separately at present. Strategic Executive / Integrated Care Board are asked to note the interrelationship between our current performance and system level risks.			
Management of Conflicts of Interest	None			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	See section of the Integrated Performance Report on Finance.			
Regulatory and Legal Issues (including NHS Constitution)	None. The Integrated Performance Report will be used to inform regional discussions as part of the Oversight Framework.			
Impact on Health Inequalities	One of the future measures (to be included) will include our progress against the Core20PLUS5 areas. A number of the measures included are already being considered by programmes for their impact on different groups of the population e.g. continuity of carer work in maternity services seeking to focus work first of all at people living in deprived communities. Work will also be undertaken to ensure that there is a wider review of our progress to address health inequalities (as stated above) including consideration of where we can assess the impact of performance on different groups of the population.			

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Impact on Equality and Diversity	See above section on health inequalities.		
Impact on Sustainable Development	None		
Patient and Public Involvement	The Integrated Performance Report (Quality section) currently provides information on patient and public feedback. Going forward there will be a need to review the measures and areas being considered to ensure that we have a rounded picture of performance including service user and patient feedback.		
Recommendation	Strategic Executive / Integrated Care Board are asked to: • Discuss the key highlights from the Integrated Performance Report identifying any further actions that may be required • Review the format of the first Integrated Performance Report and provide comment and suggestions to support future development		
Author	Kat Doherty (Performance) Clare Hines (Workforce) Rob Mauler (Quality) Stephen Edmonds (Finance) Mark Golledge (PMO)	**Role Title**	Senior Performance Management Lead Workforce and OD Project Lead Senior Manager – Quality and Commissioning Finance Programme Manager Associate Director – ICS Development
Sponsoring Director (if not author)	• Mark Walkingshaw, Director of Operational Planning & Performance – NHS Gloucestershire ICB		

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	• Tracey Cox, Interim Director – People, Culture & Engagement – NHS Gloucestershire ICB • Marion Andrews Evans – Executive Chief Nurse – NHS Gloucestershire ICB • Cath Leech – Chief Finance Officer – NHS Gloucestershire ICB

Glossary of Terms	**Explanation or clarification of abbreviations used in the paper**
GHFT	Gloucestershire Hospital NHS Foundation Trust
GHC	Gloucestershire Health and Care Foundation Trust
GCC	Gloucestershire County Council
ICB	Integrated Care Board
CQC	Care Quality Commission
IPR	Integrated Performance Report
IDP	Integrated Delivery Plan

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One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

Integrated Performance Report – NHS Gloucestershire ICB

July 2022

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Part of the One Gloucestershire Integrated Care System (ICS)

Hot Topics / Headline Summary

Improving Services & Delivering Outcomes

Our Performance (Improving Services & Delivering Outcomes)

- Urgent and emergency care system continues to be under pressure: discharge delays, ED performance and Ambulance handover delays.
- Recent increase in Covid-19 cases adding to pressure (including workforce pressures).
- Planned care recovery performance strong (particularly reducing longest waiters) but also facing significant challenges – particularly diagnostics (Echocardiography) & cancer 62 day performance.
- Pressure upon primary care, community and inpatient mental health services.
- Continued pressure on adult social care capacity and workforce, with particular pressure upon domiciliary care and reablement services

Key areas of focus for improvement

- Continuing to maintain zero breaches for over 104 week waits within Gloucestershire and reduce long waits for Gloucestershire patients seen out of county.
- Reduction of over 78/52 week waits for elective treatment across all providers.
- Stabilising urgent and emergency care position and planning for Autumn/Winter – includes support from Local Government Association peer review and Newton Europe.
- Recovering elective performance against 104% weighted cost activity target (against 19/20 cost level).
- Begin to recover cancer 62 day performance.
- Responding to increased demand for mental health services.
- Respond to underlying workforce pressures (see workforce report).

Hot Topics / Headline Summary

Our People

Our People

- Gloucestershire GP workforce remains above the national average. Since the inception of Primary Care Networks the range of roles & staff numbers have increased with an additional 197 whole time equivalent (wte) at end of June 22.
- NHS Staff Engagement Score for the System has deteriorated from 7.0 to 6.8 (down for GHT and remained the same for GHC). This is a national trend.
- Numbers of vacancies is increasing and is identified as a major risk for Gloucestershire – there are issues across all sectors. Acute nurse vacancy rates increased from 514 to 523 (April to May 22 data) although partly driven by increases to establishment levels.
- Staff leaving within one year of employment seems to be an issue which will require further work to understand – this would be a retention priority.
- Cost of living increases impacting on staff wellbeing and may impact on recruitment and retention as the year progresses.
- Local metrics are still being developed to provide a suite of information that will provide both context and useful intelligence.

Quality – Safety, Experience and Effectiveness

Quality – Safety, Experience and Effectiveness

- There are currently several Care Quality Commission (CQC) inspections in progress which may change inspection ratings for healthcare providers.
- One Social Care provider has recently been rated ‘inadequate’ by the CQC. The Quality Assurance Team within Commissioning are working closely with the provider, CQC, Safeguarding and others to help raise the quality of provision to the standard necessary.
- The Urgent and Emergency Care System level CQC inspection results will be triangulated with other system information in the first Rapid Quality Review as part of the new System Quality Group process.
- GHC Physical Health shows positive above national average Friends and Family Test scores.
- In Q1 2022/23 the system recorded 31 Serious Incidents and two Never Events.
- The local maternity system has made good progress against the 15 Immediate & Essential actions we needed to take as a result of the Ockenden Review.

Headline Summary

Finance and Use of Resources

Finance and Use of Resources

- All organisations are forecasting to deliver to a break-even financial position at year-end in line with the plan, however there are risks in these forecasts.
- The ICS year-to-date (YTD) deficit position of £2.1m is the result of a £2.2m adverse to plan position from GHFT, and a small £0.1m YTD surplus position at GHC.
- Capital is due to break-even against the budget for the year.
- Key risks in the ICS's financial position are:
    - Elective activity and recovery performance
    - Under-delivery of savings and efficiency plans
    - Inflation – pay and price
    - Ambulance handover delays
    - Demand and growth pressures

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality and Safety

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

APPENDIX: Our Themes

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Transformation Area Performance Dashboards and Exception Reporting

Improving Services & Delivering Outcomes

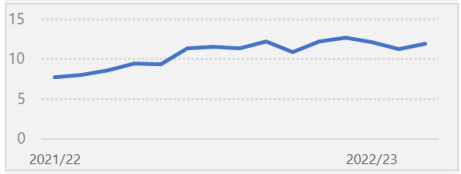
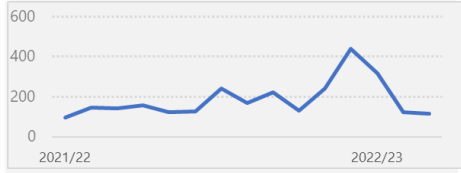
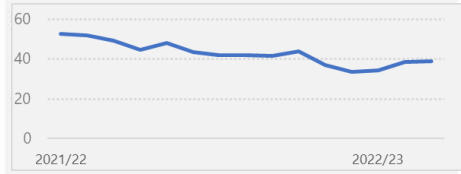
ICS Transformation Programme Area	Page(s)	Exceptions
Urgent and Emergency Care	7-13	ED Performance (Page 10) / Ambulance Response Times (Page 11), Ambulance Handover Delays (Page 12), Length of Stay (Page 13)
Planned Care / Elective Recovery	14-18	Elective Recovery – Outpatient Activity (Page 15), Elective Activity (Page 16) RTT (Page 18)
Cancer	19-21	Treatment within 62 days (Page 20)
Diagnostics	22-24	Endoscopy (Page 23), Echocardiography (Page 24)
Adult Mental Health	25-27	IAPT Access (Page 27)
Children's Mental Health	28-29	CYP Eating Disorders (Page 29)
Learning Disabilities and Autism	30-31	
Maternity and Neonatal	32-34	Continuity of Care (Page 34)
Primary Care	35-36	
Continuing Healthcare	37	
Community & Ageing Well	38	
Medicines Optimisation	39	
Personalised Care	40	
Diabetes	*To be included in future months*	
CVD/Circulatory	*To be included in future months*	
Respiratory	*To be included in future months*	
Enabling Active Communities & Individuals	*To be included in future months*	
Financial Improvement	See Finance section of report	
Workforce	See Workforce section of report	
Fit for the Future	N/A	
Estates	N/A	
Digital, Data and Technology	N/A	
Population Health Management	N/A	

Indicates exception reporting provided against the metric.

Please note that due to the timing of the report, all data shown in the summary dashboards contains the latest *validated* position. A verbal update will be made during the meeting where new published data has become available since the publication of this report.

Urgent & Emergency Care

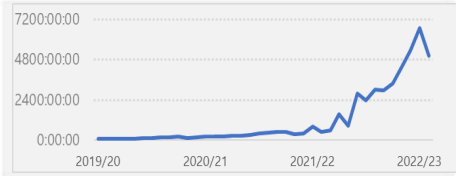
NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
S020a	Ambulance response times (Category 1) ★	Low	7 minutes	7 minutes	00:11:55 Gloucester ICS	00:12:38 Other SW ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of June 2022
S020b	Ambulance response times (Category 2) ★	Low	18 minutes	18 minutes	01:01:28 Gloucester ICS	01:07:23 Other SW ICS				End of June 2022
S020c	Ambulance response times (Category 3)	Low	120 minutes	120 minutes	02:55:37 Gloucester ICS	02:45:30 Other SW ICS				End of June 2022
S020d	Ambulance response times (Cateogry 4)	Low	180 minutes	180 minutes	01:54:06 Gloucester ICS	03:00:15 Other SW ICS				End of June 2022
X000x	Ambualnce Conveyance rates (% incidents conveyed)	Low			38.86 Gloucester ICS	33.74 Other SW ICS				End of June 2022

8.1

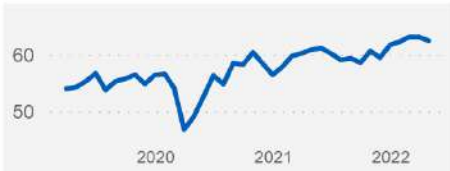
Urgent & Emergency Care

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Emergency Department Attendances (Type 1) ★	Low		12,685 (June)	12069 (June)	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of June 2022
X000x	A&E 4 Hours - % seen, treated and discharged/admitted within 4 hours of arrival to ED ★	High	95%	95%	59% (GHFT)	56.5% All ICS	58.8% All ICS				End of June 2022
X000x	Ambulance Handovers - Total resource time lost ★	Low			5056:45:28 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				01 May 2022

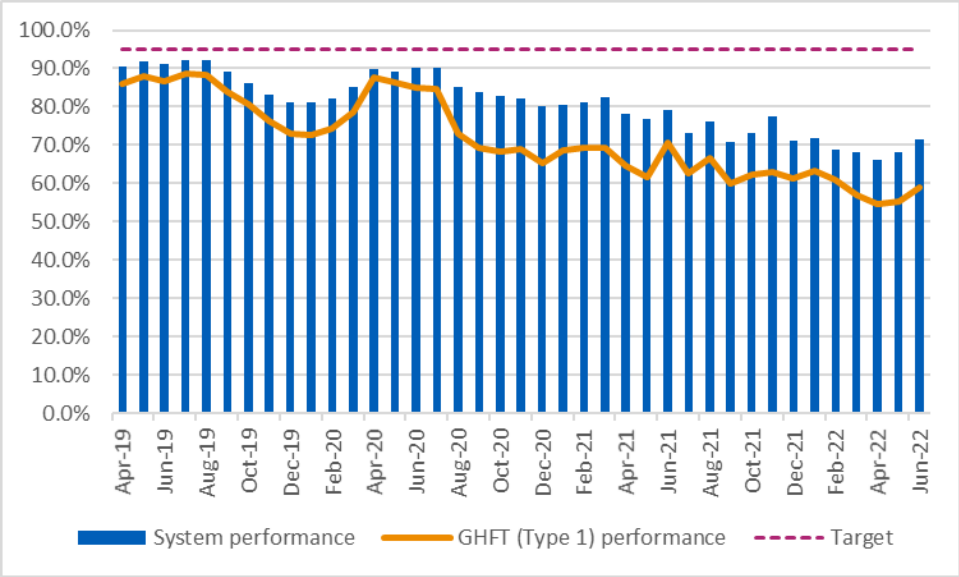
Urgent & Emergency Care

NHS Gloucestershire

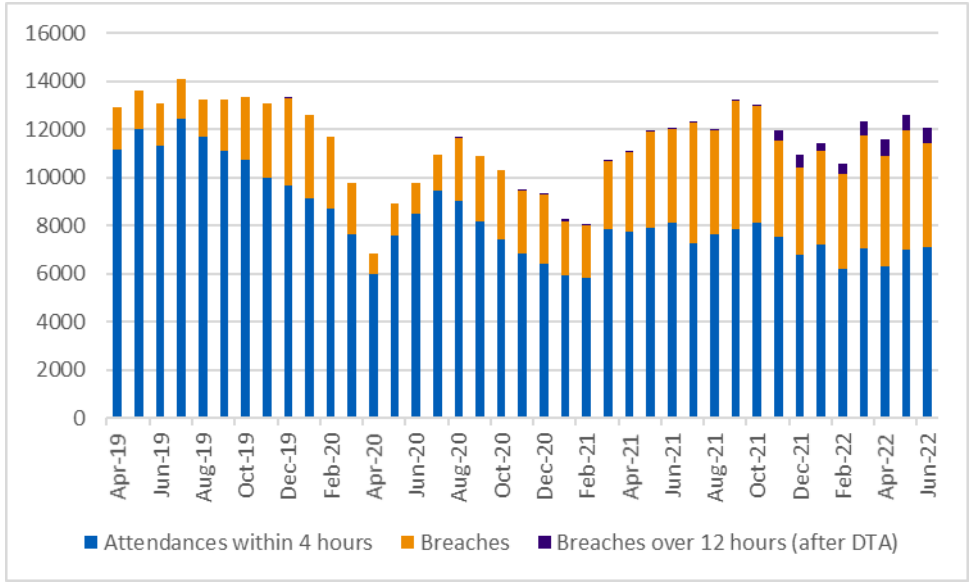
Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
S025a	% Zero Length of Stay Admissions	Low			62.43 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	Daily discharges as a & of those considered 'no longer meeting the criteria to reside'	High			0.00 Gloucester ICS	0.00 Average of Value	0.00 All ICS			*Snapshot NCTR data is available from GHFT – exploring how to consistently report a monthly average position*	
X000x	Number of people on pathway 0	High			0.00 Gloucester...	0.00 Other Sout...	0.00 All ICS			*Discharge pathway data under development*	
X000x	Number of people on pathway 1	Low			0.00 Gloucester...	0.00 Other Sout...	0.00 All ICS			*Discharge pathway data under development*	
X000x	Number of people on pathway 2	Low			0.00 Gloucester...	0.00 Other Sout...	0.00 All ICS			*Discharge pathway data under development*	
X000x	Number of people on pathway 3	Low			0.00 Gloucester...	0.00 Other Sout...	0.00 All ICS				

Urgent Care: Emergency Department

4 hour ED performance



ED activity and 4/12 hour breaches

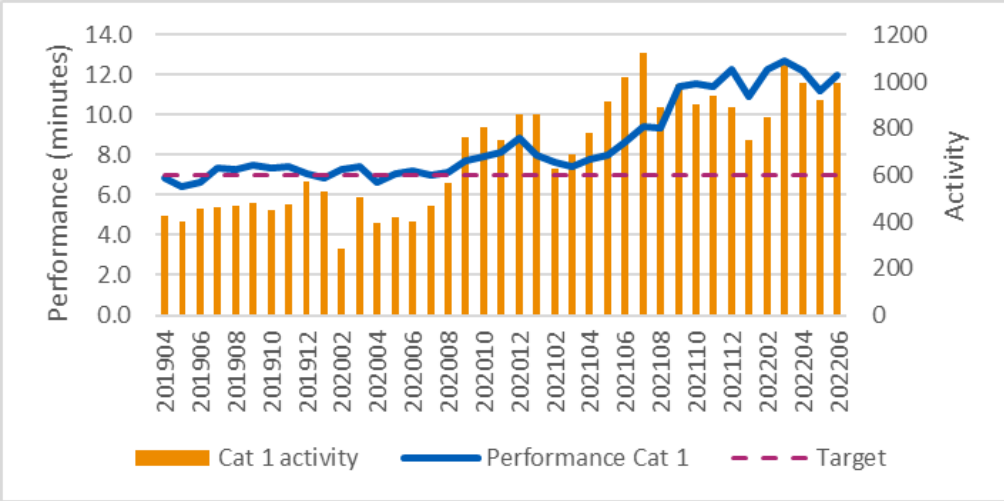


Urgent Care across the whole patient pathway is currently under pressure with declining performance against the 4 hour ED target, ambulance response times and increasing long waits for patients for admission. To address this the Sloman/System Wide Risk Mitigation Plan has been reviewed and strengthened by all system partners. The plan focuses upon delivering against 7 KPI's with provider specific urgent care actions supporting overall delivery of avoidance of ED attendance and admission, ensuring patients access the right service first time and improving hospital flow and patient discharge. ED attendances in June 2022 were slightly below the planned level (12,069 against a planned level of 12,685).

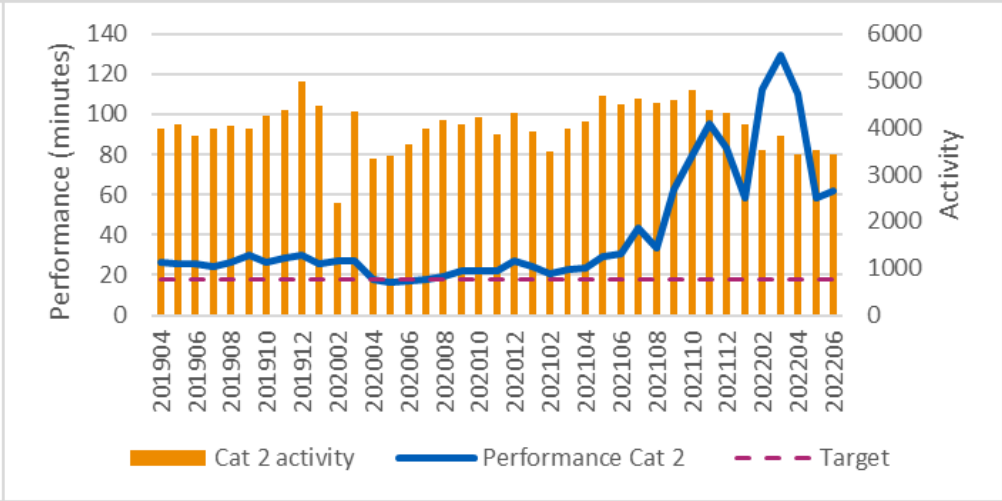
The key areas of focus are reduction in the number of patients not meeting the 'criteria to reside' in a hospital bed, to reduce Ambulance Handovers delays, to improve Ambulance Category 2 performance, reduce ED congestion and reduce long length of stay (LLOS). In addition the system has commissioned additional support through the Local Government Association peer review process and from the Newton Europe specialists in operational improvement (with a particular focus upon discharge and flow).

Urgent Care: Ambulance Response Times

Category 1 Response Times



Category 2 Response Times



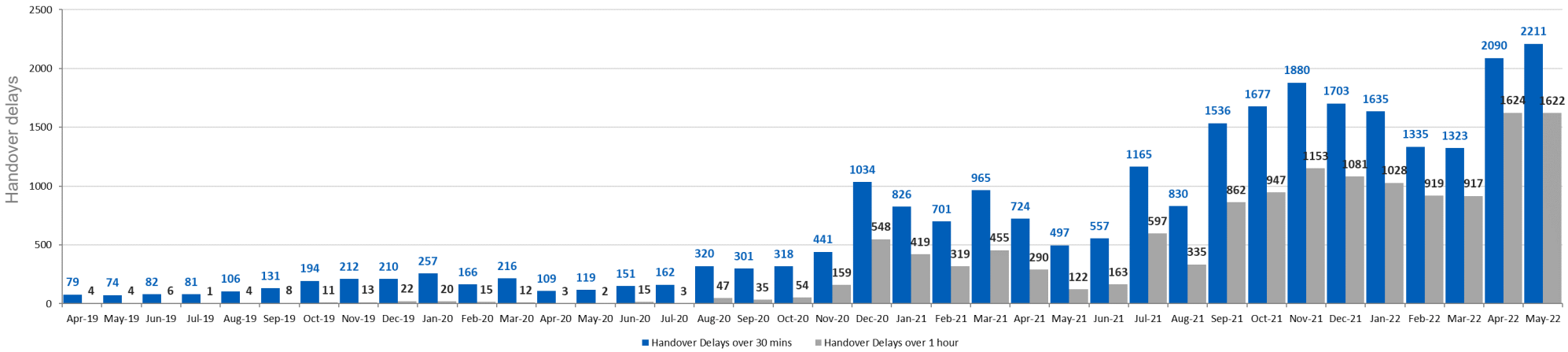
Ambulance response times continue to exceed the Category 1 and 2 targets (7 and 18 minutes respectively).

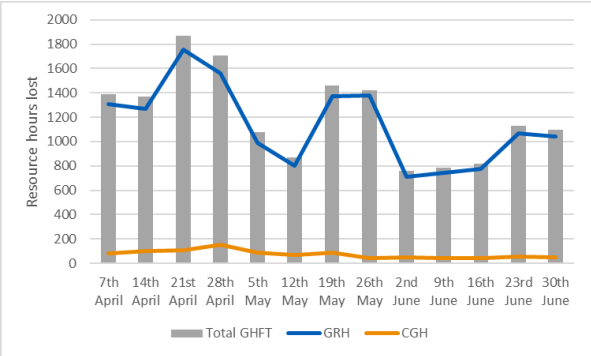
Category 1 incidents have increased significantly compared to the pre-COVID baseline predominantly due to reclassification of patient symptoms, however overall demand across Category 1 and 2 remains similar to the position pre-pandemic.

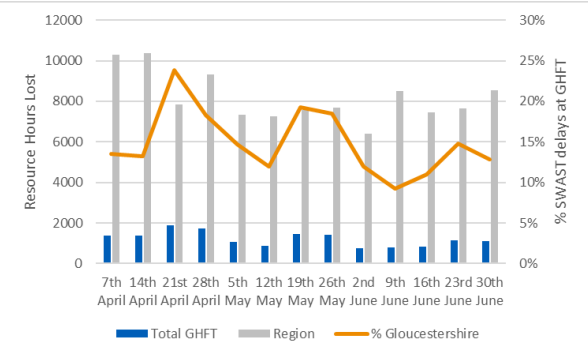
While conveyance rates have been significantly reduced through investment in clinical triage and support for Hear and Treat in SWAST, handover delays at acute sites are contributing to the longer response times.

Additional investment is under discussion with SWAST, including third party support to lower category calls (to free up SWAST crews to prioritise the most urgent calls) and to increase clinical assessment resources within their clinical hub.

Urgent Care: Ambulance Handover Delays







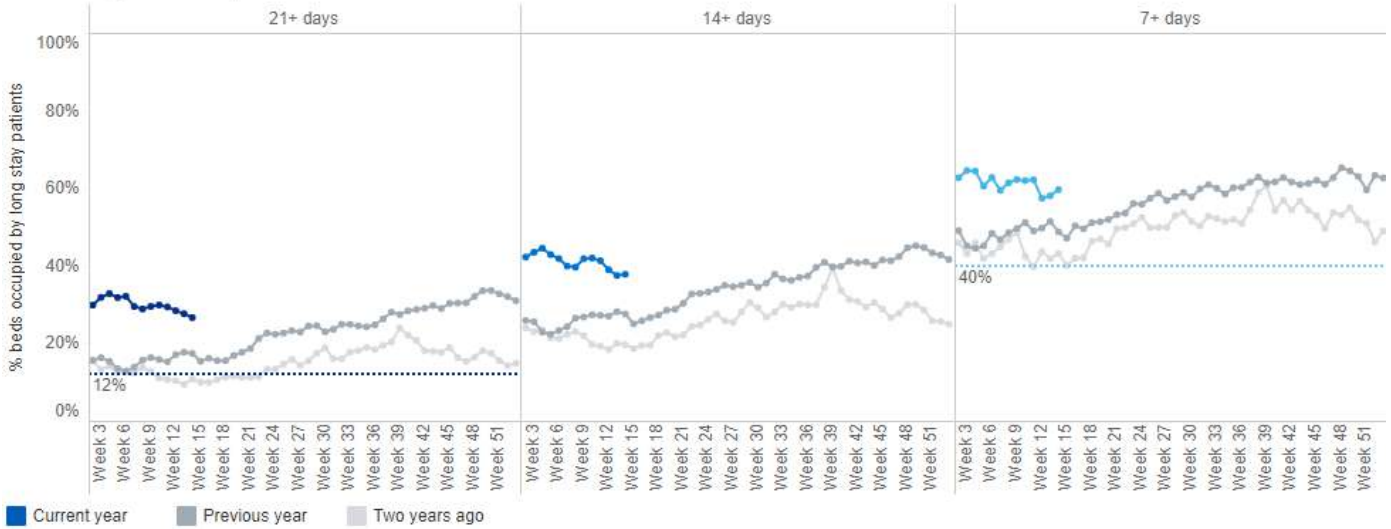
The volume of handover delays rose to the highest ever levels at the start of 2022/23, however since then, weekly analysis of resource time lost shows a steady reduction in total time lost at GHFT, and a lessening contribution of Gloucestershire to SWAST overall time lost.

Currently Gloucestershire delays account for 13% of total resource time lost, down from 24% at the end of April.

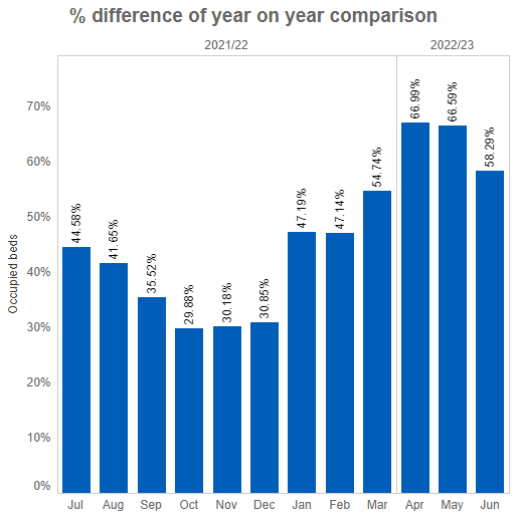
The action plan to reduce ambulance handover delays has been updated to include both a ‘front door’ and ‘back door’ flow focus aiming to increase the number of patients who bypass ED and go direct to rapid assessment areas, reduce falls conveyances, and reduce frailty related admissions.

Urgent Care: Length of Stay

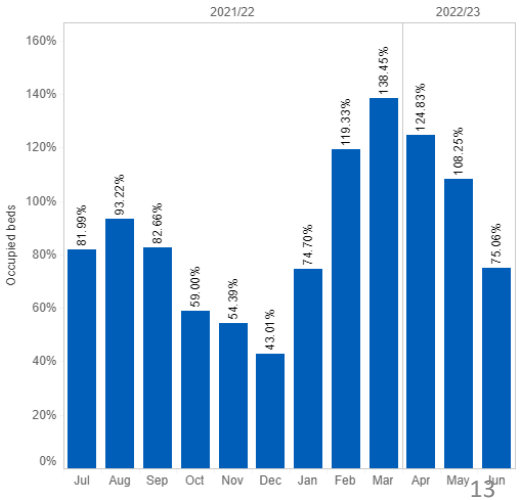
Beds occupied by long stay patients as a proportion of total occupied beds
Year on year comparison



National – 21 day comparison



GHFT – 21 day comparison



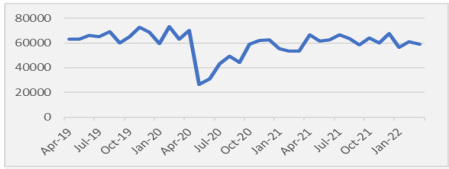
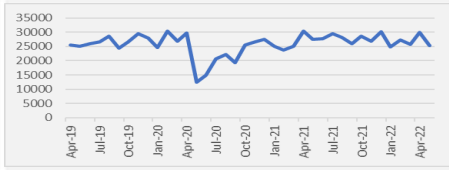
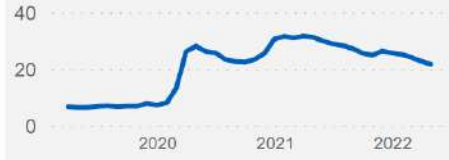
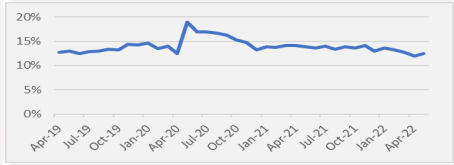
A systemwide daily check and challenge aims to focus on the most complex and long staying patients in acute and community hospitals; we have reduced the number of over 75 day NCTR at GHFT from 29 to 11 in the last 8 weeks and GHC now only have 4 patients with a greater than 75 day NCTR length of stay (LOS), enabling a reduction in the benchmark to over 50 day NCTR patients in hospital.

Numbers of GHFT “no criteria to reside” (NCTR) patients have decreased from a peak of 284 in February 2022 to 206 as of the 7th July. The increase in COVID transmission is likely to contribute to a more challenging flow situation in the coming weeks however.

Patients with an over 21 day total length of stay continue to decrease steadily- now at 215 at GHFT. The focus on improved ward round, board round and weekend planning are supporting this programme of work and aiming to reduce length of stay earlier in the patient pathway.

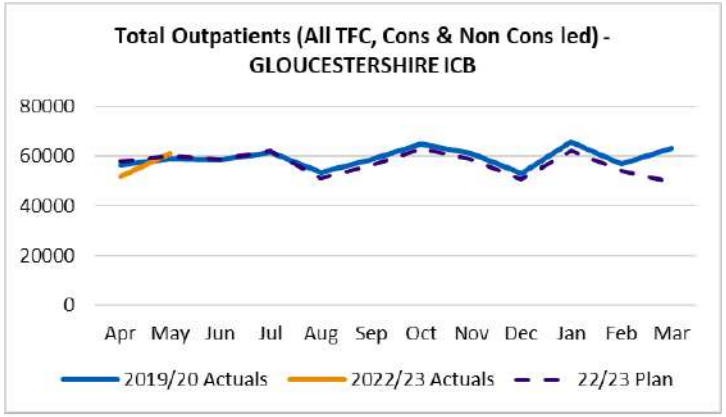
Planned Care & Elective Recovery

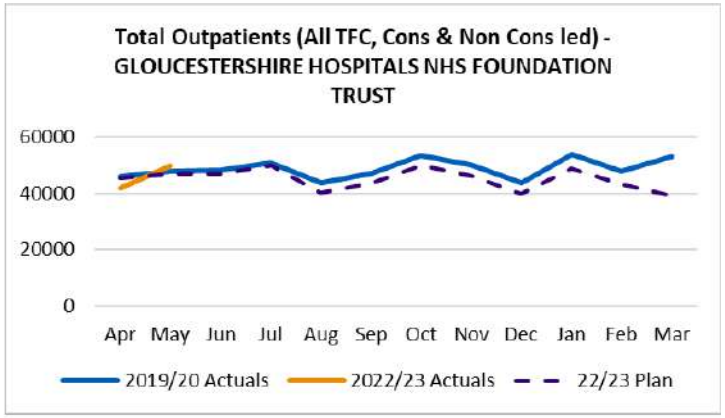
NHS Gloucestershire

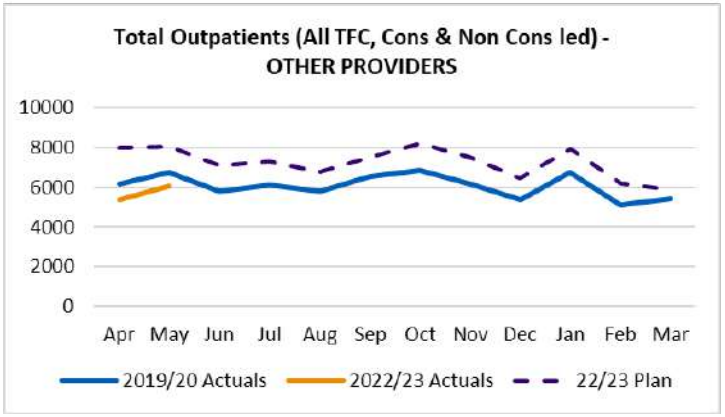
Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Elective activity - Recovery (% activity vs 19/20 baseline) ★	High	110%		90.4% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	Elective activity - ERF (% weighted cost activity vs 19/20 baseline)	High	104%		89.83 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	Consultant-led Follow Up Outpatient Appointments	High			30215 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	Virtual Outpatient Appointments - % of outpatient activity which is virtual/telephone	High	25%		21.80 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	PIFU - % all outpatient appointments moved or discharged to PIFU (Patient initiated follow up)	Low	8%		12% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022

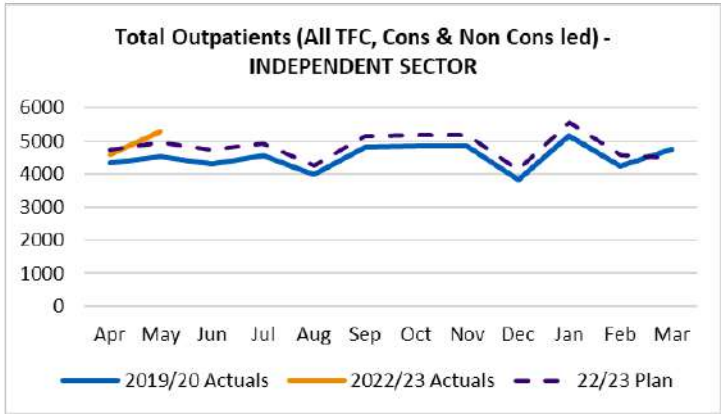
8.1

Planned Care: Elective Recovery - Outpatients









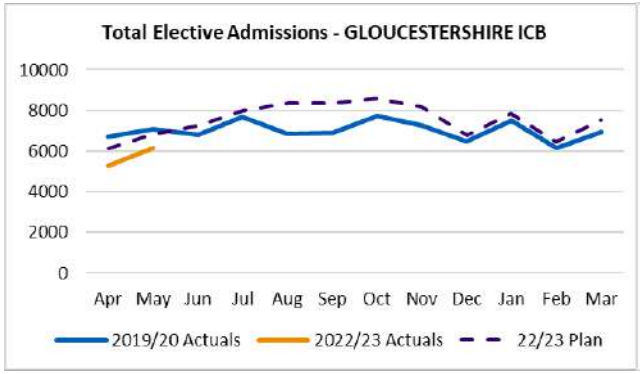
Overall outpatient recovery has improved to move above the proposed activity plan, with around 85% of activity for Gloucestershire taking place at GHFT (which in May exceeded both the May 2019 and planned activity position).

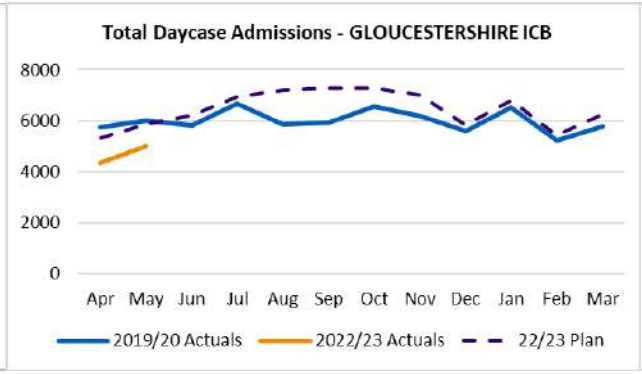
Activity at other NHS providers (Out of County) remains 20% below the activity planned for 2022/23 in May reflecting the challenge to elective recovery seen across the South West in particular.

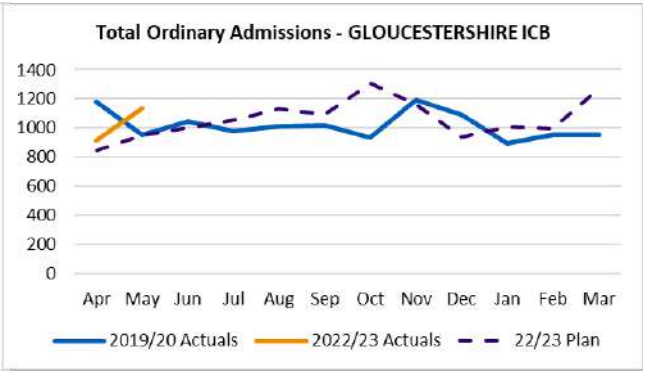
Plans in place to recover activity levels in the remainder of the year.

Overall outpatient activity carried out virtually, and total use of advice and guidance across the system is below the current planned level, though remains higher than the pre-pandemic baseline and will support a more agile approach to consultant led treatment.

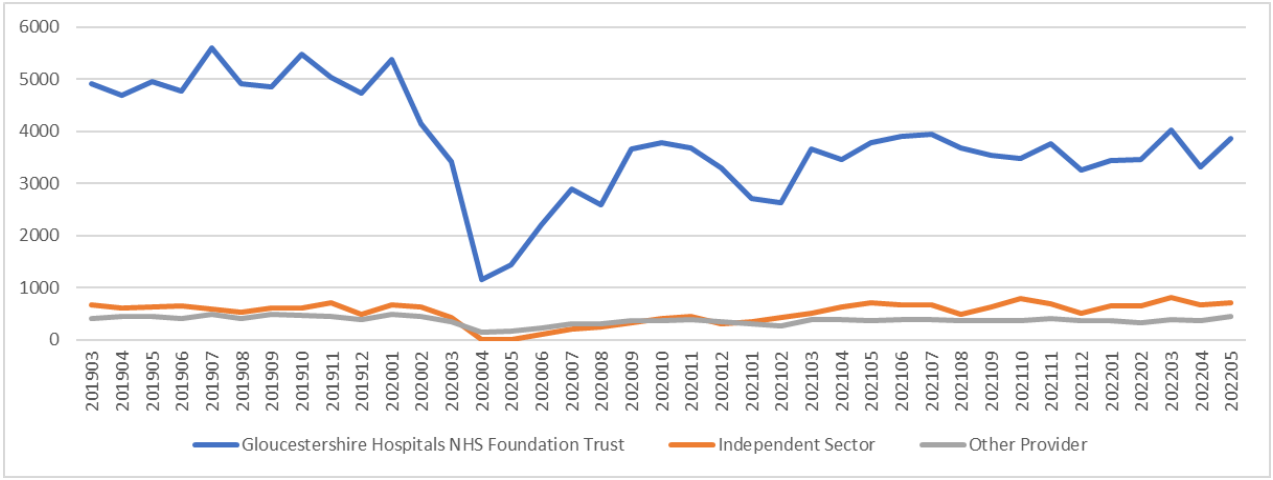
Planned Care: Elective Recovery - Admissions







Day Cases - Activity



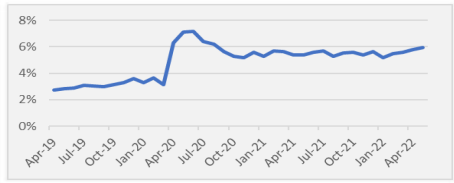
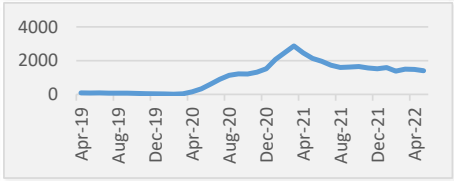
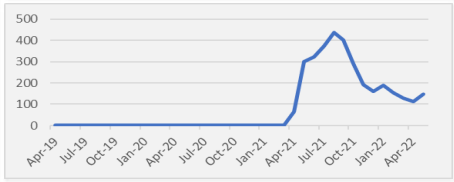
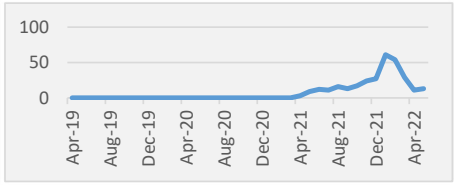
Elective admission activity is failing to meet the overall recovery target despite strong performance in inpatient admissions.

Day Cases at GHFT are driving this, with Gastroenterology and Upper GI Surgery specialties both seeing significantly lower activity than their pre-pandemic baseline (Gastroenterology seeing a larger drop and a smaller recovery, partly due to the capital build – see Diagnostic exception report).

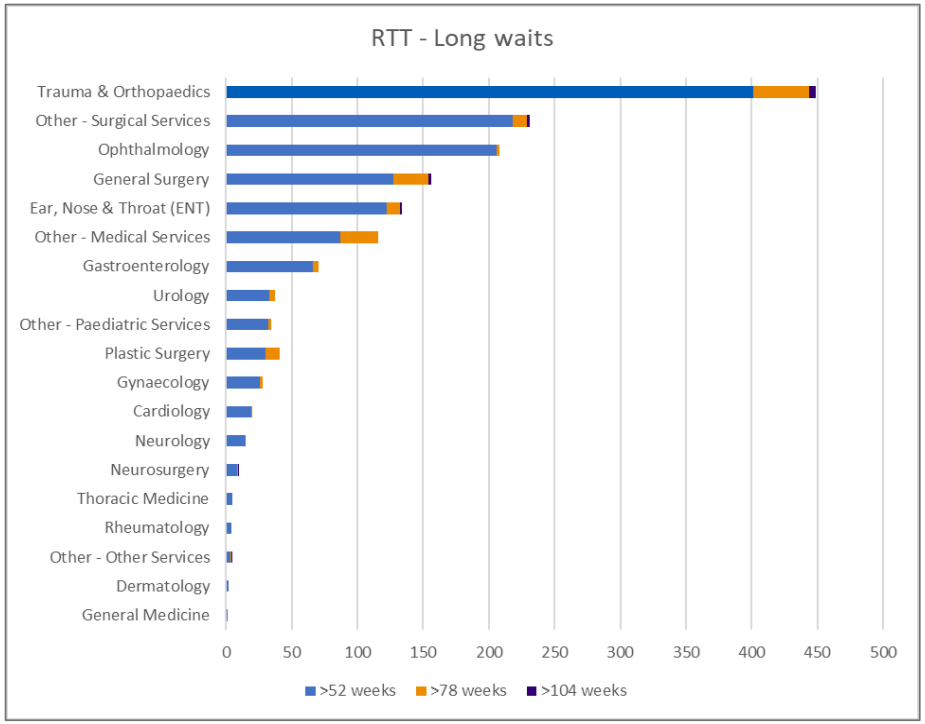
Additional day case lists are taking place across the remainder of the year including evening and weekend lists.

Planned Care & Elective Recovery - RTT & A&G

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
S016a	A&G - Rate of patients revieving Adivce and Guidance	High		16%	6% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	RTT (18 week) - % waiting list waiting under 18 weeks	High	92%		73.4% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
S009a	RTT (52 week waits) - Number of patients on RTT list >52 weeks	Low	0		1405 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	RTT (78 week waits) - Number of patients on RTT list >78 weeks	Low	0		148 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	RTT (104 week waits) - Number of patients on RTT list >104 weeks	Low	0		13 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022

Planned Care: RTT *(Data to May 2022)*



Overall RTT performance remains stable both at GHFT and OOC. RTT waiting list numbers have increased to 59,456 in May 2022 (2.1% increase on April levels), however the number of patients waiting over 18 weeks has reduced by 553 (3.4% decrease on April levels).

Very long waits have increased slightly with OOC providers currently having 103 patients waiting over 78 weeks (including 13 over 104 week waits). GHFT currently have 58 patients waiting over 78 weeks. GHFT continue to have 0 over 104 week RTT waits, fully meeting the national standard.

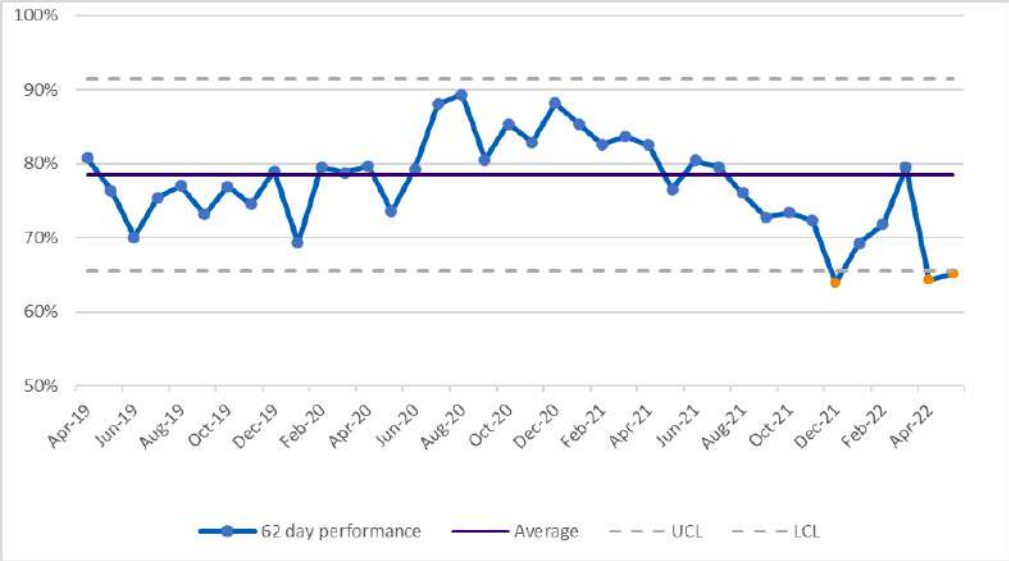
Additional capacity across the independent sector is supporting clearance of backlogs for particular conditions (such as hernias) and the patient access support service has been contacting patients to validate and escalate patients whose conditions have deteriorated. Equipment to assist primary care in requesting advice and guidance (such as dermascopes) and potentially avoiding the need for consultant referrals has also been delivered and continued work on outpatient efficiency and Cinapsis eRS will support timely access to specialist support and treatment.

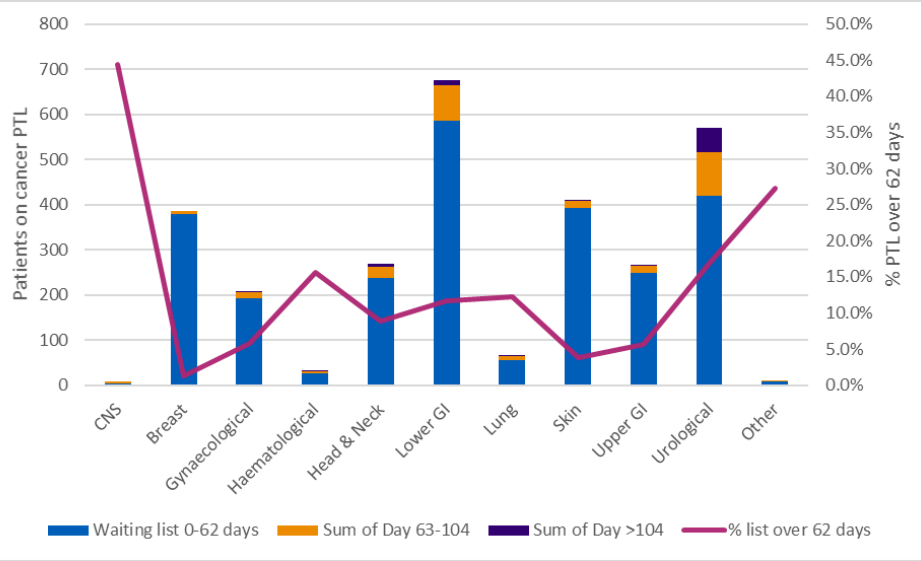
Cancer Performance

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)		Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	2 Week Wait - % patients seen or STT within 2 weeks of referral	High	93%		93.31 Gloucester...	0.00 Other Sout...	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	28 day Faster Diagnosis - % patients recieving diagnosis or all clear within 28 days of referal	High	75%		80.63 Gloucester...	0.00 Other Sout...	0.00 All ICS				End of May 2022
X000x	31 day Treatment - activity	High			370.00 Gloucester...	0.00 Other Sout...	0.00 All ICS				End of May 2022
X000x	31 day Treatment - % patients recieving treatment within 31 days of DTT	High	96%		95.41 Gloucester...	0.00 Other Sout...	0.00 All ICS				End of May 2022
S011a	62 day Treatment - patient waiting list number beyond 62 days ★	Low			69.00 Gloucester...	0.00 Other Sout...	0.00 All ICS				End of May 2022
X000x	62 day Treatment - % patients recieving treatment within 62 days of referral ★	High	85%		68.06 Gloucester...	0.00 Other Sout...	0.00 All ICS				End of May 2022

Cancer: 62 days performance





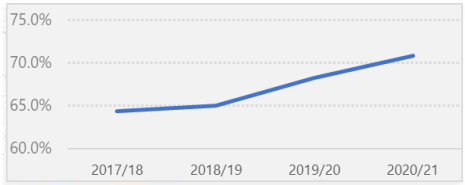
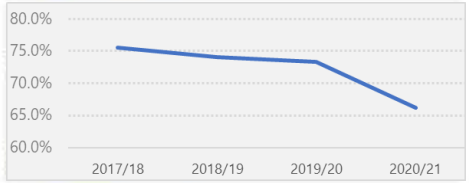
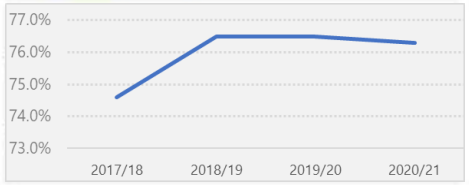
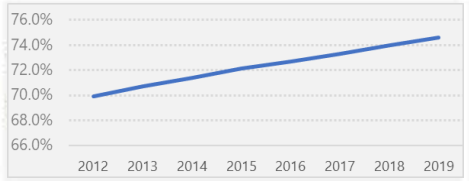
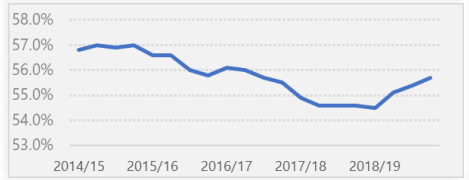
62 day performance averaged 74.9% patients treated within 62 days from referral during 2021/22, however from June 2021 there has been a significant downward trend in overall performance. This is partly due to treating long waiters in specialties where capacity has been challenged (e.g. in gynaecology and urology – where additional recruitment has now taken place).

Performance at the start of the 2022/23 financial year has dropped compared to the pre-COVID baseline, with treatment volumes in April also seeing a dip, possibly driven by capacity across a number of specialties and the Easter holiday period. Activity has recovered in May however the current backlog of patients waiting over 62 days for treatment has also increased significantly with the latest snapshot position (June 2022) showing 332 patients waiting against a local target of 221 (note that not all of these patients will receive a cancer diagnosis/ require treatment).

A performance recovery plan at GHFT is in place. In particular the increased endoscopy capacity, removal of some infection control measures introduced during the COVID-19 pandemic and additional clinical staffing across a number of specialties will help to drive performance improvements in the coming months.

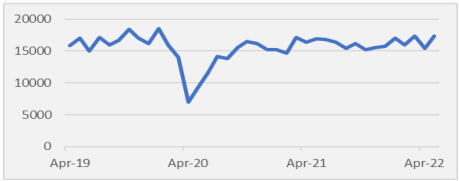
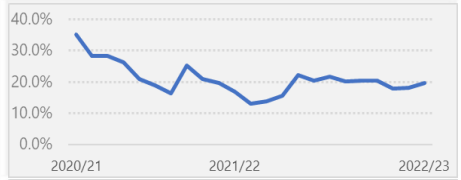
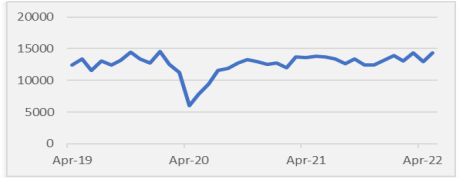
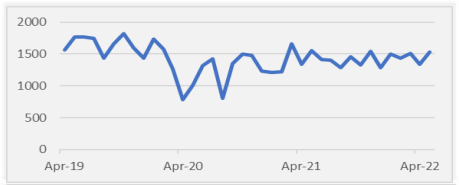
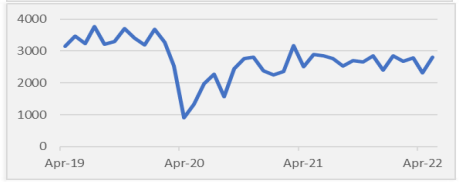
Cancer

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
S048a	Cancer Screening (Bowel) - % eligible population screened	High	>60%		70.9% Gloucester ICS	0.00 Other South West ICS	66.8% All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		2020
S049a	Cancer Screening (Breast) - % eligible population screened	High	>80%		66.2% Gloucester ICS	251.82 Other South West ICS	61.3% All ICS				2020
S050a	Cancer Screening (Cervical) - % eligible population screened	High	>80%		76.3% Gloucester ICS	0.00 Other South West ICS	69.1% All ICS				2020
S014a	Early Diagnosis - % patients surviving for at least 1 year following diagnosis	High			73.9% Gloucester ICS	0.00 Other South West ICS	74.6% All ICS				2019
s015a	Survival - % cancers diagnosed at stage 1/2	High	75%		55.7% Gloucester SWAG	0.00 Other South West ICS	54.5% All ICS				Q4 2018/19

Diagnostics

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Latest Performance (worse than)	Quartile (Q1 = High Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Activity - % activity vs 19/20 baseline	High	120%		101.7% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	Waiting Times - % patients waiting more than 6 weeks for diagnostic test ★	Low	<1%		19.1% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
S013a	Diagnostic Activity Levels - imaging	High			107.4% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
S013b	Diagnostic Activity Levels - physiological measurement	High			87.1% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
S013c	Diagnostic Activity Levels - endoscopy ★	High			81.1% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022

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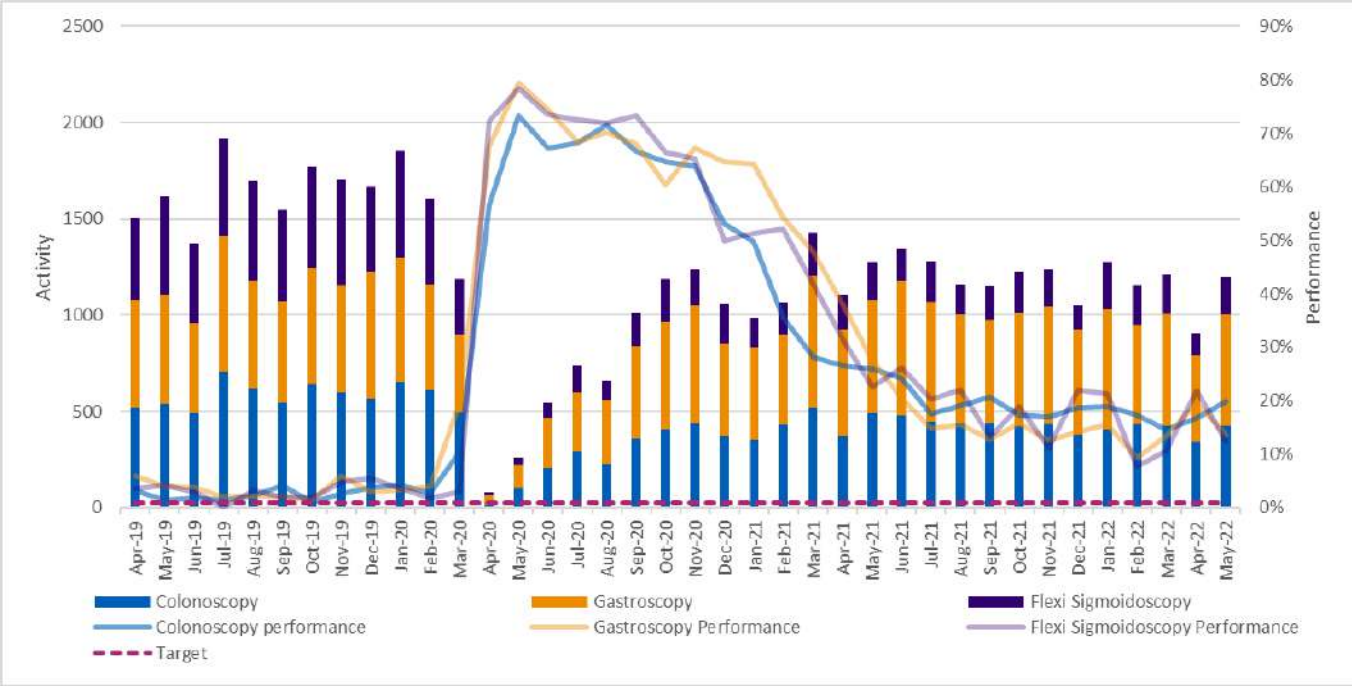
Diagnostics: Endoscopy



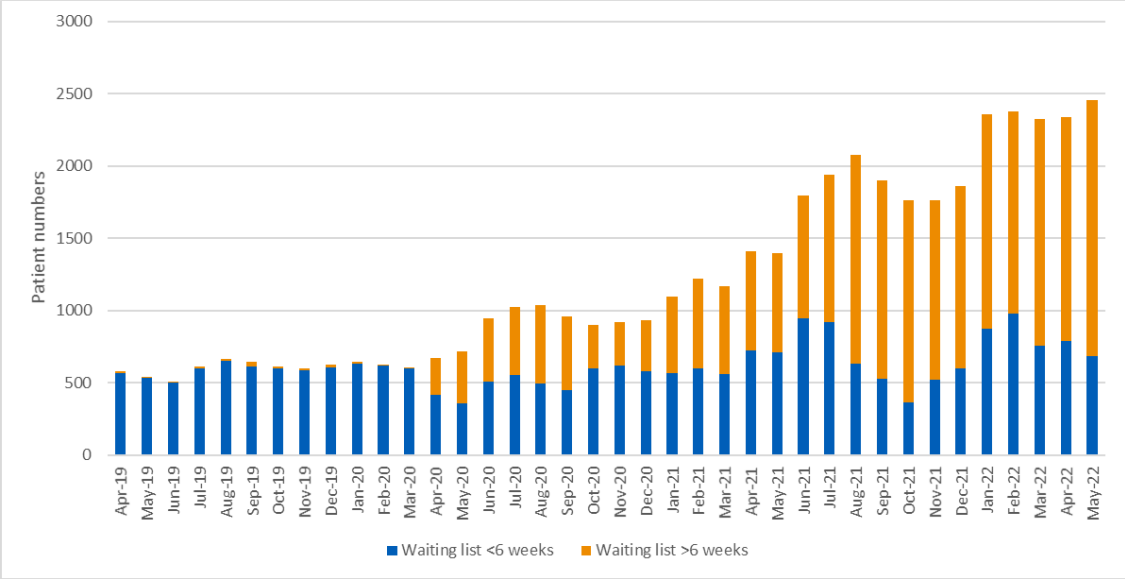
Activity for all endoscopy tests dropped dramatically during the COVID-19 pandemic with both a reduction in demand and capacity in theatres. Due to long standing infection control measures and continued capacity pressure activity has struggled to return to pre-COVID baselines.

A new training theatre for endoscopy was delayed, with space also under pressure while this building work was carried out, so now this is complete should begin to positively impact on performance and reduction of the waiting list in the coming months. Changes in the pathway for some specialties has led to an overall reduction in demand for colonoscopy and, in particular, flexi sigmoidoscopy (such as enhanced use of FIT testing for patients presenting with bowel symptoms).

Overall activity in endoscopy has returned to 74.4% of the 2019/20 level in May 2022, however this reflects a 78.4% recovery in colonoscopy, 101.7% recovery in gastroscopy and a 38.7% recovery in flexi sigmoidoscopy.

Despite having the lowest recovery, the backlog for flex sigmoidoscopy is lower than the other endoscopic tests, implying that the demand has shifted significantly from this pathway.

Diagnostics: Echocardiography

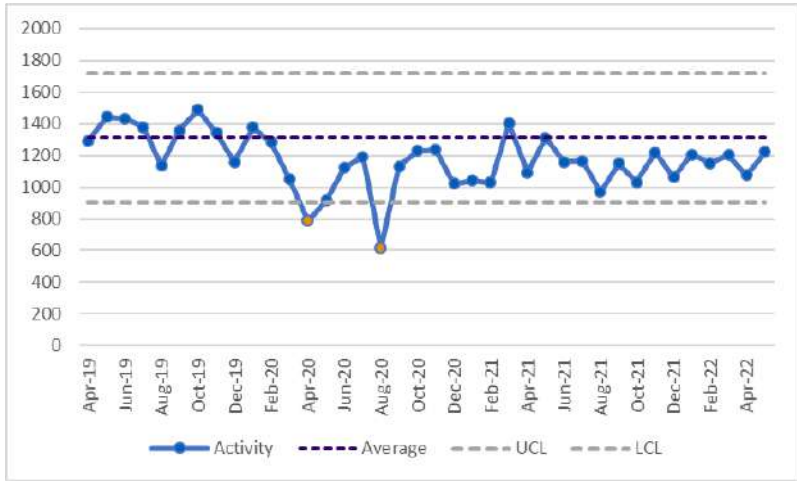


Referrals for echocardiography have remained relatively stable with the number of patients on the waiting list for less than 6 weeks remaining relatively consistent over the last 3 years.

Activity dropped significantly during the COVID-19 pandemic and remains significantly below the pre-COVID baseline average, which has caused a large increase in long waits. Clinical triage has been carried out to ensure delays are not affecting patient safety.

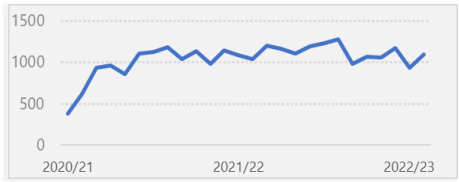
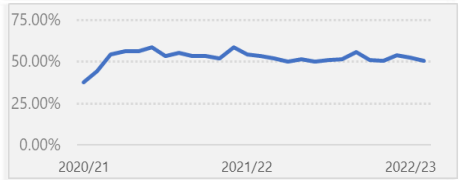
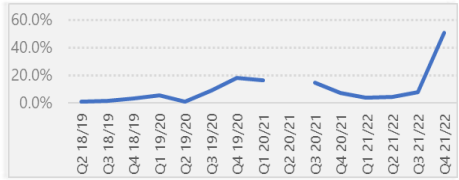
Staffing for echocardiography has been challenging, with vacancies in the service, and resource unable to meet the demand across both the acute hospital and community service (which are run from the same resource).

While GHFT is meeting it's current local activity trajectory, this is below the 19/20 activity levels. A plan to bring down the waiting time and ensure a robust service provision is being worked up by GHFT in conjunction with ICS partners, and additional independent sector provision is being investigated to assist with backlog clearance.



Mental Health - Adults

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
s081a	IAPT Access - number of patients accessing IAPT in year ★	High		14,573	13489 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		Year to end of May 2022
s082a	IAPT Recovery - % patients entering recovery following IAPT	High	>50%	>50%	50.5% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	SMI Physical Health Checks - % SMI register recieving/declining full health check	High	>60%	>60%	50.8% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				Q4 2021/22
X000x	Psychosis Treatment - % patients commencing treatment within 2 weeks of referral	High	>60%		0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Exploring local datasets for this indicator*	
X000x	Access to IPS - number of patients accessing service	High		468	0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Exploring local datasets for this indicator*	

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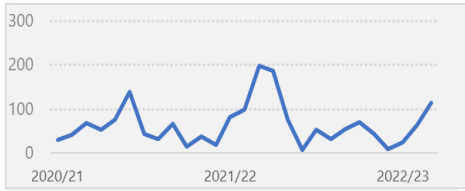
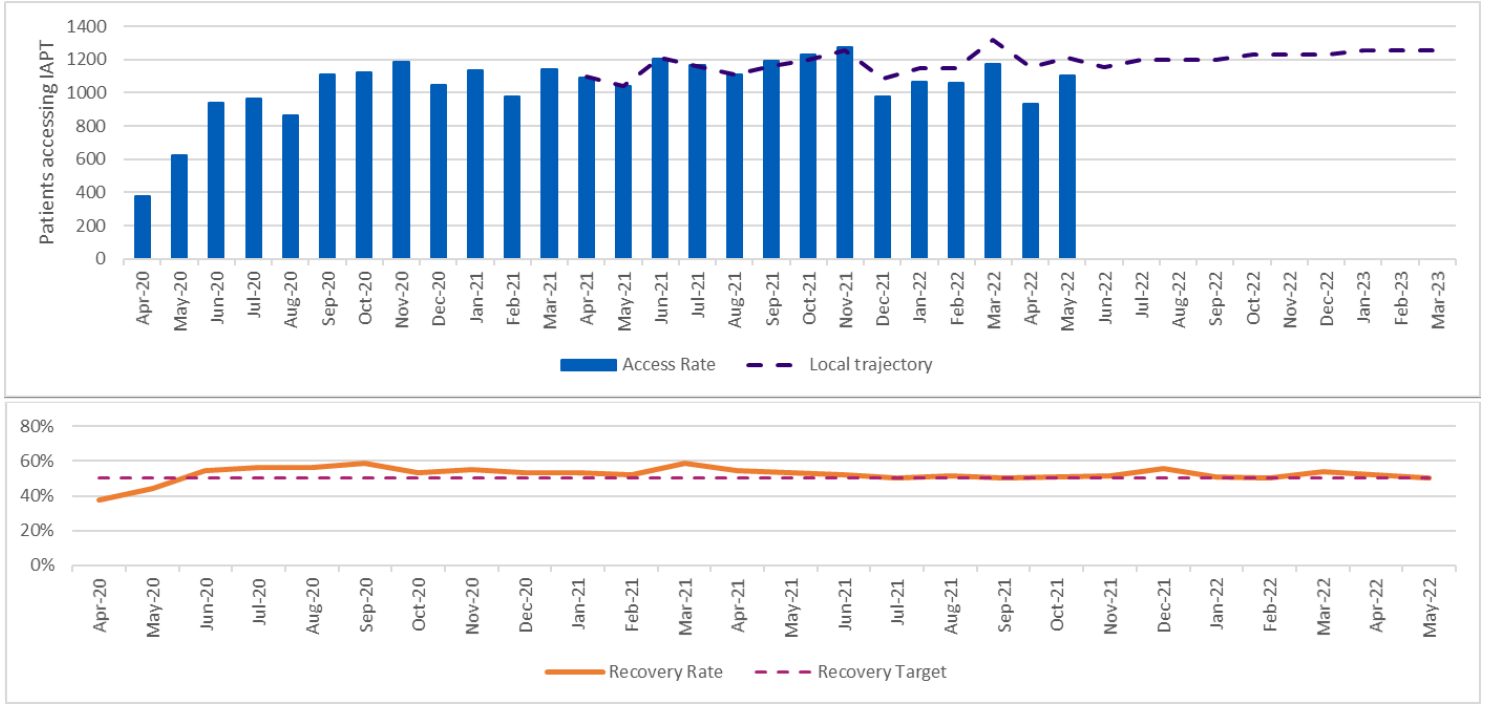
8.1

Mental Health - Adults

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000x	Inpatient Follow Up - % patients recieving follow up within 72 hours of discharge	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*Exploring local datasets for this indicator*	
s086a/b	Out of Area Placement Bed Days - inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Low	0	200 / quarter	203 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				Q1 2022/23
X000x	Access to Core Community Mental Health Services - number of patients accessing service	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Exploring local datasets for this indicator*	

Mental Health: IAPT access

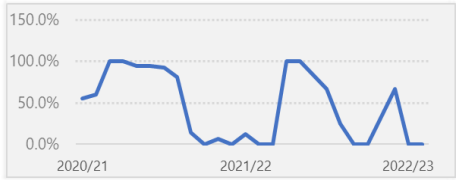
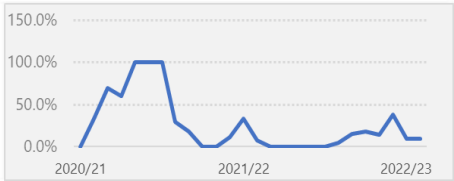


GHC have been working to meet the locally agreed IAPT access target, following a substantial reduction in patients accessing IAPT at the start of the COVID-19 pandemic. Demand has now returned to the pre-COVID position, however significant workforce issues are constraining the service's ability to increase access without then leading to a reduction in the currently well performing recovery rates.

2022/23 planning commitments reflect this balance, with an overall target of 14,573 patients to access the service in the year. Workforce recruitment is ongoing however in a challenging market – with high demand for psychological therapy practitioners in private healthcare provision as well as across all areas of the country.

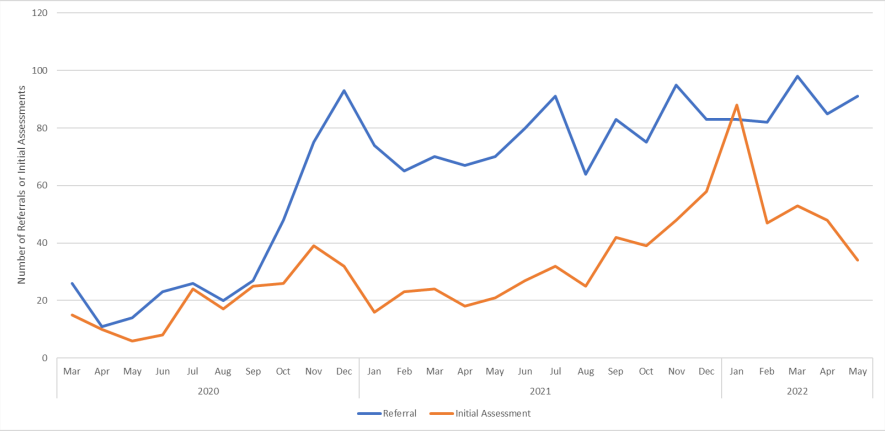
Mental Health - Children & Young People

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	CYP Eating Disorder (Urgent) - % patients recieving treatment within 1 week of referral ★	High	>95%		9.1% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	CYP Eating Disorder (Routine) - % patients recieving treatment within 4 weeks of referral ★	High	>95%		0% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	CYP Mental Health Access - number of CYP accessing services	High		4172	0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*CYP access data to follow – to encompass all providers for Gloucestershire*	
X000x	CYP Mental Health Waiting Times - % CYP recieving first contact within 4 weeks	High	>95%		0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*CYP access data to follow – to encompass all providers for Gloucestershire*	

CYP: Eating Disorders

CYP: Eating Disorders Referrals and Activity

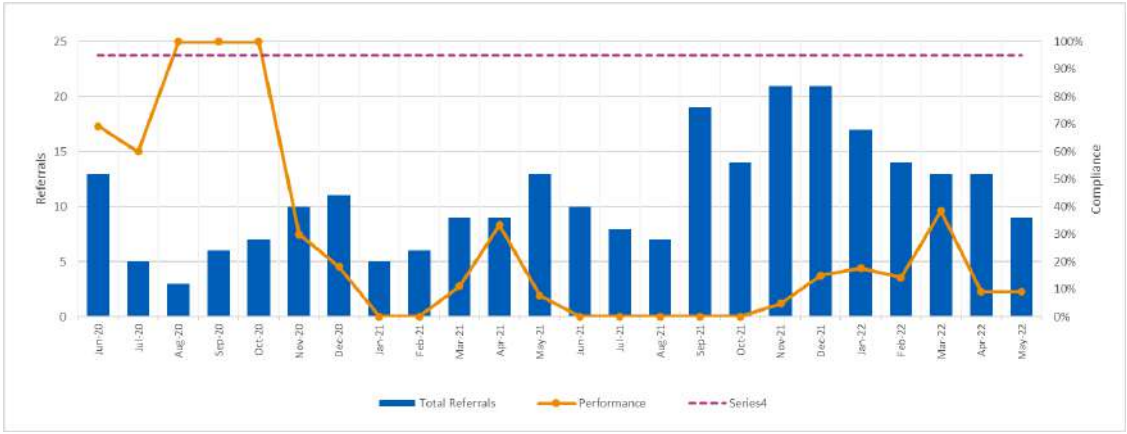


During the COVID-19 pandemic, referrals increased significantly to the eating disorders service – in particular urgent referrals. Activity across the whole service has increased but below the pace of referral increases, leading to the deterioration in performance seen.

The ED service has been increasing recruitment and has developed a local trajectory aiming to recover performance throughout 2022/23 and has currently closed referrals to the routine service to ensure urgent referrals can be treated as quickly as possible.

Additional support for patients on the waiting list for services has been commissioned from the Beat Eating Disorder charity.

Urgent Referrals and Performance to Treatment target (1 week)



Routine Referrals and Performance to Treatment target (4 weeks)

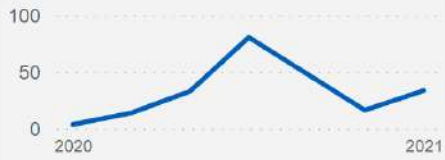
LD & Autism - Inpatient

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance (worse than)	Latest Performance (worse than)	Quartile (Q1 = High Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Learning Disability Inaptient rate per million ONS Resident Population (care commissioned by ICSs)	Low		7.98	11.97 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*Snapshot of current inpatient numbers provided – trend data to follow*	
X000x	Learning Disability Inaptient rate per million ONS Resident Population (care commissioned by NHSE)	Low		19.95	29.93 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Snapshot of current inpatient numbers provided – trend data to follow*	
X000x	CYP - Learning Disability Inaptient rate per million ONS Resident Population (care commissioned by NHSE for children & young people)	Low		7.87	0 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Snapshot of current inpatient numbers provided – trend data to follow*	

LD & Autism

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
S030a	Learning Disability Registers & Annual Health Checks Delivered by GPs - % LD register over 14 recieving an annual health check	High	75%		33.50 Gloucester ICS	38.65 Other South West ICS	40.50 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		Q2 2021/ 22
X000x	LeDeR	Low			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Developing local reporting data flow and metrics*	
X000x	Autism Diagnosis Waiting Times - % patients waiting more than 18 weeks	Low			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*National data published as experimental statistics – exploring a local data flow*	

National LD healthcheck data via SOF monitoring data shown which has discrepancies with local data (shows a higher performance figure – 79.8% for 2021/22). Under development to use local data for future reports.

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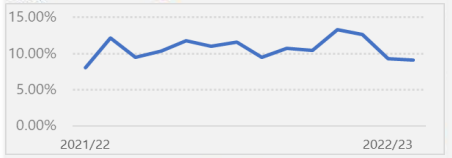
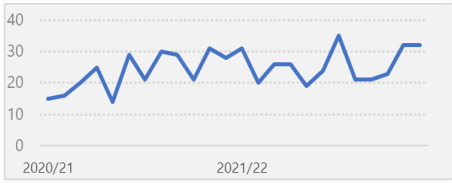
8.1

Maternity

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Perinatal Access - % pregnant women accessing perinatal mental health service	High			32 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
S021a	Continuity of Care Pathway - % of women on CoC pathway	High	51%	35%	9.15 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of May 2022
X000x	Smoking in Pregnancy - % SATOD	Low		8%	11.51% Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				Q4 2021/22
X000x	Smoking Cessation Services - proportion of acute/maternity inpatient settings offering smoking cessation services	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				

Query – to be included in future reports

N.B National maternity data quality under review – these figures may not match locally reported GHFT data

Maternity

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Pre-term Birth Clinic - % women who are expected to give birth at <27 weeks gestation who are able to do so in a hospital with appropriate on-site neonatal care	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*Query – this measure is a regional measure, may be removed*	
S022a	Stillbirth rate per 1000 births	Low		2.52	0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of March 2022
S023a	Neonatal mortality rate per 1000 births	Low		0.89	0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS				End of March 2022
X000x	Brain Injury Rate per 1000 births	Low		3.72	0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*N.B National maternity data quality under review – these figures may not match locally reported GHFT data*	End of March 2022

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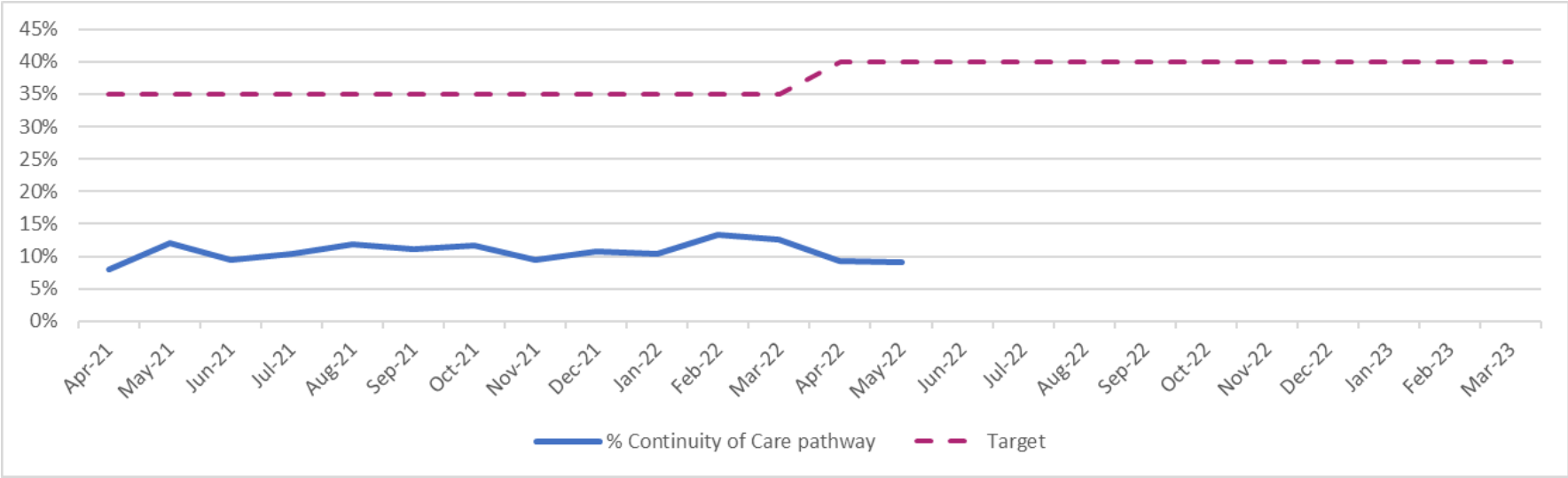
Maternity: Continuity of Care



The national ambition is for Maternal Continuity of Carer (MCoC) to be the default position for maternity care (delivered by team of midwives across antenatal, intrapartum and postnatal care). Recognising the shift in ways of working, this ambition has a national target of 51% set to be delivered by 2024/25, with stepped increases in provision annually. While implementing the pathway, systems have been urged to prioritise those women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway.

The COVID-19 pandemic, and long term staffing challenges has led to delays in scaling up the MCoC pathway, with 2 teams currently active and a third suspended (due to be relaunched in September 2022).

The national Maternity Transformation team are very clear that adequate staffing must be in place prior to roll out of further teams. A further 5 teams are planned to be launched by March 2023. It is therefore anticipated that the current performance, which has remained stable at around 10% since April 2021, will increase over the next 2 years.

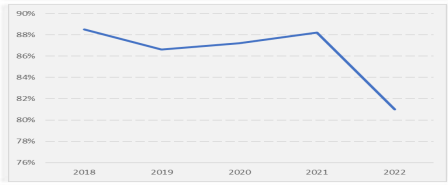
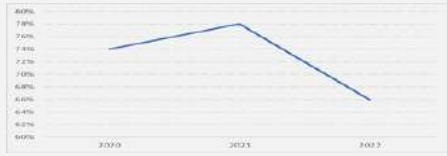
Primary Care

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Primary Care Activity - number of appointments in GP (average per month)	High			173,490 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		End of May 2022
X000x	Digital Access - proportion of population with access to online GP consultations per 100,000 population	High			1,487 Gloucester ICS	2,143 Other South West ICS	1,564 All ICS				Q4 2021/ 22

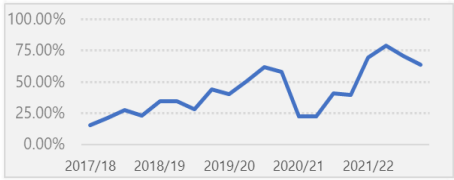
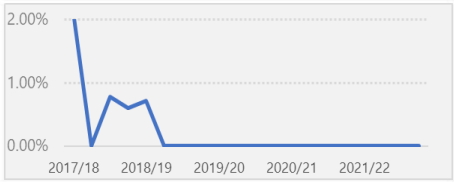
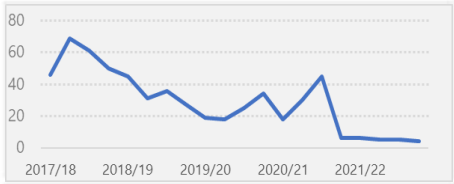
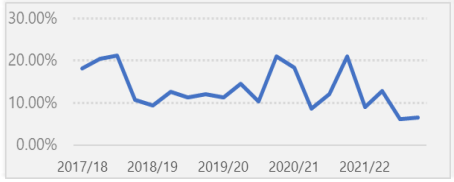
Primary Care

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Increase in Recruitment in Primary Care via ARRS Scheme Aginst Workforce Plans	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*May move to workforce section in future*	
X000x	Recruit & Retain Doctors in General Practice	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*May move to workforce section in future*	
X000x	Impact & Investment Fund (IIF) Indicator Performance	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Indicator under development*	
X000x	Increase the Number of Patients that Rate their GP Practice as 'good'	High			81% Gloucester ICS	0.00 Other South West ICS	72% All ICS				2022
X000x	Increase the Number of Patients that rate their experience of making an appointment as "good"	High			66% Gloucester ICS	0.00 Other South West ICS	56% All ICS				2022

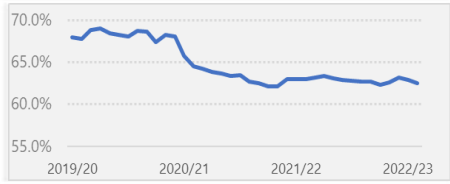
Continuing Healthcare

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance (better than)	Latest Performance	Latest Performance (worse than)	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	Referral Completion - % referrals completed within 28 days of referral	High	80%		63.58 Gloucester ICS	0.00 Other South West ICS	73.91 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development		Q4 2021/22
X000x	Place of Assessment - % assessments in hospital	Low			0.00 Gloucester ICS	0.00 Other South West ICS	0.55 All ICS				Q4 2021/22
X000x	Long Waits - number of cases waiting >12 weeks	Low			4 Gloucester ICS	0.00 Other South West ICS	448 All ICS				Q4 2021/22
X000x	Conversion Rate - % referrals converted to CHC	Low			6.60 Gloucester ICS	0.00 Other South West ICS	16.98 All ICS				Q4 2021/22

Community Care & Ageing Well *(under development)*

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance: better than	Latest Performance: worse than	Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
X000a	2 Hour Community UCR Contacts - % cases recieving a response within 2 hours	High			0.00 Gloucester ICS	0.00 Other South West ICS; 0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*Data quality to be resolved – measure to be included in future reports*	
X000x	Measures being developed for Falls and Frailty admissions	High			0.00 Gloucester ICS	0.00 Other South West ICS; 0.00 All ICS			*Defining additional metrics for the Ageing Well programme*	
X000x		High			0.00 Gloucester ICS	0.00 Other South West ICS; 0.00 All ICS			*Defining additional metrics for the Ageing Well programme*	
s083a	Dementia Diagnosis - % estimated elidgible population recieving a formal dementia diagnosis	Low			62.5% Gloucester ICS	0.00 Other South West ICS; 61.9% All ICS				01 May 2021
X000x	Measures being developed for End of Life	Low			0.00 Gloucester ICS	0.00 Other South West ICS; 0.00 All ICS			*Defining additional metrics for the Ageing Well programme*	

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8.1

Medicines Optimisation *(under development)*

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
					better than		worse than				
X000a	Antimicrobial Rate - appropriate prescribing of antibiotics in primary care	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*To be included in next report*	
X000x	Antimicrobial Resistance Rate - appropriate prescribing of broad spectrum antibiotics in primary care	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*To be included in next report*	
X000x	Monitor the Shift Towards Novel Anticoagulants in Medicines	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*To be included in next report*	
X000x	Increase Referrals to the Discharge Medication Service & Community Pharmacy Consultation Service	Low			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*To be included in next report*	

Personalised Care *(under development)*

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Local Target	Latest Performance			Quartile (Q1 = High, Q4 = Low)	Value Change	Trend	Latest Reporting Period
					better than		worse than				
X000a	Personal Health Budgets - number of PHBs	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS	Benchmarking and calculation of Quartile performance under development	Value Change (to previous reporting period) under development	*Exploring data collection for personalised care*	
X000x	Personalised Care and Support Planning - number of PCSPs	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Exploring data collection for personalised care*	
X000x	Social Prescribing Referrals - number of referrals to social prescribing/social prescribing plus	High			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*To be included in next report*	
X000x	MyCAW - number of people showing improved health and care outcomes	Low			0.00 Gloucester ICS	0.00 Other South West ICS	0.00 All ICS			*Exploring data collection for personalised care*	

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Priorities)

(System Resources Committee)

Our People

(People Committee)

Quality and Safety

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

APPENDIX: Our Themes

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People Committee

Accountable Non-Executive Director	Tracey Cox
Meeting Date	14th July 2022

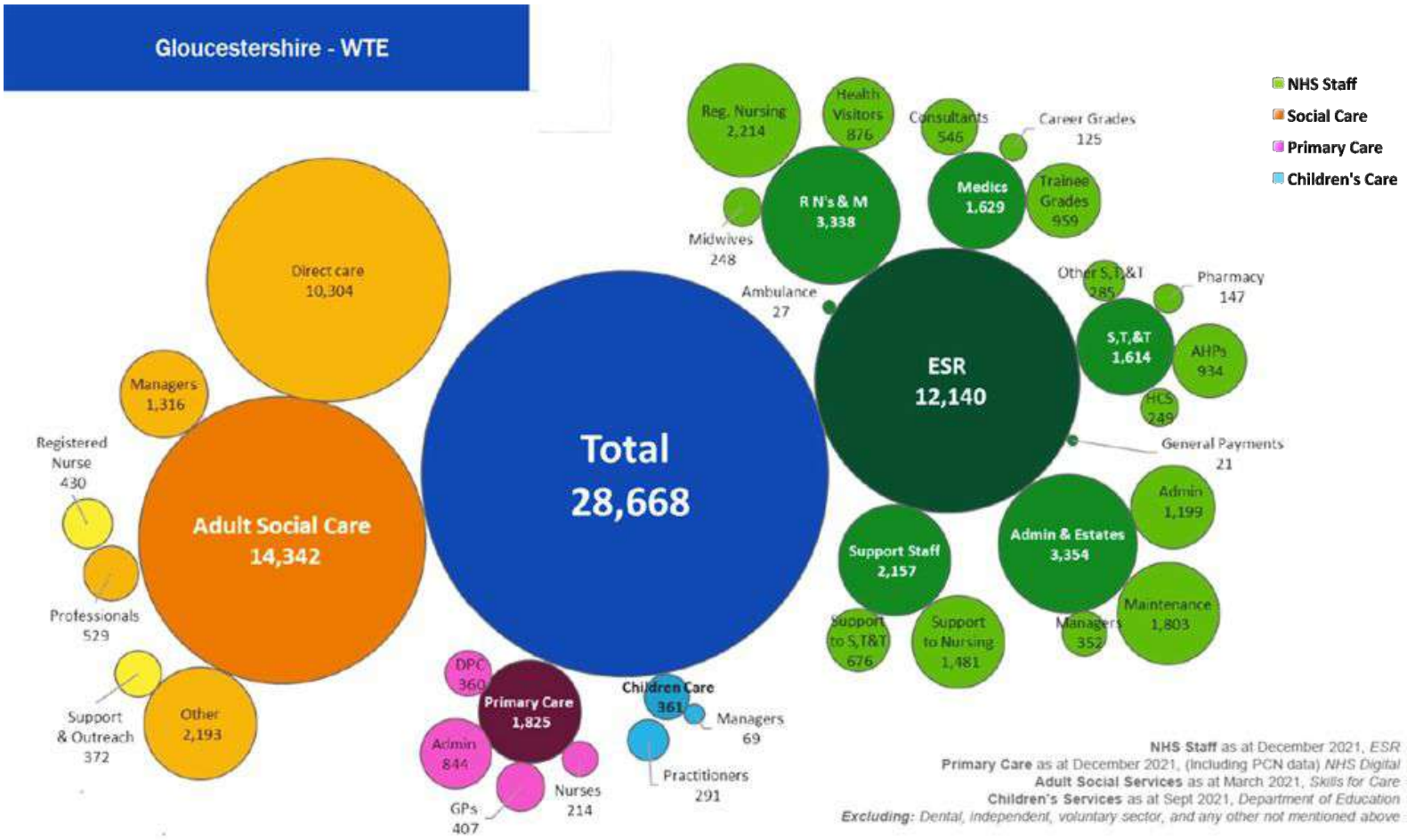
Assurance Level	Colour to use in risks/actions below
Not assured	Red – there are significant gaps in assurance, and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Limited	Amber – there are gaps in assurance, but we are assured appropriate action plans are in place to address these
Significant	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives
Full	Blue – Delivered and fully embedded

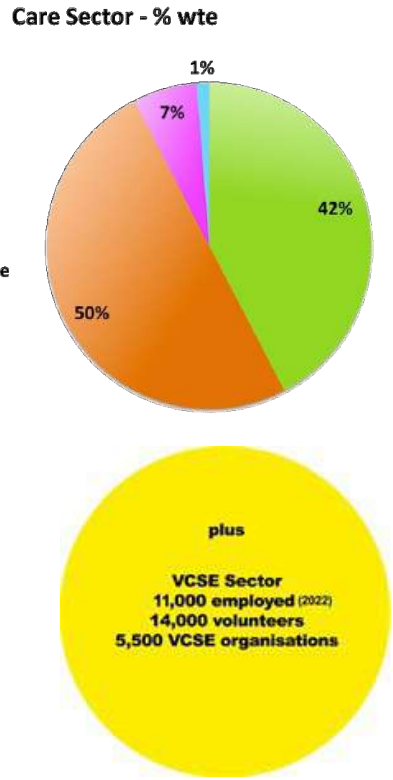
Issues identified at the Committee

Key Area	Assurance	Actions	Committee Update	Next Action(s)	Timescales
Vacancy numbers – particularly in Health Care Assistants and Registered Nurses			• Recruitment events underway across the system. ICS proposed supporting infrastructure includes additional project capacity to support action to tackle both retention issues and recruitment • 10 Yetis commissioned to review our approach to use of digital and social media with a view to wider participation and recruitment reach to individuals not normally considering health and sector • Scoping a potential system wide approach to Heath and Care Support Worker recruitment following success in systems in Bristol and Plymouth	Retention role out to advert week comm. 12th July 2022 Baseline assessment of current approaches underway Meeting with Regional Colleagues	End September 2022 role to be in place End July 2022 for baseline to be completed 5th July 2022
Cost of living issue impacting on staff			• Directors of HR to consider system wide approach to supporting staff with cost of living issues against national recommendations	Collation of current system position to be reviewed on 20/7/2022	End of July for confirmed system position

Topic	Committee
None	None

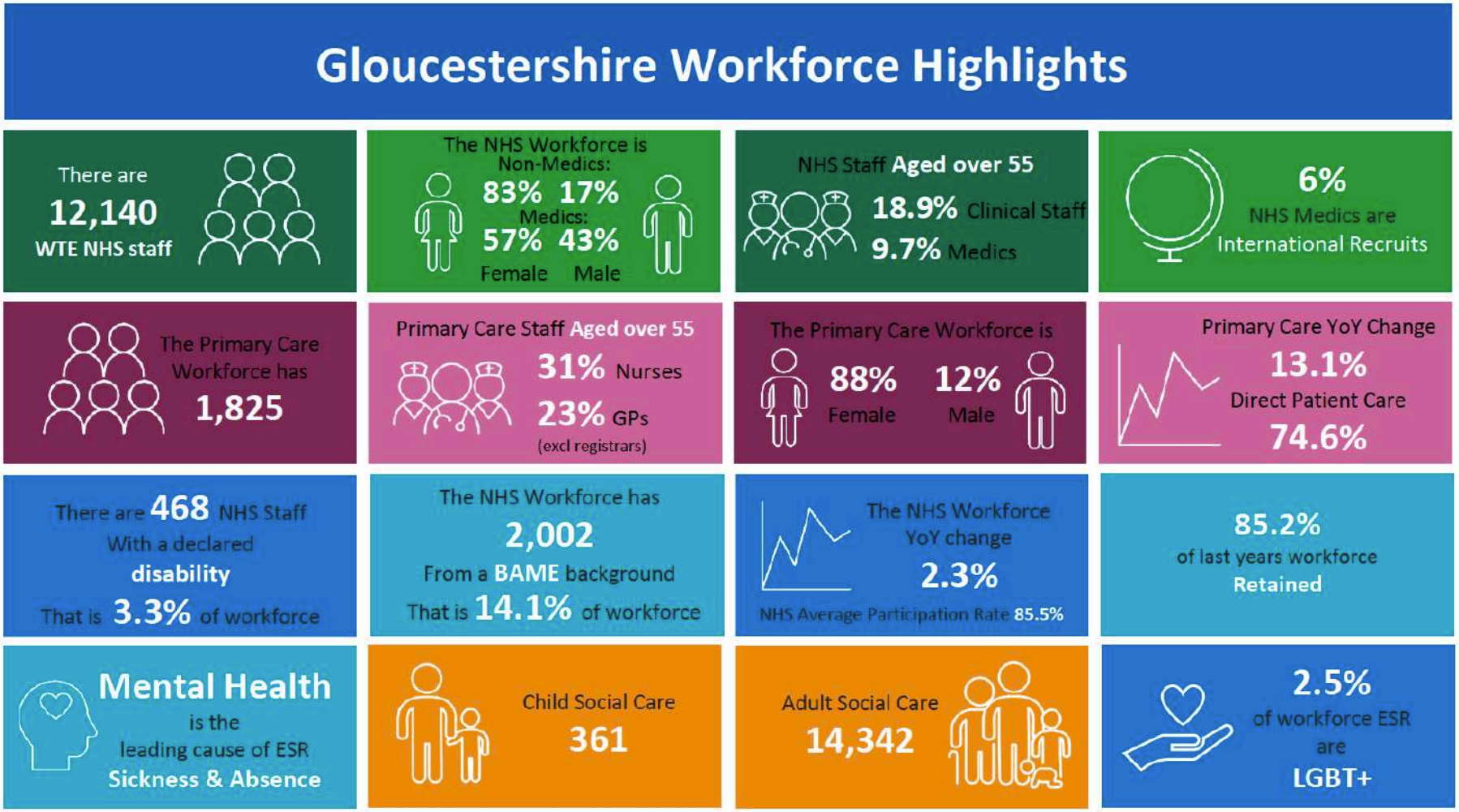
People Metrics – ICS Workforce Overview





An initial set of slides to provide a Gloucestershire workforce context

People Metrics – ICS Workforce Overview



Workforce data as Whole Time Equivalent (WTE), workforce characteristics as Headcount (HC)

People Metrics – ICS Workforce Overview

Workforce Characteristics Overview | Gloucestershire | All Workforce

as at December 2021

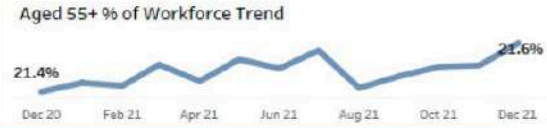
NHS Health Education England

80% are **Female** | **20%** are **Male**

Sex
The Gloucestershire workforce consists of 80% female and 20% male. This equals roughly 4 females to every male.

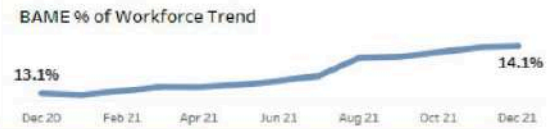
43 years is the workforce **average age**

Age
The average age of the Gloucestershire workforce is 43 years. The workforce has 21.6% aged 55 and over, and 2.3% of the workforce aged 65 and over.
The workforce aged 55 and over has increaseed over the past year from 21.4% in December 2020.



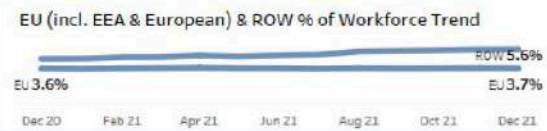
14.1% of the workforce are **BAME**

Ethnicity
The Gloucestershire workforce includes 14.1% (2,002 HC) of staff from a BAME background (Black, Asian and Minority Ethnic). This falls to 9.6% in pay grades 7-9 or Medical Consultant. The Asian community is the largest BAME group with 7.8% of the workforce. The BAME workforce has increaseed over the past year from 13.1% in December 2020.



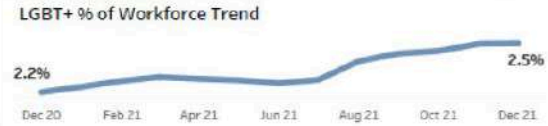
9.3% of the workforce are from **outside Britain**

Nationality
The Gloucestershire workforce includes 9.3% international staff. While 3.3% are classified as international recruits in ESR.
The EU workforce has increaseed over the past year from 3.6% to 3.7%. The workforce from outside Europe has increaseed from 4.7% to 5.6%.



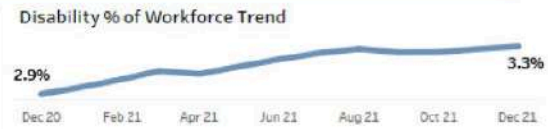
2.5% of the workforce identify as **LGBT+**

Sexual Orientation
LGBT+ represents the following groups as classified in ESR; Bisexual, Gay or Lesbian, and Other Sexual orientation. The Gloucestershire workforce includes 2.5% of staff identifiying as LGBT+.
This has increaseed over the past year from 2.2% in December 2020.



3.3% of the workforce have a declared **disablity**

Disability
The Gloucestershire workforce includes 3.3% (468 HC) of staff with a declared disability. ESR provides no further definition on the types of disability.
This has increaseed over the past year from 2.9% in December 2020.



People Metrics – Overall Performance

Key Performance Measures

Looking After Our People Metric		Update Frequency	Level	Latest Data Date	Previous Position	Latest Position	Change (+/-)	Direction of travel	Target (If set)	Distance from target
S069a:	NHS Staff Survey Engagement theme score	Annual	ICS-NHS	2021	7.0	6.8	-0.2	Down		
			GHFT	2021	6.9	6.6	-0.3	Down		
			GHC	2021	7.2	7.2	0.0	Same		
S063a:	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from; a) managers	Annual	ICS-NHS	2021	0.40%	0.40%	0.00%	Same		
	b) other colleagues	Annual	ICS-NHS	2021	0.90%	1.30%	0.40%	Up		
	c) patients / service users, their relatives or other members of the public in the last 12 months	Annual	ICS-NHS	2021	13.70%	13.90%	0.20%	Up		
S067a:	NHS Leaver Rate (12 month rolling leaver as % of all staff)	Monthly	ICS-NHS	May-22	14.00%	14.30%	0.30%	Up		
			GHFT		14.30%	14.40%	0.10%	Up		
			GHC		13.80%	14.20%	0.40%	Up		
S068a:	Sickness absence rate (working days lost to sickness)	Monthly	ICS-NHS	May-22	5.80%	4.70%	-1.10%	Down		
			GHFT		5.90%	5.00%	-0.90%	Down		
			GHC		5.80%	4.40%	-1.40%	Down		
SC Local metric	Adults Directorate - Staff Turnover (12 month rolling year, staff leaving as a % of all staff)	Qtrly	GCC - Adult	Q4 21-22	12.42%	14.06%	-14.06%	Up		
SC Local metric	Adults - Sickness absence rate (Average working days lost per FTE)	Qtrly	GCC - Adult	Q4 21-22	3.72%	3.71%	-3.71%	Down	2.25%	2.25%
NHS Local metric	Proportion of all staff net change – this is monthly data and needs to change to 12 months rolling data	Monthly	ICS-NHS	May-22	0.21%	-0.16%	-0.37%	Down		
			GHFT		0.27%	-0.09%	-0.36%	Down		
			GHC		0.10%	-0.03%	-0.13%	Down		
NHS Local metric	Proportion of all staff leaving the NHS that leave within one year (12 month rolling)	Monthly	ICS-NHS	May-22	10.03%	8.83%	-1.20%	Down		
			GHFT		1.72%	1.18%	-0.54%	Down		
			GHC		23.55%	20.97%	-2.58%	Down		
SC Local metric	Adults - total number of leavers in 12 months employed 12months or less	Qtrly	GCC - Adult	Q4 21-22	14.07% (19)	16.45% (25)	6	Up		
NHS Local metric	Time to hire (definition tbc)	Qtrly	ICS-NHS	Q1	n/a					
NHS Local metric	FFT metric from Pulse survey	Qtrly	ICS-NHS	Q1	n/a					

National metrics look at both ICS and Trust level data – however ICS data only includes NHS Trusts
There may be opportunity to look at truly system wide metrics - but comparable data sources may not be available

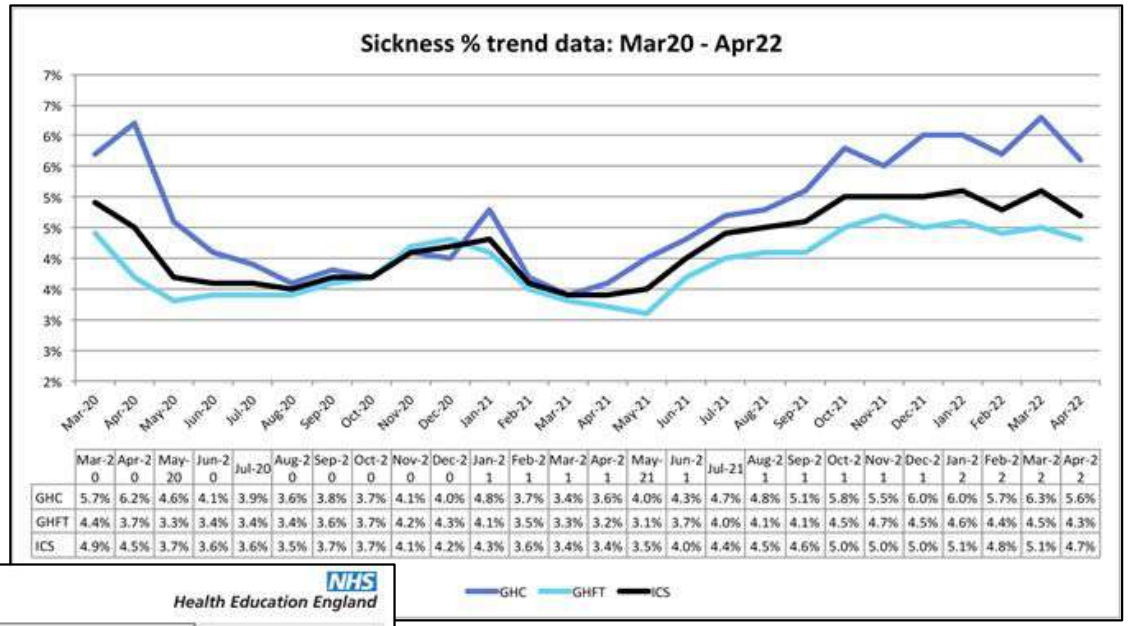
The difference between the two trusts for this metric is significant – further work required to verify data / explore via deeper analysis

Areas for local metrics development have been identified but still require definition based on what data might be available.
Monthly data has been requested to populate all possible metrics with latest data – 2 months ahead of national datasets

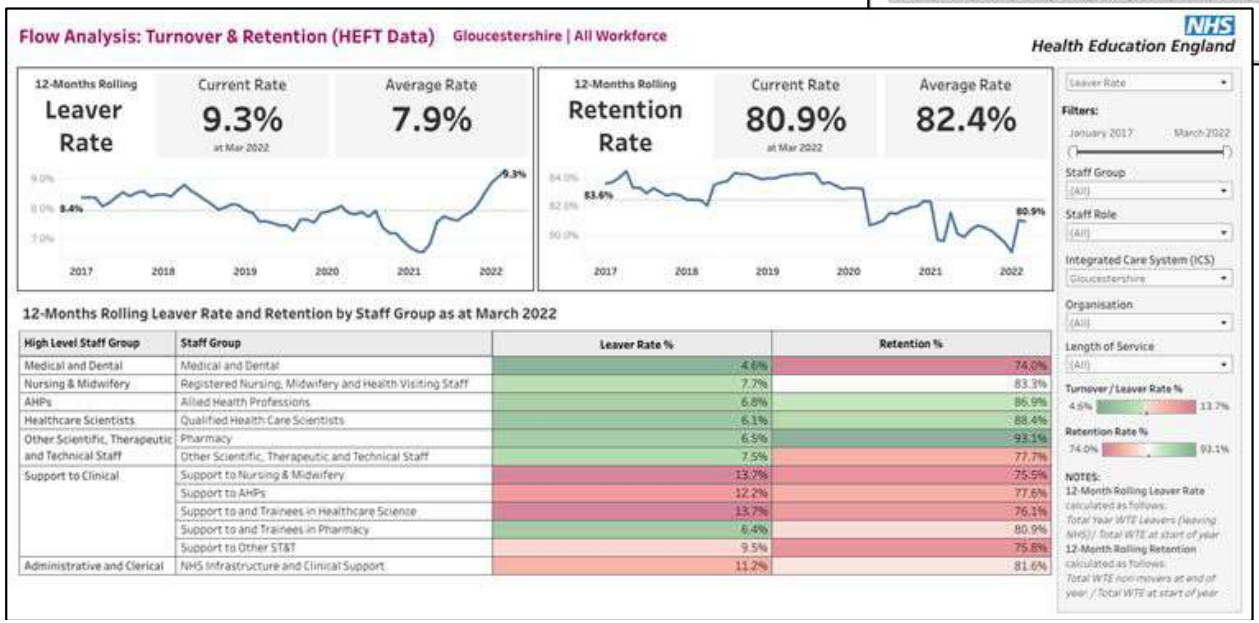
Key Performance Measures

Looking after our People: Identified Metrics In Depth

- This in-depth trend data is taken from the national data portal
- The leaver rate shown in the graph below is leavers % from the NHS (The leaver rate for the national System Oversight Framework (SoF) metric is % of all leavers)
- Further work is required to ensure technical definitions align.



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
GHC	5.7%	6.2%	4.6%	4.1%	3.9%	3.6%	3.8%	3.7%	4.1%	4.0%	4.8%	3.7%	3.4%	3.6%	4.0%	4.3%	4.7%	4.8%	5.1%	5.8%	5.5%	6.0%	6.0%	5.7%	6.3%	5.6%
GHFT	4.4%	3.7%	3.3%	3.4%	3.4%	3.4%	3.6%	3.7%	4.2%	4.3%	4.1%	3.5%	3.3%	3.2%	3.1%	3.7%	4.0%	4.1%	4.1%	4.5%	4.7%	4.5%	4.6%	4.4%	4.5%	4.3%
ICS	4.9%	4.5%	3.7%	3.6%	3.6%	3.5%	3.7%	3.7%	4.1%	4.2%	4.3%	3.6%	3.4%	3.4%	3.5%	4.0%	4.4%	4.5%	4.6%	5.0%	5.0%	5.0%	5.1%	4.8%	5.1%	4.7%



High Level Staff Group	Staff Group	Leaver Rate %	Retention %
Medical and Dental	Medical and Dental	4.6%	74.0%
Nursing & Midwifery	Registered Nursing, Midwifery and Health Visiting Staff	7.7%	83.3%
AHPs	Allied Health Professions	6.8%	86.9%
Healthcare Scientists	Qualified Health Care Scientists	6.1%	88.4%
Other Scientific, Therapeutic and Technical Staff	Pharmacy	6.5%	93.1%
	Other Scientific, Therapeutic and Technical Staff	7.5%	77.7%
Support to Clinical	Support to Nursing & Midwifery	13.7%	75.5%
	Support to AHPs	12.2%	77.6%
	Support to and Trainees in Healthcare Science	13.7%	76.1%
	Support to and Trainees in Pharmacy	6.4%	80.9%
	Support to Other ST&T	9.5%	75.8%
Administrative and Clerical	NHS Infrastructure and Clinical Support	11.2%	81.6%

The highest leaver rates post Covid are in the bands 2-4 support and infrastructure roles – this is likely to be the attractiveness of jobs in the retail and hospitality industry that are now active again after Covid.

People Metrics – Overall Performance

Key Performance Measures

Belonging in the NHS Metric		Update Frequency	Level	Latest Data Date	Previous Position	Latest Position	Change (+/-)	Direction of travel	Target (If set)	Distance from target
S071a:	Proportion of staff in senior leadership (director) roles who are from a BME background	Qtrly	ICS-NHS	Q4 21-22		13%			-	-
	Proportion of staff in senior leadership (director) roles who are women	Qtrly	ICS-NHS	Q4 21-22		33%			-	-
S072a:	Proportion of staff who agree that their organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	Annual	ICS-NHS	2021	54.70%	55.00%	0.30%	Up		

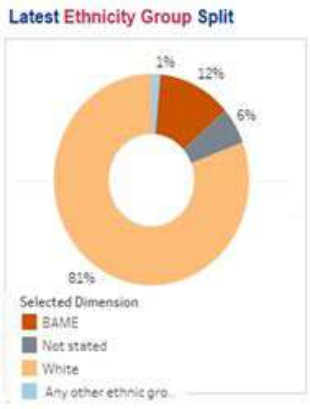
SC Local metric	GCC - Proportion of staff in senior leadership (director) roles who are from a BME background	Qtrly	GCC	Q4 21-22	2.70%	2.63%	-2.63%	Down		
SC Local metric	GCC - Proportion of staff in senior leadership (director) roles who are women	Qtrly	GCC - Adult	Q4 21-22	67.12%	67.54%	-67.54%	Up		
NHS Local metric	Relative Likelihood of staff being appointed from shortlisting across all posts - WRES/WDES	tbc								
NHS Local metric	Model employer target Band 8+ diversity: %BME	Qtrly	ICS-NHS	Q4 21-22	n/a	10.30%				
NHS Local metric	band 1-4 diversity: %BME	Qtrly	ICS-NHS	Q4 21-22	n/a	10.10%				
NHS Local metric	band 5-6 diversity: %BME	Qtrly	ICS-NHS	Q4 21-22	n/a	15.20%				

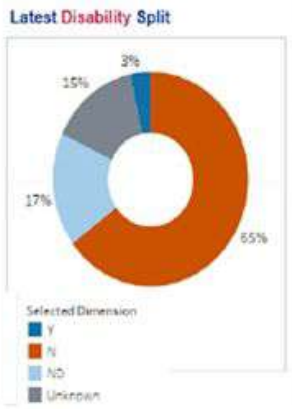
- 80% of NHS staff in Gloucestershire are female.
- 50.4% of Gloucestershire working age population are female.
- 12% NHS staff in Gloucestershire are BME
- 8% working age population is BME

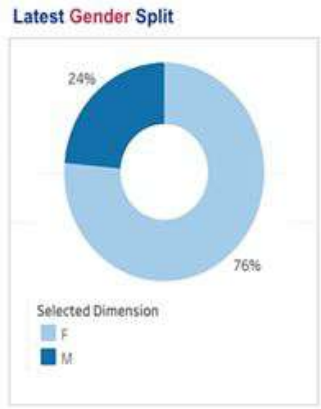
Key Performance Measures

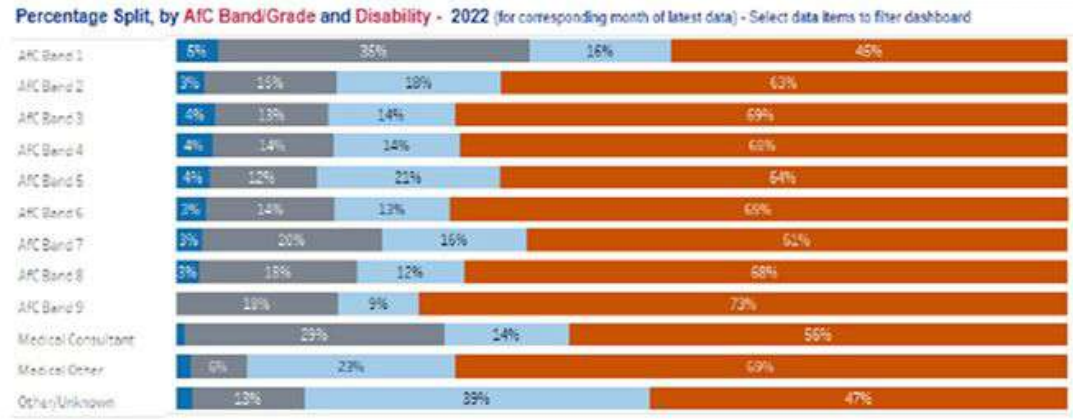
Belonging in the NHS: Identified Metrics in Depth

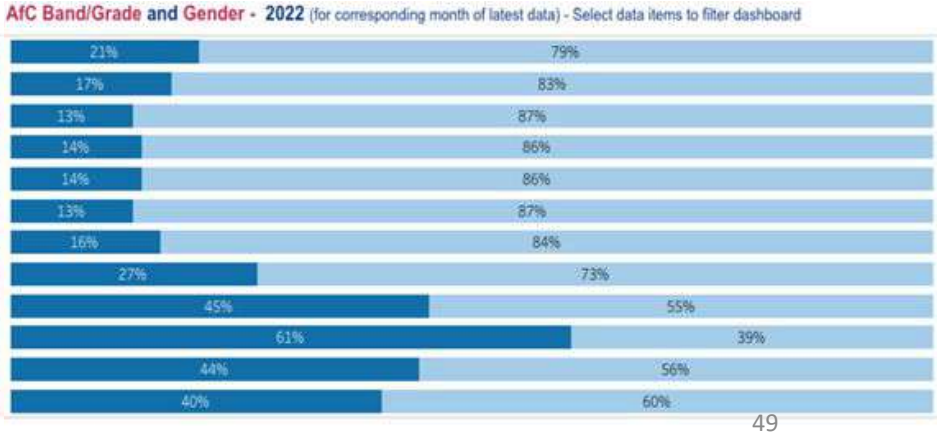
ESR Secondary Care Equality, Diversity and Inclusion Profile Detail











People Metrics – Overall Performance

Key Performance Measures

Growing for the Future Metric		Update Frequency	Level	Latest Data Date	Previous Position	Latest Position	Change (+/)	Direction of travel	Target (If set)	Distance from target
S074a:	Number of Doctors working in General Practice - placeholder (Inc Registrars)	Monthly	ICS-NHS	Apr-22	417	419	2	Up		
newSoF metric	Direct patient Care staff in GP practices and PCNs per 10,000 wieghted patients	tbc	ICS-NHS							

NHS Local metric	Nursing Vacancy rate:	Monthly	ICS-NHS	May-22	13.40%	13.60%	0.20%	Up		
NHS Local metric	Nursing Vacancy wte:	Monthly	ICS-NHS	May-22	514.30	523.70	9.40	Up		
SC Local metric	Adult Social Workers	Qtrly	GCC - Adult	Q4 21-22	111.89	113.21	1.33	Up		
NHS Local metric	Nursing workforce - delivery of planned growth - WTE employed	Monthly	ICS-NHS	May-22	3,336	3,326	-10.0	Down	3373	-1.4%
NHS Local metric	Agency wte	Monthly	ICS-NHS	Mar-22	322.0	381	59.0	Up		
NHS Local metric	Bank wte	Monthly	ICS-NHS	Mar-22	710	816	106.0	Up		
NHS Local metric	SIP vs Establishment - all staff	Monthly	ICS-NHS	May-22	90.00%	89.70%	-0.30%	Down		

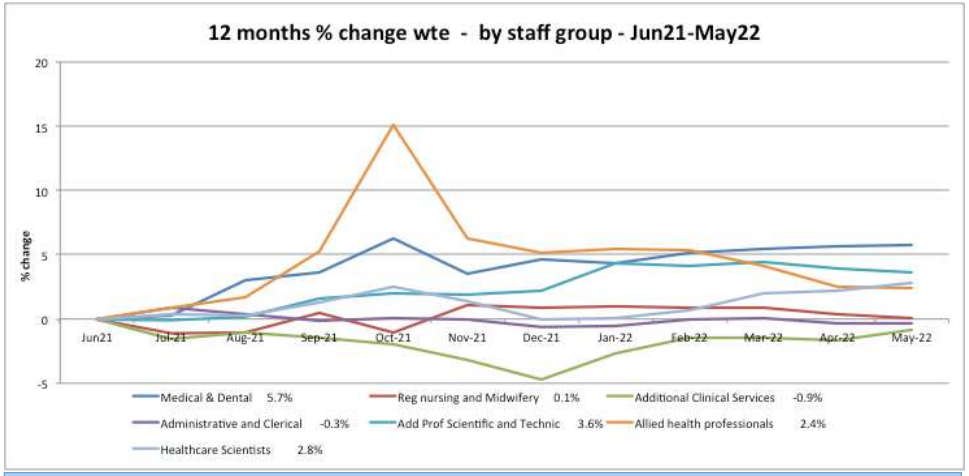
- Primary Care data is available through the national data portal, however the technical specification for the SoF metrics has not yet been confirmed.
- However, Primary Care is currently excluded from the other NHS SoF metrics.
- It is felt that a local metric which might provide a more useful indicator is number of Qualified GPs (Registrars are supernumerary). Further, the measurement may not precisely represent the actual capacity of GPs in the system, as sessions do not accurately translate to Whole Time Equivalent (WTE)
- Further clarification will be sought.

- Local monthly data has been requested to populate all possible metrics with latest data, 2 months ahead of national datasets. National data in yellow.
- Bank and Agency data tends to be held by finance.
- WTE data is taken from the national data portal.

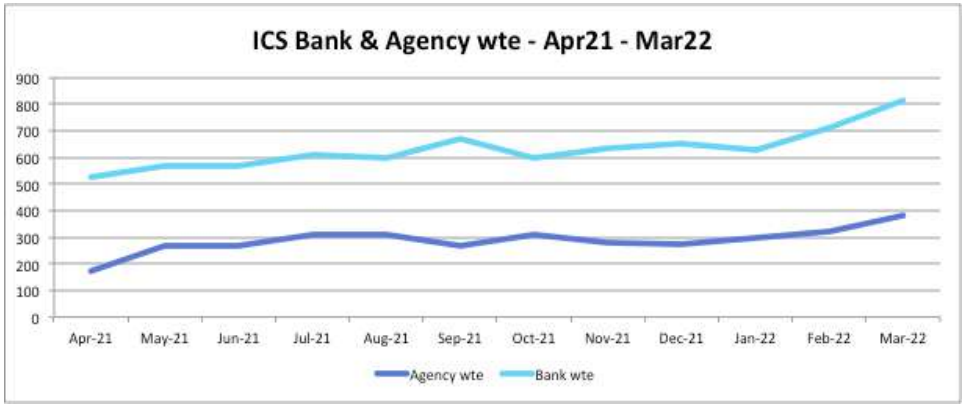
Growing for the Future: Identified Metrics in Depth

Key Performance Measures

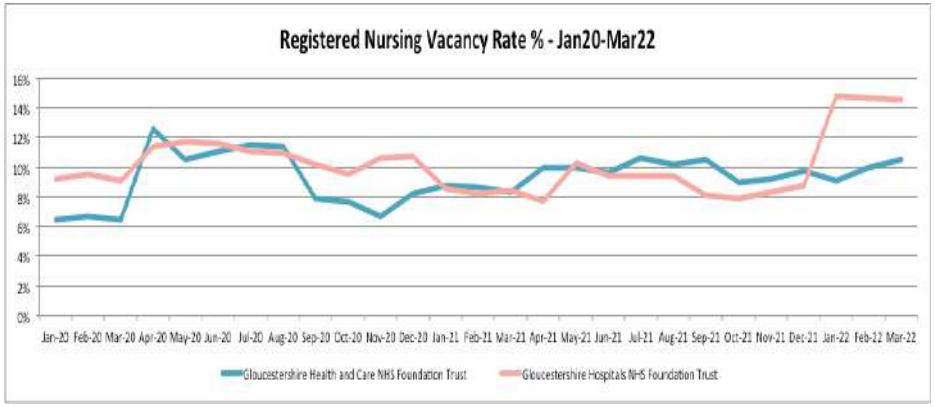
The below trend data sets are taken from the National data portal



Local ESR data showing % change by staff group over the last 12 months



Note: Bank and agency use increases in Feb22 and Mar22. Jan22 was 631/298: Mar22 was 816/381



Note: GHFT vacancy increase in Jan22 is due to increased Establishment supporting increased recruitment of registered nurses

People Metrics – Overall Performance

Key Performance Measures

New Ways of Working Metric		Update Fergency	Level	Latest Data Date	Previous Position	Latest Position	Change (+/-)	Direction of travel	Target (If set)	Distance from target
NHS Local metric	e-job planning and e-rostering metric (tbc)	Qtrly	ICS-NHS	Q1	n/a	n/a				
NHS Local metric	NHS Cadets - numbers	Qtrly	ICS-NHS	Q1	n/a	n/a				
NHS Local metric	NHS Reservists metric - numbers	Qtrly	ICS-NHS	Q1	n/a	n/a				
NHS Local metric	Number of Apprentices wte	Qtrly	ICS-NHS	Q1	n/a	n/a				
NHS Local metric	Number of Apprenticeship starts	Annual	ICS-NHS	21-22	338	353	15	Up		
NHS Local metric	Number of Apprenticeship on programmes	Annual	ICS-NHS	Q4 21-22	683	781	98	Up		
NHS Local metric	Use of Apprenticeship Levy %	Annual	ICS-NHS	21-22	52%	65%	13%	Up		

Target set for 22-23 is 70%

- Initial areas for local metrics have been identified for New Ways of Working, but still require definition based on what data might be available.
- Additional metrics may be useful.

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NHS

Improving Services & Delivering Outcomes (Our Priorities)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

APPENDIX: Our Themes

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Quality – Assurance

Core Healthcare Providers CQC Inspections and Ratings

Provider	Last published Rating	Published date
Cobalt	GOOD	18/09/2019
Ezec	Inspected but not rated	01/06/2021
GHCFT	GOOD	Currently being reviewed
GHFT	GOOD	Currently being reviewed
GPCare	GOOD	21/04/2020
InHealth	GOOD	15/03/2019
NewMedica	GOOD	20/04/2022
Nuffield	GOOD	29/07/2016
PML	GOOD	20/11/2019
PPG 111	OUTSTANDING	16/03/2022
PPG OOH	REQUIRES IMPROVEMENT	17/03/2022
SWAST	GOOD	Currently being reviewed
Tetbury Hospital	REQUIRES IMPROVEMENT	Currently being reviewed
Winfield	REQUIRES IMPROVEMENT	Currently being reviewed

Social Care CQC Inspections and Ratings (Outstanding and Inadequate)

Provider	Last published Rating	Published date
Abbymead Lodge	OUTSTANDING	18/10/2018
Elizabeth House	OUTSTANDING	11/12/2020
Fern Court	INADEQUATE	07/06/2022
Foundation House	OUTSTANDING	28/04/2020
Jendot	OUTSTANDING	26/06/2018
Machlo	OUTSTANDING	07/04/2021
Stroud Lodge	OUTSTANDING	03/03/2021
Tomlen	OUTSTANDING	10/03/2022

GP CQC Inspections and Ratings (Outstanding and Inadequate only)

Practice	Last published Rating	Published date
Mythe Medical	OUTSTANDING	07/06/2017
Minchinhampton	OUTSTANDING	28/06/2018
Winchcombe	OUTSTANDING	10/11/2016
Walnut Tree	OUTSTANDING	27/12/2017

Urgent and Emergency Care CQC Inspection

In November and December 2021 inspectors visited our emergency departments, minor illness and injury units, the emergency operation centre and the emergency ambulance service, the 111 service and out of hours service. In May 2022 they released their report on the position of UEC in Gloucestershire. This report will be triangulated with other local data and will form part of the first Rapid Quality Review (RQR). The RQR will be reported through to the first ICB Quality Committee for formal assurance.

Charlton Lane

Following a comprehensive CQC inspection of Chestnut Ward (February 2022) and Charlton Lane Hospital (March 2022), the hospital received an overall rating of Requires Improvement. As a result, the Trust has combined both sets of actions into an overarching action plan and is making good progress.

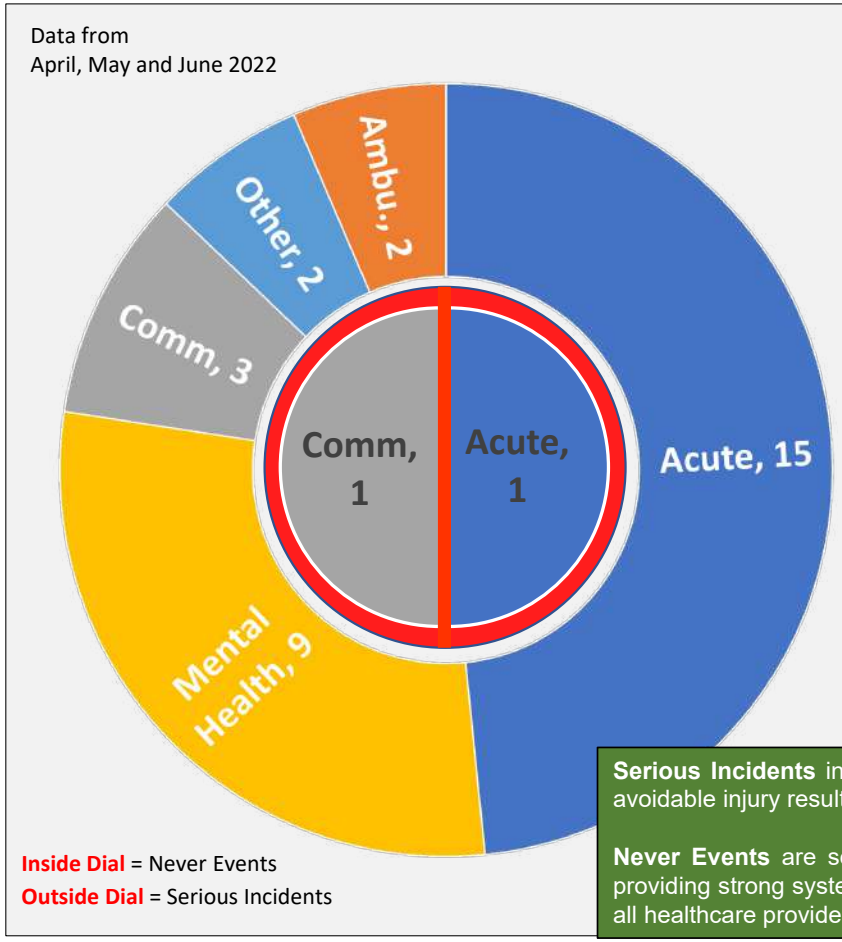
Fern Court

Fern Court was recently inspected by the CQC and found to be inadequate. Placements have been suspended and the Quality Assurance Team within Commissioning are working closely with Fern Court, CQC, Safeguarding and local Social Care & Health teams to ensure that the Home raises the quality of provision to the standard necessary.

Key updates from Foundation Trusts

GHFT have recently undergone a series of CQC inspections which include Maternity Services, Surgery and a Well-Led inspection which took place in June 2022. A number of themes have begun to emerge from the visits and the Trust are preparing share the finding of these emerging themes via the Quality Delivery Group in July. GHCFT has also undergone a CQC 'Well Led' inspection but has not yet had a formal report.

Quality – Safety



Serious Incidents in a Mental Health setting predominantly related to Self-Harm events, while those in an Acute setting focused on delays. Three acute incidents related to maternity cases, two of which have been taken forward by HSIB for investigation. In all three maternity cases the patients have been discharged and are not receiving ongoing care.

The two **Never Events** recorded relate to a retained swab and a wrong route administration of a drug.

Patient Safety at a strategic level continues to evolve with the ongoing implementation of the NHS Patient Safety Syllabus. Led by Patient Safety Specialists (who are charged with providing dynamic senior patient safety leadership), this will see a shift change in how Patient Safety is viewed across the system.

Key dates in the patient safety calendar include the introduction of 'Patient Safety Partners' who must be in place by September 2022. The ICS is currently scoping how we can adopt a joined-up approach to ensure we comply with this requirement.

NHSE have also set the deadline for 31st March 2023 for systems to switch reporting to the 'Learn from Patient Safety Events' (LFPSE) system.

Serious Incidents include acts or omissions in care that result in: unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm , including those where the injury required treatment.

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.

Quality – Experience

		Apr-22	
		Provider	Nat Ave
GHFT Inpatients	% Positive	88%	94%
	% Negative	7%	3%
GHFT A&E	% Positive	63%	75%
	% Negative	27%	17%
GHCFT Mental Health	% Positive	81%	86%
	% Negative	8%	7%
GHCFT Physical Health	% Positive	95%	93%
	% Negative	3%	3%

You said:

Please make the information leaflets available for patients, accessible online so that our screen readers and other plug ins support the format.

'You Said- We Did' example from GHFT

We did:

We have now started to put all of our 600+ leaflets for patients into a format online which is supported by screen readers and other plug in's to support patients to access information. In addition, this format will mean our patient information leaflets will become accessible from mobile devices too. This is being carried out using a phased approach and forms part of a wider ongoing piece of work to ensure our information is accessible.

Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS funded services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

The FFT asks a simple question: how likely, on a scale ranging from extremely unlikely to extremely likely, are you to recommend the service to friends and family if they needed similar care or treatment.

Data on all services is published on a monthly basis. During the 2020 reporting of FFT results was suspended. During the past 12 months phased reporting has resumed across all NHS funded services, with GP practices recommencing reporting from July 2022.

FFT is one of many experience measures used to inform service quality improvement, evaluation and development; for the purposes of providing a standard measure for the ICB it is useful as it highlights overall experience across all services using the same methodology.

NB The GP Primary Care FFT will restart in July 2022.

The latest data available is for April 2022

Quality – Effectiveness

Each system partner has to reassure their own board that what they are doing is 'Effective'. However, we know that there are opportunities to bring together our work across the ICB.

For several years a CCG Clinical Effectiveness Group met to review 'effectiveness' across a limited number of areas. The last Clinical Effectiveness Group (CEG) was held on 27th June 2022 where there was a discussion regarding how the group can become more outward looking and harness the opportunities brought by the ICB. Over the next year this group will transition into a System Effectiveness Group and focus on:

- Understanding the standards we measure ourselves against
- Measure current provision against standards
- Describing variance
- Discussing and reporting why there are variants
- Working towards closing variance
- Challenging system partners to measure the benefit of our work to demonstrate the value

The new System Effectiveness Group will first focus on ensuring we achieve the 'must do' elements of effectiveness and will then build a programme of work that will link more effectively with the Clinical Programme Groups and Primary Care.

In our Quality Strategy we set out our vision for Effectiveness:

Effectiveness

We believe the effectiveness of how individual services run, the way they work together and their impact on quality, should be the main objective of local systems.

- One Gloucestershire aims to do the right thing, at the right time, for the right patient
- We will continue to develop a culture where clinical effectiveness underpins the decisions we make
- Patients know the pathway they're on is the most effective it can be to achieve the best outcome
- We will utilise evidence, guidelines and standards to identify and implement best practice, working with CPGs on pathway development
- Ensuring our population can access care which is personalised so that 'what matters to me' drives decision making

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NHS

Improving Services & Delivering Outcomes (Our Priorities)

(System Resources Committee)

Our People

(People Committee)

Quality and Safety

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

APPENDIX: Our Themes

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Financial Overview & Key Risks

Overview

- All organisations are forecasting to deliver to a break-even financial position at year-end in line with the plan, however there are risks in these forecasts (next page).
- The ICS year-to-date (YTD) deficit position of £2.1m is the result of a £2.2m adverse to plan position from GHFT, and a small £0.1m YTD surplus position at GHC.
- GHFT's YTD deficit position has been caused by increased urgent and emergency care demand and the requirement to cover vacancies leading to Medical and Surgical Divisions overspending on both nursing and medical staff.
    - Weekly 'grip and control' meetings are being held with Surgical and Medical Divisions to support the financial performance. The Surgical Division's position has improved for months 2 and 3, and is working towards a break-even position by year-end. The Medical Division's position is continuing to overspend
    - Underspends in corporate areas are mitigating the current financial pressures in other parts of the organisation
    - GHFT are currently carrying 929 whole time equivalent (wte) vacancies in month 3
- Workforce pressures exist for GHC, with substantive vacancies leading to increase demand for bank and agency staff, although this is not currently affecting the organisation's overall financial position
- NHS Gloucestershire has received a 12-month financial allocation from NHSE; this will be split between the CCG and the ICB. Due to budget profiling issues, the YTD position for the CCG shows a significant underspend, this will be adjusted by NHSE and take account of this when finalising the ICB's allocation for the next 9 months.
- Capital is due to break-even against the budget for the year

Financial Overview & Key Risks

Key Financial Issues and Risks

- Elective activity within GHFT is currently below the planned trajectory of the 104% delivery target, putting at risk the Elective Services Recovery Funding (ESRF), which contributes to the ICS's financial position. The ICS has budgeted to receive £19.2m for non-specialised services and £3.2m for specialised services; within this there is a contribution of £15m to the ICS's overall financial position, therefore under-delivery on this position will lead to an overspend for the ICS.
    - Elective activity with Independent Sector Providers is above planned levels, which, while contributing to the delivery of Elective Recovery for the ICS, is currently unfunded unless the ICS over-delivers against the Elective Recovery value-weighted 104% delivery target
    - Elective performance across the ICS is being closely monitored, along with additional costs incurred to deliver elective activity
- Risk of under-delivery of savings and efficiency plans
    - Currently projected for GHFT (£6.8m) and GICB (£0.8m)
    - Plans to monitor / mitigate under-delivery with over-delivery of other schemes and / or identification of new schemes
    - The ICB medicines management savings plans are currently showing as amber due to slippage in the realisation of some savings programme; the medicines team are currently developing alternative plans to mitigate this slippage
- Growth and demand pressures in Continuing Healthcare (CHC) and other placements may exceed budget levels leading to an overspend
- Inflation is exceeding planning assumptions leading to the increased potential for providers (in particular for the cost of care packages both domiciliary and residential) to negotiate increases in contract amounts to cover costs.

Financial Overview & Key Risks

Key Financial Issues and Risks

- NHS pay inflation – funding is planned for a 3% cost increase (2% pay award + employer's NI contribution inflation). Should a higher than planned pay award be agreed without additional funding to meet this pressure, this will need to be found from existing budget lines.

- Ambulance handover delays – the system has significant handover delays and has developed a trajectory based on agreed system actions to reduce the number of handover delays across the course of the financial year. There are ongoing discussions with South West Ambulance NHSFT on the financial implications of the handover delays and sharing of financial risk if delays continue above the trajectory set, there remains a financial risk to the system if handover delays do not reduce to the level of the trajectory.

- Actions are being taken within each organisation to manage the financial position. In addition, Directors of Finance within the system are reviewing the position and looking a potential areas of mitigation should current financial pressures continue.

Finance and Use of Resources – Dashboard

Finance and Use of Resources

Month 3 2022/23 - June Statement of Comprehensive Income	Year to Date Plan Surplus/ (Deficit) £'000	Year to Date Actual Position Surplus / (Deficit) £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn Plan Surplus / (Deficit) £'000	Forecast Outturn Actual Position Surplus / (Deficit) £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000
Gloucestershire Hospitals NHS Foundation Trust	(2,101)	(4,322)	(2,221)	(0)	0	0
Gloucestershire Health and Care NHS Foundation Trust	(2)	86	88	(0)	0	0
Gloucestershire CCG / Integrated Care Board	0	10,017	10,017	0	0	0
CCG / ICB Transition Allocation Adjustment	0	(10,017)	(10,017)	0	0	0
Remove intra ICS trading	0	0	0	0	0	0
System Surplus/(Deficit)	**(2,103)**	**(4,236)**	**(2,133)**	**(0)**	**0**	**1**

Month 3 2022/23 - June Efficiency Programme	Year to Date Efficiency Plan £'000	Year to Date Efficiency Achieved £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn Efficiency Plan £'000	Forecast Outturn Efficiency £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn as % of Target £'000	High-Level In-Year Risk Rating
Gloucestershire Hospitals NHS Foundation Trust	2,730	2,848	118	19,038	12,238	(6,800)	64%	RED - High Risk
Gloucestershire Health and Care NHS Foundation Trust	1,706	1,711	5	6,822	6,822	0	100%	GREEN - Low Risk
Gloucestershire CCG / Integrated Care Board	1,839	1,839	0	11,097	11,097	0	100%	AMBER - Medium Risk
Total	**6,275**	**6,398**	**123**	**36,957**	**30,157**	**(6,800)**	**82%**	AMBER - Medium Risk

Month 3 2022/23 - June Other Metrics	GHFT	GHC	GICB	ICS
Better Payment Pratice Code (total paid w ithin 30 days or due date by value)	92%	95%	99%	97%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	0	0	0	(0)
Cash status	Green	Green	Green	Green

Key:
Green arrow up = favourable variance to plan
Red arrrow down = adverse variance to plan
Yellow horizontal arrow = breakeven

Elective Services Recovery Fund

ICS-Commissioned Activity	M1 Year to Date - FREEZE Baseline Plan £'000	Actual £'000	Variance £'000	M2 Year to Date - FLEX Baseline Plan £'000	Actual £'000	Variance £'000	Forecast Outturn Baseline Plan £'000	Actual £'000	Variance £'000
Cost-Weighted Activity	13,673	13,028	(645)	28,721	27,026	(1,695)	190,049	190,049	0
Elective Recovery Funding							**19,257**	**19,257**	**0**
Activity % of Baseline by PoD									
Elective Ordinary (EL)	89.0%	81.9%	-7.1%	90.8%	81.9%	-8.9%	104.1%	104.1%	0.0%
Day Case (DC)	92.5%	85.7%	-6.7%	97.5%	85.7%	-11.7%	109.2%	109.2%	0.0%
Outpatient Procedure (OPPROC)	101.4%	90.4%	-10.9%	109.2%	90.4%	-18.8%	97.9%	97.9%	0.0%
First Outpatient Appointment (OPFA)	103.4%	107.2%	3.8%	103.5%	107.2%	3.7%	104.0%	104.0%	0.0%
Outpatient Follow-Up Appointment (OPFUP)	97.7%	108.7%	11.0%	105.3%	108.7%	3.4%	91.7%	91.7%	0.0%
Elective Pathway Activity	**93.3%**	**89.8%**	**-3.5%**	**94.6%**	**89.8%**	**-4.9%**	**101.6%**	**101.6%**	**0.0%**
Advice and Guidance (A&G)	514.6%	336.6%	-177.9%	504.6%	347.4%	-157.2%	470.5%	470.5%	0.0%
Total ICS-Commissioned Activity	**100.7%**	**95.9%**	**-4.7%**	**99.4%**	**93.5%**	**-5.9%**	**104.8%**	**104.8%**	**0.0%**

Flex: initial submission of data before reconciliation undertaken and amendments made
Freeze: final submitted version of data following reconciliation and any necessary amendments

The annual plan for ESRF is based on the ICS achieving the 104% delivery target, although with a lower trajectory in Q1. After two months, actual delivery is 93.5%; nearly 6% away from planned trajectory – in financial terms, this puts at risk £1.27m of ESRF funding.

It is important to note that the M2 data is 'flex', so may improve as uncoded activity is accurately reconciled. Additionally, Advice and Guidance data contain high numbers of uncoded activity so also has potential to improve.

Savings and Efficiencies

Month 3 2022/23 - June Efficiency Programme	Year to Date Efficiency Plan £'000	Year to Date Efficiency Achieved £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn Efficiency Plan £'000	Forecast Outturn Efficiency £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn as % of Target £'000	High-Level In-Year Risk Rating
Gloucestershire Hospitals NHS Foundation Trust	2,730	2,848	118	19,038	12,238	(6,800)	64%	RED - High Risk
Gloucestershire Health and Care NHS Foundation Trust	1,706	1,711	5	6,822	6,822	0	100%	GREEN - Low Risk
Gloucestershire CCG / Integrated Care Board	1,839	1,839	0	11,097	11,097	0	100%	AMBER - Medium Risk
Total	**6,275**	**6,398**	**123**	**36,957**	**30,157**	**(6,800)**	**82%**	AMBER - Medium Risk

- GHFT's efficiency programme is under pressure, with slippage in a number of areas. The Trust is currently working through validation of this position and mitigations to slippage in programmes.
- GHC is reporting a small risk in unidentified non-recurring efficiencies, but these are expected to be identified and delivered before financial year-end
- GICB's amber risk reflects concerns over the Medicines Optimisation project relating specifically to Direct Oral Anticoagulation (DOACs) medications, which is forecasting a £0.865m shortfall against a £2.365m target. The project team are working with GP Practices to focus on the process of patient reviews and patient consultations to then understand the potential benefit of patients switching DOACs, formulary changes have also been made, while at the same time developing further projects around delivering medicines value, and exploring the possibility of increasing opportunities of prior year programmes

Capital: Organisation Positions, Challenges and Opportunities

Month 3 2022/23 - June Capital Expenditure	Year to Date Plan £'000	Year to Date Actual Position £'000	Year to Date Variance to Plan (Under) / Over Delivery £'000	Forecast Outturn Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan (Under) / Over Delivery £'000
Gloucestershire Hospitals NHS Foundation Trust	10,060	8,422	(1,638)	67,096	67,096	(0)
Gloucestershire Health and Care NHS Foundation Trust	475	1,947	1,472	27,386	27,386	0
Gloucestershire CCG / Integrated Care Board	0	0	0	1,472	1,472	0
Total System (NHS)	**10,535**	**10,369**	**(166)**	**95,954**	**95,954**	**(0)**

Capital Expenditure Category	£'000	£'000	£'000	£'000	£'000	£'000
Equipment	797	915	118	18,457	17,701	(756)
IT	1,206	1,566	360	10,509	10,432	(78)
Plant & Machinery	0	0	0	0	129	129
New Build	7,556	5,730	(1,826)	42,718	41,435	(1,283)
Backlog Maintenance	302	155	(147)	4,350	5,493	1,143
Routine Maintenance	299	775	476	2,917	2,325	(592)
Net Zero Carbon	0	0	0	500	0	(500)
Fire Safety	75	0	(75)	730	715	(15)
Fleet, Vehicles & Transport	0	0	0	3,167	3,167	0
Forest of Dean	300	1,228	928	11,500	13,452	1,952
GP Surgery Developments	0	0	0	1,106	1,106	0
Brokerage	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	**10,535**	**10,369**	**(166)**	**95,954**	**95,954**	**0**

Funding Sources	£'000	£'000	£'000	£'000	£'000	£'000
System Capital	2,923	4,358	1,435	42,630	42,630	(0)
National Programme	7,333	5,807	(1,526)	24,678	24,679	0
Donations & Government Grants	75	0	(75)	1,281	1,281	0
Lease Liability - IFRS16	0	0	0	25,076	25,076	(0)
Residual Interest	0	0	0	0	0	0
IRFIC	204	204	(0)	817	817	0
CCG Capital Allocation	0	0	0	1,472	1,472	0
Total	**10,535**	**10,369**	**(166)**	**95,954**	**95,954**	**(0)**

All organisations' capital programmes are forecast to deliver to plan by financial year end.

GHC's YTD over-delivery relates to materials purchased early for Forest of Dean scheme in order to avoid further inflationary risk.

GHFT's YTD under-delivery has been caused by capital slippage, but the position is expected to recover by year-end.

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ICB / CCG Finance Report

July 2022

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Financial Overview and Key Risks

Overview

- Forecast in line with planned position to break-even

- NHS Gloucestershire has received a 12-month financial allocation from NHSE; 3 months for the CCG and 9 months for the ICB – due to budget profiling issues, the YTD position for the CCG shows a significant underspend. However, NHSE will take account of this when finalising the ICB's allocation for the next 9 months.

- Emergent pressures

    - Inflation rising over and above funded levels on some smaller contracts, assessment of potential risk underway
    - Forecast shortfall in Medicines Optimisation savings programme for Direct Oral Anticoagulation medicines (DOACs), however Medicines Management Lead is developing further projects around delivering medicines value and exploring the possibility of increasing the benefits seen from prior year programmes
    - Elective activity with Independent Sector Providers above planned levels, which, while contributing to the delivery of Elective Recovery for the ICS, is currently unfunded unless the ICS over-delivers against the Elective Recovery value-weighted 104% delivery target

- Emergent pressures are currently covered by underspends in other areas

Financial Overview and Key Risks

Key Financial Risks

- Prescribing savings may not be realised leading to an overspend against budgets
- Growth and demand pressures in Continuing Healthcare (CHC) and other placements may exceed budget levels leading to an overspend
- Inflation is exceeding planning assumptions leading to the increased potential for providers (in particular for the cost of care packages both domiciliary and residential) to negotiate increases in contract amounts to cover costs.
- Elective activity is currently below the planned trajectory of the 104% delivery target, putting at risk the Elective Services Recovery Funding (ESRF), which contributes to the ICS's financial position and funds some of the costs, already being incurred, to deliver the elective recovery
- NHS pay inflation – NHS pay inflation funding is 3%, there is a high risk that pay inflation is likely to be higher, potentially 5%, than allowed for in budgets.

CCG / ICB Allocation

The CCG's confirmed allocation as at 30th June 2022 is £287m for M1-3 of the financial year.

Due to the split between the CCG and ICB in 2022/23, a part of the allocation will show in the CCG and the remainder in the ICB.

£'000	Description
240,709	Programme Allocation
25,788	Delegated Allocation
3,018	Running Cost Allocation
206	Ockenden
4,672	COVID
4,814	Elective Services Recovery Fund (ESRF)
474	Health Inequalities
3,497	Sustainability Development Fund (SDF)
1,406	General Inflation
375	Ambulance Handovers
875	Other Continuing Healthcare and Funded Nursing Care
200	Private Finance Initiative
705	Additional allocation
238	Q1 Additional 6.3% Pension
286,977	**Total Funding @ M03**

CCG / ICB Statement of Comprehensive Income

Month 3 2022/23 - June Statement of Comprehensive Income	Year to Date Plan £'000	Year to Date Actual Position £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000
Acute Services	137,760	138,429	(669)	137,760	137,760	0
Mental Health Services	28,407	27,967	440	28,407	28,407	0
Community Health Services	26,387	24,491	1,897	26,387	26,387	0
Continuing Care Services	17,968	15,568	2,400	17,968	17,968	0
Primary Care Services	33,337	32,165	1,172	33,337	33,337	0
Primary Care Co-Commissioning	26,458	25,707	752	26,458	26,458	0
Other Programme Services	13,402	10,158	3,244	13,402	13,402	0
Total Commissioning Services	**283,721**	**274,485**	**9,236**	**283,721**	**283,721**	**0**
Running Costs	3,256	2,475	781	3,256	3,256	0
TOTAL NET EXPENDITURE	**286,977**	**276,960**	**10,017**	**286,977**	**286,977**	**0**
ALLOCATION	**286,977**	**286,977**	**0**	**286,977**	**286,977**	**0**
CCG / ICB Transition Allocation Adjustment	**0**	**(10,017)**	**10,017**	**0**	**0**	**0**
Underspend / (Deficit)	**0**	**0**	**(0)**	**0**	**0**	**0**

CCG / ICB Statement of Financial Position

	Closing Position as at 30/06/2022 £'000	Opening Position as at 01/04/2022 £'000
Property, Plant and Equipment	1,495	0
Intangible Assets	0	0
Total Non-Current Assets	**1,495**	**0**
Trade and Other Receivables	6,142	5,275
Cash and Cash Equivalents	21	46
Total Current Assets	**6,163**	**5,321**
Total Assets	**7,658**	**5,321**
Trade and Other Payables	(53,030)	(65,747)
Provisions	(5,552)	(5,648)
Total Current Liabilities	**(58,582)**	**(71,395)**
Total Assets less Current Liabilities	**(50,924)**	**(66,074)**
Non-Current Liabilities	0	0
Total Non-Current Liabilities	**0**	**0**
Total Assets less Total Liabilities	**(50,924)**	**(66,074)**
General Fund	50,924	66,074
Reserves	0	0
Total Equity	**50,924**	**66,074**

ICB Savings and Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB) - 2022/23 SAVINGS PROGRAMME - AS AT MONTH 3									
PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN EFFICIENCY PLAN £'000	FORECAST OUTTURN EFFICIENCY (YTD ACTUALS + FORECAST REMAINING MONTHS) £'000	FORECAST OUTTURN VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN AS % OF TARGET	HIGH LEVEL IN-YEAR RISK RATING
PRIMARY CARE MEDICATION OPTIMISATION	Direct Oral Anticoagulants (DOACs)	-	-	-	2,365	1,500	(865)	63%	RED - High Risk
	Primary Care Medicines Savings	90	90	-	1,000	1,000	-	100%	GREEN - Low Risk
	Medicines Optimisation (MO) Value Savings	-	-	-	250	250	-	100%	GREEN - Low Risk
	Medicines Optimisation (MO) Variation Projects	-	-	-	200	200	-	100%	GREEN - Low Risk
	Unidentified Medicines Optimisation Scheme				-	865	865		RED - High Risk
PRIMARY CARE MEDICATION OPTIMISATION - TOTALS		90	90	0	3,815	3,815	0	100%	
CONTINUING HEALTHCARE	Electronic Call Monitoring (ECM)	201	201	-	806	806	-	100%	GREEN - Low Risk
	End of Life Care (EoL) - >12 Weeks	90	90	-	518	518	-	100%	GREEN - Low Risk
	Placement Review (Top 20 Most Expensive @ 2%)	48	48	-	200	200	-	100%	GREEN - Low Risk
CONTINUING HEALTHCARE - TOTALS		339	339	-	1,525	1,525	-	100%	
Other - 1.1% contract efficiency, running cost savings and additional efficiencies		1,410	1,410	-	5,757	5,757	-	100%	GREEN - Low Risk
2022/23 ICB SAVINGS PROGRAMME - TOTALS		1,839	1,839	-	11,097	11,097	0	100%	AMBER - Medium Risk

RAG Key:

We have applied the following criteria in order to determine the 'In-Year Finance' RAG status of each scheme:

	<75% Delivery
	75% to 95% Delivery
	95% to 100% Delivery

ICB Savings and Efficiencies

- Based on Operational Lead updates and latest available data the ICB's savings programme is anticipated to deliver £10.232m of the £11.097m target (92.2%).

- The shortfall reflects concerns over the Medicines Optimisation project relating specifically to Direct Oral Anticoagulation (DOACs) medications, which is forecasting a £0.865m shortfall against a £2.365m target, based on reservations over the scale of DOAC medication switches.

- The project team are working with GP Practices to focus on the process of patient reviews and patient consultations to then understand the potential benefit of patients switching DOACs, while at the same time developing further projects around delivering medicines value, and exploring the possibility of increasing opportunities of prior year programmes

Agenda Item 9

Integrated Care Board Meeting

27 July 2022

Report Title	**Proposed Operating Model and Terms of Reference for Gloucestershire Health and Wellbeing Partnership.**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
Route to this meeting	This proposal has been developed by a short-life Task and Finish Group comprised of colleagues from the ICB, Gloucestershire County Council and the VCS Alliance					
Executive Summary	The purpose of this paper is to set out a proposed approach to the Integrated Care Partnership (ICP) for Gloucestershire. As agreed through the naming convention process, the Integrated Care Partnership will be referred to as the Gloucestershire Health and Wellbeing Partnership.					
Key Issues to note	The Integrated Care Partnership (ICP) will be a critical component of the Gloucestershire Integrated Care System (ICS). It will be jointly convened as a statutory committee by Gloucestershire County Council and the Integrated Care Board as equal partners and will comprise a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population they serve.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The key risk to be managed is the risk of confusion and duplication of the respective roles of the Health and Wellbeing Board and the Health and Wellbeing Partnership. The model has been designed to help mitigate this risk and ensure that these forums have a complementary role in Gloucestershire. Add a risk rating, even if low: (4x2) 8 (4x1)4 (residual meaning accepted risk)					
Management of Conflicts of Interest	There is no conflicts of interests related to this paper					
	Financial		**Information Management & Technology**			

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Resource Impact (X)	**Human Resource**		**Buildings**	
Financial Impact	In the first instance the financial impact is small but once it is developed, the Integrated Care Strategy developed by the Partnership will inform financial priorities and decisions across the Integrated Care System.			
Regulatory and Legal Issues (including NHS Constitution)	Integrated Care Partnerships, in line with the Health and Care Act 2022, are statutory committees within each Integrated Care System.			
Impact on Health Inequalities	Reducing health inequalities is central to the role and remit of the Health and Wellbeing Partnership.			
Impact on Equality and Diversity	An EIA should be completed for large scale projects and initiatives and the outcomes should be included here.			
Impact on Sustainable Development	N/A			
Patient and Public Involvement	Public engagement will be planned as an integral component of developing the Integrated Care Strategy.			
Recommendation	The Board is requested to: • Approve the operating model and the Terms of Reference for the Gloucestershire Health and Wellbeing Partnership			
Author	Helen England	**Role Title**	Improvement and Development Director	
Sponsoring Director (if not author)	Mary Hutton, Chief Executive			

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

Proposed Operating Model

Gloucestershire Health and Wellbeing Partnership

Purpose

The purpose of this paper is to set out a proposed approach to the Integrated Care Partnership (ICP) for Gloucestershire. As agreed through the naming convention process, the Integrated Care Partnership will be referred to as the Gloucestershire Health and Wellbeing Partnership. Further national guidance is expected, and this may lead to changes in this proposal.

The draft Terms of Reference for the Gloucestershire Health and Wellbeing Partnership are included in appendix 1.

Background

Under the Health and Care Act 2022, section 26, and *Health and social care integration: joining up care for people, places and populations (DHSC, 2022)* the formation of the statutory ICS will include two equally important and complementary components:

- **A statutory ICS NHS Body (Integrated Care Board)** which will lead and oversee the planning and delivery of NHS services across the whole system, develop a capital plan for NHS providers, hold the budget for the system, and meet the system control target, maintaining appropriate governance and accountability
- **A statutory Health and Care Partnership or Integrated Care Partnership (Integrated Care Partnership)**, bringing partners together to address the wider health, social care and public health needs of the population and the wider determinants of population health and wellbeing

Status of the Integrated Care Partnership

The Integrated Care Partnership (ICP) will be a critical component of the Gloucestershire Integrated Care System (ICS). It will be jointly convened as a statutory committee by Gloucestershire County Council and the Integrated Care Board as equal partners and will comprise a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population they serve.

The ICP will be built on existing partnerships and collaboration and will be focused on addressing the wider determinants of health. It will be fundamental to the way in which an Integrated Care System pursues integration through partnership working, in a way that enables people to live healthier and more independent lives for longer. The ICP will have the a central role in the planning and improvement of health and care, with a strong emphasis on taking a holistic and place-based view.

ICPs are intended to play a dynamic part of Integrated Care Systems, building on the assets that already exist in places, communities, and neighbourhoods. As such whilst the legislation and guidance are more detailed in relation to the ICB, national guidance is permissive and flexible in relation to the ICP.

In Gloucestershire, a set of key principles has guided the design of the Integrated Care Partnership. There is a shared commitment for the Partnership to be aspirational in its outlook, and for innovation to be rewarded and success celebrated, barriers acknowledged openly and learning embedded.

Key Principles to guide the design of the Gloucestershire Health and Wellbeing Partnership

- The Health and Wellbeing Partnership will operate at a strategic level with infrastructure below it to do the delivery
- Members will recognise the triple aim system mandate against which the Partnership will discharge its duties and responsibilities, and the pursuit of better health and wellbeing for all will be core to its purpose
- The Health and Wellbeing Partnership will be a partnership of equals and a culture of partnership and co-production will be reflected in its approach to developing and implementing the integrated care strategy
- The Health and Wellbeing Partnership will be both comprised of and draw on the leadership, expertise, and membership necessary for the ICS to deliver its purpose in relation to taking **a whole population approach** to improving health outcomes and tackling health inequalities
- It will embody the **importance of the VCSE** as strategic partners and will adopt a model that enables the strength and diversity of the sector to contribute to the success of the ICS
- The ICP will promote and work within the agreed **Memorandum of Understanding** between the ICB and the VCSE sector
- The ICS governance and decision-making models will be based on the principle of subsidiarity with decisions taken as close to the communities and people they affect as possible
- **Distributed leadership** and a collective model of decision-making and accountability will strengthen mutual accountability for achieving the shared vision and objectives for Gloucestershire. This will include accountability to local residents.
- **Senior Local Authority officers** will be members of both the Health and Wellbeing Partnership and the Integrated Care Board.
- The **voice of local people and communities** will be an essential input to the Health and Wellbeing Partnership, and this will be achieved through a comprehensive community engagement model and not solely through membership
- There will be an explicit **commitment to diversity** that underpins the process for Health and Wellbeing appointments as well as being reflected in how the Partnership operates
- The Health and Wellbeing Partnership will employ transparent mechanisms for **managing conflicts of interest**, informed by existing examples of good practice within One Gloucestershire
- The ICS will commit **to agile working** through both the Integrated Care Board and the Health and Wellbeing Partnership. Their committees and any task and finish groups together with the Executive Team and function will be designed to assist both Boards in targeting the right business and decisions. Supporting structures will facilitate this and will be predicated on the principle of subsidiarity outlined above.

- Integral to being a **learning system**, there will be a review process for Health and Wellbeing Partnership composition and effectiveness after the first two years. This will allow any changes indicated through assessment and feedback to be considered and agreed
- The Health and Wellbeing Partnership will commit **to ongoing facilitated development** to ensure that performance is optimised, and is informed by good practice from other Integrated Care Systems
- The Health and Wellbeing Partnership will **collaborate** as necessary with other NHS, statutory bodies, or voluntary sector partners to fulfil its core purposes and deliver its commitment to the Gloucestershire population

Relationship between the Integrated Care Board and Health and Wellbeing Partnership

The Integrated Care Board and Health and Wellbeing Partnership will have a very close interface. We have described it as operating with a semi-permeable membrane whereby there are members of the Partnership who will also either be members of the ICB or be invited to attend specific ICB meetings. These arrangements will include:

- The Health and Wellbeing Partnership Chair will attend the ICB and the Chair of the ICB will be a member of the Partnership
- The Director of Public Health will sit on both the ICB and the Partnership
- Healthwatch Gloucestershire will attend ICB twice a year as well as sitting on the Health and Wellbeing Partnership
- Our model for embedding Voluntary, Community and Social Enterprise (VCSE) accountable representation will mean that VCSE Strategic Partnership Board representatives will be invited to attend the ICB twice a year.
- Healthwatch Gloucestershire and VCSE Strategic Partnership Board representatives will be invited to report key insights, intelligence and developments to ICB to inform debate and decisions as well as being core members of the Health and Wellbeing Partnership

Role and Remit of the Health and Wellbeing Partnership

The role of the Health and Wellbeing Partnership is to bring partners together to address the wider health, social care, and public health needs of the population of Gloucestershire and address the wider determinants of health and wellbeing.

The Partnership will lead and oversee the delivery of an Integrated Care Strategy which co-ordinates the work of partners and programmes across the county to achieve agreed health and wellbeing outcomes for Gloucestershire.

It will agree the mandate for key programmes of work and will hold to account the system delivery infrastructure through which health and wellbeing goals and improvements are pursued within defined timescales. The Partnership will ensure that intelligence and involvement from localities, districts and communities are core to how it operates and will work to remove barriers to delivery across the system.

The Health and Wellbeing Partnership will promote equity across the delivery infrastructure by ensuring that meeting and funding arrangements support inclusion and participation across partners.

Relationship between the Health and Wellbeing Partnership and the Health and Wellbeing Board

The Health and Wellbeing Partnership and Health and Wellbeing Board will adopt an aligned model. What this means in practice is the following arrangements will be applied:

- The Health and Wellbeing Board (HWB) will meet twice a year – once to sign off the ICB plan and once to review mid-point progress[1]. These meetings will also allow the Health and Wellbeing Board to continue with its other core responsibilities which including signing off a suite of returns, needs assessments, annual reports and evaluations.
- There will be a large degree of commonality between the membership of the HWB and the Health and Wellbeing Partnership
- The HWB should hold a mirror up to the system and hold the Health and Wellbeing Partnership to account for delivery of the system wide priorities for health, wellbeing and reducing health inequalities.
- The HWB will retain its important role in monitoring specific progress against agreed priorities including the current seven Health and Wellbeing Board strategy priorities.
- The HWB retains responsibility for signing off ICB plans.
- The Chair of the Health and Wellbeing Board is elected annually. It is proposed that the Health and Wellbeing Board and Health and Wellbeing Partnership share a chair in common. The annual process through which the Chair of the Health and Wellbeing Board is elected will be used to confirm that both forums wish to continue the chair in common model.

Membership

Delivering on strategic priorities through partnership will involve a wide range of partners. It is recognised that the nationally suggested list is very extensive and includes, but is not limited to, voices of children and young people, the voluntary and community sector, primary care, housing, and criminal justice. However, the Gloucestershire Health and Wellbeing Partnership will ensure that a process to support continuous engagement with partnership is adopted such that not all partners need to be a member of the Partnership for their voice to be heard and shape the strategic agenda.

- The Health and Wellbeing Partnership will work to strengthen collaboration through existing and new partnership forums, for example through partnering with the VCSE Strategic Partnership Board to co-design and plan regular engagement events and opportunities with VCSE partners
- The membership of the Health and Wellbeing Partnership will be closely aligned with the membership of the Health and Wellbeing Board (HWB), although there will also be some differences.
- Membership on the Health and Wellbeing Partnership will include the Lead Governor for Gloucestershire Hospitals Foundation Trust (GHFT) and Gloucestershire Health and Care (GHC) given the important role of governors in public representation.

It is expected that members will be readily able to appreciate the strength of others and senior enough to not only shape the delivery of health and wellbeing priorities but also to

[1] Changing the frequency of current HWB Board Meetings needs to follow formal procedure so this will take time to enact

change and influence organisational practices. Members will together hold organisations, programmes and local networks and partnerships to account for supporting the progress needed to achieve agreed goals and outcomes.

Proposed membership of the Health and Wellbeing Partnership will include:

- Chair (proposed to be shared Chair with Health and Wellbeing Board)
- ICB Accountable Officer
- One member drawn from the ICB Executive Team
- One member drawn from Gloucestershire Hospitals NHS Foundation Trust
- One member drawn from Gloucestershire Health and Care NHS Foundation Trust
- One member drawn from Healthwatch Gloucestershire,
- GCC Executive Director of Adult Social Care
- GCC Director of Public Health
- GCC Executive Director of Children's Services
- One member drawn from primary care, either a member or participant of the ICB
- Lead Governor for Gloucestershire Hospitals NHS Foundation Trust
- Lead Governor for Gloucestershire Health and Care NHS Foundation Trust
- Six members drawn from each of the Integrated Locality Partnerships (ILPs)
- Six members drawn from each of the District Councils
- One member drawn from Clinical Programme Groups (CPG)
- One member drawn from Enabling Active Communities and Individuals (EAC – I) representative
- One member drawn from the VCSE Strategic Partnership Board
- One member drawn from the VCS Alliance
- One member drawn from the Independent Social Care Provider Sector
- Chair of the Integrated Care Board

Priorities

There are already a large number of system wide priorities including priorities from the Health and Wellbeing strategy and board, strategic programmes, such as Enabling Active Communities and Individuals and Healthy Communities Together, the work delegated to and led through Clinical Programme Groups (CPGs) and Integrated Locality Partnerships (ILPs).

The priorities cannot be delivered by the public sector alone. The civic society and our communities are essential to the success of achieving positive outcomes in each of these priorities. The Health and Wellbeing Partnership will work to add value to the delivery of agreed programmes, in line with shared priorities. Health inequalities will be the golden thread through the work overseen by and supported by the Health and Wellbeing Partnership.

Meetings

The following arrangements for meetings will be adopted:

- The Health and Wellbeing Partnership will meet every two months.
- There will be an appointed joint Chair of the Partnership and Health and Wellbeing Board.
- Twice a year, the HWB will meet to hold the Health and Wellbeing Partnership to account. This will be once to sign off the ICB five-year and annual plans and once at a midway point to review and assess progress against agreed strategic priorities.
- A series of events will be facilitated by the Health and Wellbeing Partnership outside of the formal meetings to engage and collaborate with a range of partners and stakeholders. VCSE engagement and collaboration will be co-designed with the VCSE Strategic Partnership Board.
- The meetings will be supported by a secretariat.

Secretariat

A shared secretariat will be established to help minimise separation between HWB/HWBP/ICB and align reporting. This will require senior resource in the shared secretariat to understand the governance and delivery architecture across the whole system.

Opportunities

The creation of the Health and Wellbeing Partnership presents opportunities to:

- **Build on existing governance structures** such as health and wellbeing boards (HWBs) and other place-based partnerships, and support newly forming structures to ensure governance and decision-making are proportionate, support subsidiarity and avoid duplication across the ICS
- Drive and enhance **integrated approaches and collaborative behaviours** at every level of the system, where these can improve planning, outcomes and service delivery
- Foster, structure and promote an ethos of **partnership and co-production**, working in partnership with communities and organisations within them
- Address health challenges that the health and care system cannot address alone, especially those that require a longer timeframe to deliver, such as **tackling health inequalities** and the underlying **social determinants** that drive poor health outcomes, including employment, reducing offending, climate change and housing
- Continue working with multiagency partners to **safeguard** people's rights and ensure people are free from abuse or neglect and not deprived of their liberty or subject to compulsory detainment or treatment without safeguards
- **Develop strategies** that are focused on addressing the needs and preferences of the population including specific cohorts (such as babies, children and young people; or ageing populations)

Risks

Whilst the establishment of the Health and Wellbeing Partnership presents opportunities, for a smaller system like Gloucestershire, where the majority of ICS governance will be conducted at the system level, there could be a **risk of duplication** between the work of the

Health and Wellbeing Partnership and the HWB. The proposed model enables the oversight of the delivery of the HWB priorities through the Health and Wellbeing Partnership to mitigate this risk.

- The **remit of the Health and Wellbeing Partnership will be significant** and will cover the wider determinants of health and primary through to tertiary prevention. There are already a large number of identified priorities within our system for health, wellbeing and health inequalities. The challenge will be for the Health and Wellbeing Partnership to focus on where they can most add value. The risk is that the wide remit fails to result in driving change in our system and the desired improvements in population health and wellbeing outcomes.
- Additionally, there is a risk that to address the wide scope, the **membership of the Health and Wellbeing Partnership is too extensive**. This may impact on the effectiveness of meetings and needs to be carefully managed.
- Furthermore, there is a risk that the **initial membership of the Health and Wellbeing Partnership will not reflect the range of representation required** to progress the priorities. It is recognised though that the remit of this work is very wide and once priorities have been identified, there may need to be some further refinement of the membership.

Timeline

18th July	Further national guidance expected on Integrated Care Partnerships
19th July	Draft ICP Terms of Reference and proposal presented to Health & Wellbeing Board
27th July	Draft ICP Terms of Reference and proposal presented to the Integrated Care Board
End July	Letter sent out to invite members to the ICP
20th September	First ICP meeting in shadow form
10th October	GCC Constitution committee to agree changes to HWB and ICP
Date tbc October	ICP strategy workshop
9th November	Full Council Meeting
Date tbc November	ICP Meeting
End November	Draft Integrated Care Strategy presented to Health and Wellbeing Board and Integrated Care Board
December	Additional ICP Meeting to sign off draft strategy
December	Health and Wellbeing Board and Integrated Care Board to agree draft strategy
January to March 2023	Public engagement on draft Integrated Care Strategy

Review

Recognising some of the challenges and potential risks of the proposed model, the Health and Wellbeing Partnership will be established with the agreement that there will be a formal review of this operating model after the first 12 months.

Version	Authors	Status	Date	Review
v.4.5	Zoe Clifford Public Health Consultant Helen England Improvement and Development Director	Draft	6th July 2022	Paper developed by the ICP Development Task and Finish Group after meetings on 15th March and 11th April and further iterated by HE and ZC throughout May and June. Comments received from Mary Hutton, Sarah Scott, Carole Allaway-Martin and Rob Ayliffe. For review through ICS Transition Programme Governance and approval by the Health and Wellbeing Board and the Integrated Care Board.
V4.6			11th July 2022	Paper reviewed by ICP Development Task and Finish Group after meeting on 11th July and further iterated by HE and ZC on 11th July.

Appendix 1

GLOUCESTERSHIRE
HEALTH AND WELLBEING PARTNERSHIP

TERMS OF REFERENCE

Version	Author	Approved by	Review	Type of changes
v0.1	Helen England Joint Executive Lead Governance and Accountability – ICS Transition Programme			Creation of ToR – draft v0.1 for review
v0.2	Dan Corfield			First review and formatting changes.
v0.3				Review by RA and SS - GCC
v0.4				Review by Task and Finish Group
V0.5	Helen England and Zoe Clifford			Changes following Task and Finish Group review points

1. Introduction

1.1. The Gloucestershire Health and Wellbeing Partnership is a statutory Committee of the One Gloucestershire Integrated Care System (ICS), established jointly between the NHS Gloucestershire Integrated Care Board (ICB) and Gloucestershire County Council as equal partners and statutory members. This is the Gloucestershire Integrated Care Partnership as required by section 26 of the Health and Care Act 2022.

1.2. The founding members of the Partnership, the Integrated Care Board and Gloucestershire County Council share a statutory duty to meet the health and care needs of the population.

1.3. These Terms of Reference (ToR) set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the joint approval of the ICB and Gloucestershire County Council The Terms of Reference will be subject to an annual review.

1.4. The Committee and its development will be informed by The Health and Care Act 2022 and associated national guidance and will bring partners together to address the wider health, social care and public health needs of the population and the wider determinants of population health and wellbeing.

2. Purpose and principles

2.1 The Gloucestershire Health and Wellbeing Partnership is a key component of the governance architecture for the One Gloucestershire ICS. Alongside the ICB, its purpose is to deliver the four fundamental purposes of the ICS:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

2.2 The Partnership has a statutory duty to prepare an Integrated Care Strategy that sets out how the assessed population needs of Gloucestershire and strategic priorities for health and wellbeing will be met by the Integrated Care Board, NHS England, or the responsible local authorities whose areas coincide with or fall wholly or partly within its area.

2.3 The design of the Health and Wellbeing Partnership is shaped by a set of principles agreed by partners across the ICS.

2.4 The Health and Wellbeing Partnership will operate at a strategic level with a supporting infrastructure to enable delivery of key work programmes.

2.5 Members will share a common commitment to pursue better health and wellbeing for all as a core purpose of the Partnership.

2.6 The Health and Wellbeing Partnership will promote a culture of partnership and co-production and this will be reflected in its approach to developing and implementing the integrated care strategy.

2.7 The Health and Wellbeing Partnership will be both comprised of and draw on the leadership, expertise, and membership necessary to deliver its purpose in relation to taking a whole population approach to improving health outcomes and tackling health inequalities.

2.8 The Health and Wellbeing Partnership will embody the importance of the VCSE sector as a strategic partner and will adopt a model that enables the strength and diversity of the sector to contribute to the success of the ICS, working within the agreed Memorandum of Understanding between the ICB and VCSE" or, you could make the model=the MOU by amending to "It will embody the importance of the VCSE sector as a strategic partner and will adopt the agreed Memorandum of Understanding that enables the strength and diversity of the sector to contribute to the success of the ICS.

2.9 The Partnership's governance and decision-making models will be based on the principle of subsidiarity with decisions taken as close to the communities and people they affect as possible.

2.10 Distributed leadership and a collective model of decision-making and accountability will strengthen mutual accountability for achieving the shared vision and objectives for Gloucestershire. This will include accountability to local residents.

2.11 Senior Local Authority officers/councillors will be members of both the Health and Wellbeing Partnership and the Integrated Care Board.

2.12 The voice of local people and communities will be an essential input to the Health and Wellbeing Partnership, and this will be achieved through a comprehensive community engagement model and not solely through membership.

2.13 There will be an explicit commitment to diversity that underpins the process for appointments to the Partnership as well as being reflected in how it operates.

2.14 The Health and Wellbeing Partnership will employ transparent mechanisms for **managing conflicts of interest**, informed by existing examples of good practice within One Gloucestershire.

2.15 The ICS will commit **to agile working** through both the ICB and the Health and Wellbeing Partnership. All committees and any task and finish groups together with

the ICB Executive Team and function will be designed to assist both the ICB Board and HWBP in targeting the right business and decisions. Supporting structures will facilitate this and will be predicated on the principle of subsidiarity outlined above.

2.16 Integral to being a **learning system**, there will be a comprehensive review process for Health and Wellbeing Partnership composition and effectiveness after the first two years. This will allow any changes indicated through assessment and feedback to be considered and agreed. Subsequently, there will be routine annual review of effectiveness and the Terms of Reference.

2.17 The Health and Wellbeing Partnership will commit to ongoing facilitated development to ensure that its effectiveness is optimised and is informed by good practice.

3. Statutory Role

3.1 The Gloucestershire Health and Wellbeing Partnership is a statutory committee of the Integrated Care System. Its authority is derived from the Health and Care Act 2022.

3.2 The Partnership can oversee and progress partnership working in pursuit of any health and wellbeing priorities reflected within the Health and Wellbeing Strategy or the Integrated Care Strategy.

3.3 It can seek any information it requires within its remit and request relevant data and evidence to support its work and decision-making.

3.4 It can commission reports as necessary to help fulfil its obligations.

3.5 It can create task and finish sub-groups in order to address targeted objectives. The Partnership shall determine the membership and terms of reference of any such task and finish sub-groups but may not delegate any decisions to such groups. It is essential that there is a broad range of representation in the sub-groups.

3.6 Our system already has a wide range of partnerships and boards leading and delivering on health and wellbeing priorities. The Health and Wellbeing Partnership aims to bring these together to provide a more co-ordinated approach across our system.

3.7 The Citizen's Panel will report to the Health and Wellbeing Partnership every 6 months.

4. Membership

4.1. The Health and Wellbeing Partnership shall be established by two founding members; one to be appointed by the Integrated Care Board, and one to be appointed by Gloucestershire County Council.

4.2. The founding members will then convene the remaining members of the Partnership in line with these Terms of Reference.

4.3. Members will possess between them knowledge, skills and experience in:

- The determinants of health and wellbeing;
- Primary, secondary and tertiary prevention;
- Social care;
- Clinical expertise;
- Locality and community engagement and development;
- Strategy and partnership development;
- Programme planning and delivery;
- Measurement, evaluation, and benefits realisation;
- Working with people and communities and public/citizen voice and representation.

4.4. Given the wide remit of the Health and Wellbeing Partnership, we recognise the need for breadth in the representation on the membership.

4.5. When appointing members to the Committee, active consideration will be made to promoting diversity across the Partnership's membership.

4.6. <u>Membership</u>

4.6.1. Committee members will include:

- Chair (will be the same as the Chair for the Health and Wellbeing Board); to be appointed by the County Council
- ICB CEO; to be appointed by the Integrated Care Board
- All other members below will be appointed by the Integrated Care Partnership
- One member drawn from the ICB Executive Team;
- One member drawn from Gloucestershire Hospitals NHS Foundation Trust able to contribute to strategy development and delivery;
- One member drawn from Gloucestershire Health and Care NHS Foundation Trust able to contribute to strategy development and delivery;
- One member drawn from Healthwatch Gloucestershire;
- Gloucestershire County Council Executive Director of Adult Social Care;
- Gloucestershire County Council Director of Public Health;
- Gloucestershire County Council Executive Director of Children's Services;
- One member drawn from primary care, either a member or participant of the ICB;
- Lead Governor for Gloucestershire Hospitals NHS Foundation Trust;

- Lead Governor for Gloucestershire Health and Care NHS Foundation Trust;
- Six members drawn from the Integrated Locality Partnerships (ILPs) (one from each);
- Six members drawn from the District Councils (one from each);
- One member drawn from Clinical Programme Groups (CPGs);
- One member drawn from Enabling Active Communities and Individuals (EAC–I) representatives;
- One member drawn from the Voluntary, Community and Social Enterprise (VCSE) Strategic Partnership Board;
- One member drawn from the VCS Alliance
- One member drawn from the Independent Social Care Sector.
- Chair of the Integrated Care Board

4.7. Chair and Vice Chair

4.7.1. The Chair of the Committee will also be the Chair of the Health and Wellbeing Board and shall be appointed by the County Council.

4.7.2. The Chair of the Committee shall appoint a Vice-Chair from within the membership of the Committee.

4.7.3. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference in consultation with the designated Lead Executive Officer.

4.8. Attendees and other Participants

4.8.1. Only members of the Committee have the right to attend Partnership meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter including representatives from programme groups and forums that make up the delivery infrastructure for the Health and Wellbeing and Integrated Care Strategies.

4.9. Attendance

4.9.1. Where a member is unable to attend a meeting, a suitable alternative may be agreed with the Chair in advance.

4.9.2. The Chair of the ICB may also be invited to attend any meetings as required in order to gain an understanding of the Committee's operations and to align the work of the Integrated Care Board and the Health and Wellbeing Partnership.

4.10 Meetings in public

4.10.1 Meetings will be held in public and meeting arrangements, papers and minutes will be available on the Health and Wellbeing Partnership website.

4.11 Tenure

4.11.1 Where individuals are part of the Committee's membership as a result of their executive or non-executive role, they will stay on the Committee for the duration of their time in that post.

4.11.2 Where members are drawn from a particular constituency within the health and care system, partner organisations or bodies will be invited to confirm every three years the nominated members who will form part of the Partnership's membership.

4.11.3 Where circumstances change, partner organisations or bodies can submit a request to the Chair to propose a change in individual members of the Partnership.

5. Quoracy

5.1. For a meeting to be quorate a minimum of 50% members is required, including either the Chair or Vice Chair.

5.2. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Voting and decision making

6.1. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2. Only members of the Committee who are present may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

7. Frequency and notice of meetings

7.1. The Partnership will meet at least six (6) times a year and the typical cycle will be meeting every other month. Additional meetings may take place as required at the request of the Chair

7.2. The Chair or Lead Executive may ask the Partnership to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.3. Meetings will be held in public; and where circumstances dictate, they may be conducted via electronic means.

8. Secretariat

8.1. The Committee shall be supported with a secretariat function shared with the Health and Wellbeing Board and the Integrated Care Board.

8.2. The secretariat function shall ensure that:

8.2.1. The agenda and papers are prepared and distributed at least five working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead(s).

8.2.2. Attendance by members of the Committee is monitored and reported annually as part of the respective annual reports of the ICB and the County Council;

8.2.3. Records of members' appointments and renewal dates is overseen and where required membership is renewed, or new members identified;

8.2.4. Good quality minutes are taken and agreed with the Chair and approved by the Partnership, and that a record of matters arising, action points and issues to be carried forward are kept;

8.2.5. The Chair is supported to prepare and deliver reports to the Board;

8.2.6. The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.2.7. Action points are taken forward between meetings and progress against those actions is monitored.

8.2.8. A register of interests is maintained

9. Remit and responsibilities of the Partnership

9.1. To lead and co-ordinate the pursuit of better health and wellbeing for all across system partners.

9.2. To agree and oversee the development of the Integrated Care Strategy for the whole Gloucestershire population, aligned to and integrated with the Health and Wellbeing Strategy.

9.3. To ensure that the best available evidence and data is use do inform strategic decisions across the health and social care agendas across the life course.

9.4. To drive the direction of the ICS and oversee the delivery programmes and arrangements through which the aligned Integrated Care and Health and Wellbeing Strategies will be delivered.

9.5. Where required, make recommendations to the ICB on the delivery of the Integrated Care Strategy and to collaborate with the ICB on facilitating joint action and integrated working across partners to improve health and care services.

9.6. To receive assurance from programme boards and groups throughout the delivery infrastructure that measurable progress the implementation of specific elements of the strategy is being made.

9.7. To co-ordinate measurement and evaluation of the achievement of key strategic milestones and objectives and progress in improving health outcomes for citizens and the population as a whole.

9.8. To co-ordinate programmes of work across system partners that will reduce health inequalities and embed population health strategies and approaches.

9.9. To consider the alignment of policy, plans and resource utilisation across the system to the strategic priorities expressed in the Integrated Care Strategy – including the use of pooled funds and the mobilisation of assets beyond statutory organisations.

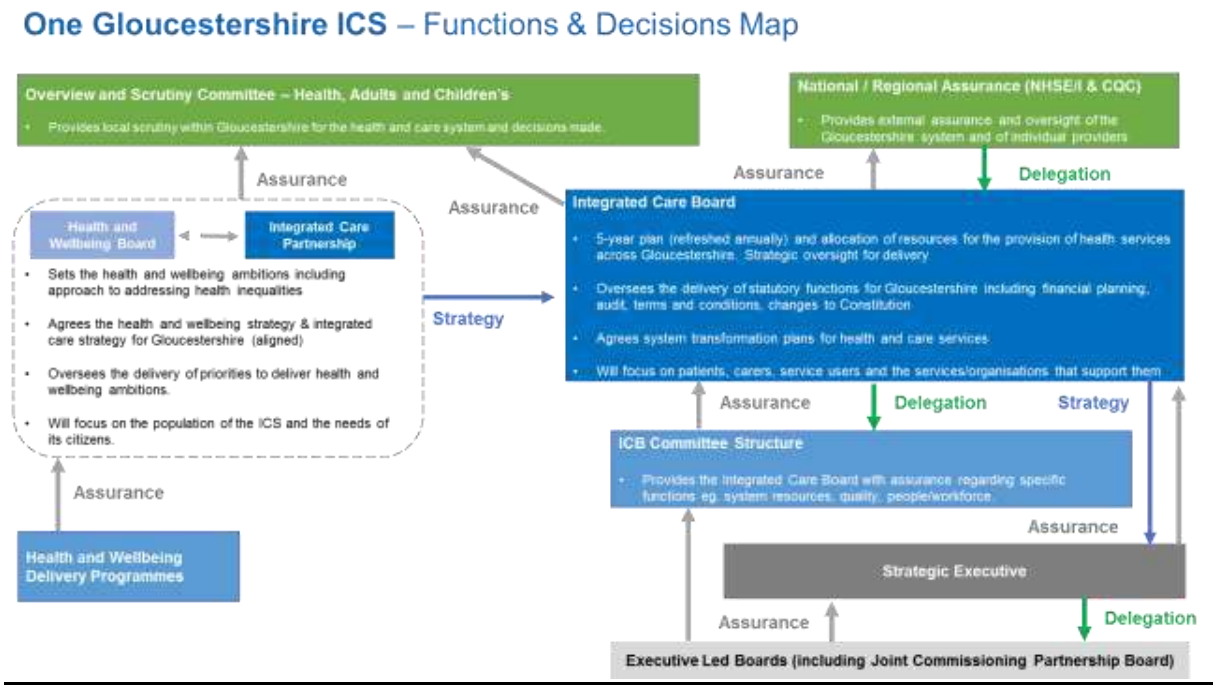
9.10. Together with the ICB, to foster an approach to collaboration and partnership working built on the shared vision and values for the One Gloucestershire ICS.

9.11. To ensure that a proactive approach to embedding best practice in equality, diversity and inclusion is role modelled throughout the work of the Gloucestershire Health and Wellbeing Partnership.

9.12. To convene and support the engagement and involvement of citizens and communities as part of delivering the Working With People And Communities (WWPAC) strategy.

10. Relationship between the Partnership and other system groups / committees / boards

10.1 The relationship between the Gloucestershire Health and Wellbeing Partnership and other key strategy and governance fora in the health and care system is illustrated in the Functions and Decisions Map:



11. Monitoring and Reporting

11.1 The minutes of the meetings shall be formally recorded by the secretariat and will be available on the Partnership's website as well as the County Council's website.

11.2 The Chair may be invited to attend meetings of the ICB and Health and Wellbeing Board in order to align strategy, planning, delivery and decisions across the Integrated Care System.

11.3 The Committee will provide an annual report to stakeholders to describe how it has fulfilled its Terms of Reference, to provide a summary of key achievements in delivering its responsibilities and to report progress in relation to the Integrated Care Strategy.

12. Conduct of the Committee

12.1 Members of the Committee will be expected to conduct business in line with the core purpose of the ICS and the shared vision and values of its partners.

12.2 Members of, and those attending, the Committee shall behave in accordance with the respective policies on Standards of Business Conduct agreed by the ICB and the County Council and in line with the Council's Code of Conduct for Councillors

12.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

12.4 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Secretariat. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair will require the affected member to withdraw at the relevant point.

13. Review of ToR

13.1 The Committee will review its effectiveness at least annually. These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference (including membership) will be submitted to the ICB Board and the County Council for approval.

Agenda Item 10

Integrated Care Board Meeting

27 July 2022

Report Title	**Frailty Strategy (Final version)**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X		X		
Route to this meeting	The frailty strategy has been collaboratively developed with a wide variety of stakeholders. During its development there has been regular engagement with public and system partners. The frailty strategy is also an agenda item on the August Quality and Governance meeting.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Frailty and Dementia Clinical Programme Group sign off June 2022.	09/06/2022	GCH, ASC, VCS, GHFT, Primary Care, Independent Sector	May 2021-April 2022			
Executive Summary	The frailty strategy works within the current Clinical programme methodology and we would like to share this with the Board and we have just set up an urgent care clinical programme group as set out in the attached slides. The strategy focuses on prevention, early identification of health needs, and improving the urgent support required when needed. This proactive approach, combined with improved collaboration between primary, community, acute and social care, will support frail and older adults to live independently for longer. The strategy has identified 4 key priorities. • To prevent frailty • To identify frailty • To manage frailty • Develop a skilled and competent Workforce The strategy also includes a number of key aims and principles these include: • Improving the health and wellbeing of the people of Gloucestershire • Increasing understanding of frailty inequity and inequalities and how to improve access to all sectors of the community • Supporting the building of compassionate, supportive local communities and neighbourhoods • Recognise and support carers • Embrace a positive view of ageing						

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Key Issues to note	Further work is required to understand the needs of specific sections of the population, such as those who are homeless, younger people (aged 64 and below) who have frailty, individuals with learning disability, individuals from BAME groups.			
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	No key risks linked directly to the strategy were identified. Overarching frailty risks have been captured on risk register. Frailty strategy implementing workstreams will revisit and capture risks and mitigations.			
Management of Conflicts of Interest	None identified			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	There is no direct financial impact linked to the development and publication of the strategy. The implementation of the strategy seeks to ensure the effective and efficient use of resources which may have financial implications.			
Regulatory and Legal Issues (including NHS Constitution)	The strategy supports system partners to collaborate as experts to support individuals who are either at risk of becoming frail or those living with frailty by tailoring supportive interventions that enable the person to live well in their place of choice. There are no known legal issues that the board should be aware of.			
Impact on Health Inequalities	One of the core principles of the strategy is to address inequalities. It seeks to improve understanding of these inequalities and engage with individuals and stakeholders to develop ways to address these.			
Impact on Equality and Diversity	An EIA has been completed for the strategy and will be regularly reviewed.			
Impact on Sustainable Development	N/A			
Patient and Public Involvement	Patient and public engagement has taken place during the development of the strategy. Continued ongoing patient and public engagement throughout the lifecycle of the strategy will help ascertain if the principles and priorities within the strategy have been met. The strategy will be made publicly accessible in a variety of formats.			
Recommendation	The Board is requested to: • Approve the Frailty Strategy • Support the communication and raise awareness of the frailty strategy and the development of the workstreams and implementation of the strategy.			
Author	Jane Haros/ Sian Cole	**Role Title**	Associate Director Nursing/ Clinical Commissioner	
Sponsoring Director (if not the author)	Mary Hutton			

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Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

One Gloucestershire
Transforming Care, Transforming Communities

Clinical Programmes Update
(With a focus on Urgent and Emergency Care and Frailty)

July 2022

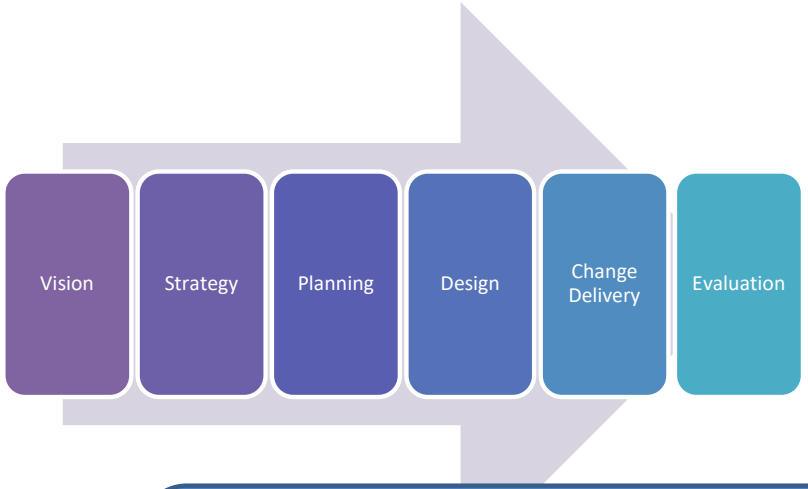
@One_Glos
www.onegloucestershire.net

Our **Mission** is to:

‘Systematically redesign the way care is delivered in the One Gloucestershire system by all partners working together to reorganise and integrate systems to deliver the right care, in the right place, at the right time.

Our **Vision** is to:

“To deliver high-value, integrated care that uses population health data to support the whole population of Gloucestershire to have the best possible physical and mental health outcomes and to lead the most happy and healthy lifestyles for them.



The Clinical Programme (Transformation) Approach is focussed on describing the steps involved in translating our Vision and Strategy into delivery of tangible change in clinical services

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The Clinical Programme Approach is:

- Central to the way we are working in Gloucestershire to **transform care pathways and improve outcomes** delivered by health and care services for our population
- **Patient and Person Centred**, with a vision to drive the best outcomes in health and care for the people we serve, within the resources that we have
- Based on the principles of the health economics framework known as 'Programme Budgeting and Marginal Analysis' (PBMA) to ensure **'best value'** and grounded in the tools and techniques of recognised **improvement methodologies**
- **Clinically Led,** with each Clinical Programme Group (CPG) chaired by a Clinical Lead with a wide membership that includes clinical and managerial colleagues from across health and care organisations in Gloucestershire, as well as **system partners, patient and public** representation
- Centred on the principle of delivering a **whole care pathway approach, supporting a shift to prevention and self-management** where possible and focused on the system objectives of delivering joined-up, evidence based and affordable care
- About planning and delivering improvement projects (some disinvestment, some investment) which then need to be resourced and delivered in a timely way and clearly **evaluated** so that the **CPG can demonstrate incremental improvement in outcomes** for the given programme area
- Standardised in terms of how we describe the **outputs of redesign work**, for example we use standard services specification templates, pathway mapping tools and an electronic pathway resource in G Care https://g-care.glos.nhs.uk

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Clinical Programme (Transformation) Approach

Overarching Strategy and Vision; Defining the Challenge, Outcomes

Our Shared Purpose

- Leadership For Change: HealthCare Leadership Model – nine dimensions
- Thinking Differently – Methodology to Unpack ideas and long held truths
- Local Values and Principles for Distributed Leadership

Planning Cycle	Programme M'gement Cycle	NHS Change Model	Activities
			Engagement of Professionals, Patients and Public throughout the Cycle
Planning	Review, Analysis Planning	Engagement To Mobilise	• Undertake population planning – taking into consideration all relevant needs presented by our population and not just considering those that are already present in care delivery systems (public health review) • Review clinical evidence base and care pathways, from prevention to end of life • Undertake benchmarking and best practice reviews to inform opportunities for change • Identify profile of resources involved in area under consideration (programme budget) to allow opportunity to enable delivery of 'best value' • Agree programme objectives and desired outcomes with key stakeholders, secure buy in • Ensure 'patient voice' informs case for change and opportunities for improvement
Design	Programme and Project Design	Improvement Methodology	• Workshop approach to bring all stakeholders together to rethink the pathway • Develop desired person centred service models using People and Place model / care pathways – consider opportunities for prevention, self-care, use of technology • Identify opportunities for innovative approaches to commissioning / contracting needed to support delivery • Formalise and prioritise outcomes that the planned change will deliver and how this will be measured - how will we know that we have achieved what we set out to deliver? • Ensure that there is a focus on creating sustainable clinical systems where any waste / unwarranted variation is minimised - right care, right time for patients
Delivery	Change Delivery		• Delivery through systematic transformation, working with partners across systems • Shared best practice approaches to change management and service redesign, building capacity of the system and wider partners to deliver • Ensure payment mechanisms (as needed) are structured to incentivise desired outcomes
Review	Evaluate	Transparent Measurement	• Formative evaluation - Monitoring of progress against objectives throughout programme / project lifecycle enabling accountability for progress and continuous cycles of virtuous improvement as required • Summative evaluation – at the close of the project / programme to report to system and ensure learning from change programme / project is applied to future improvement work

Leadership for Change / Rigorous Delivery / System Drivers

Spread of Innovation

22/23 Programmes

Respiratory	Diabetes	Circulatory	Frailty and Dementia
Cancer	Learning Disabilities and Autism	Mental Health	Pain Management
Eye Health	MSK & Rheumatology	Palliative and End of Life Care	Children and Young People
Rehabilitation Steering Group	Neurology	Renal/ Specialist services	Urgent and Emergency Care (from July 2022)

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22/23 Programmes – some delivery highlights:

- **Frailty:** CPG have worked together and with members of the public to develop an all-age frailty strategy that will better support the residents of Gloucestershire to age well and live independently for longer.
- **LD& Autism:** 3,200 people with a learning disability aged over 14 attended an Annual Health Check (this equates to 79% of people eligible receiving a check against a target of 75%). The best in the south west region
- **MSK:** Following a successful national bid, MSK are continuing to phase out the self-management app; getUbetter, currently reaching 930 registered users, resulting in avoiding 118 first GP appointments and 28 ED attendances
- **Respiratory:** over 60 practices signed up to deliver the Respiratory Diagnostic LES, diagnostic LES means that patients can access spirometry and FeNO testing to accurately diagnose COPD and Asthma respectively in practice, to ensure optimal management, fewer exacerbations and less medication wastage.
- The children's respiratory physiotherapy pilot has received overwhelming positive feedback from parents, carers and the wider health community and it has already helped reduce visits into PAU as a result of the therapy provided in the community.
- **Cancer:** We are building a team to deliver improved psychological support for cancer patients that will work across the ICS providing continuity and familiar faces for patients as they move between organisations on their cancer journey
- **Eye Health:** First in the country to provide community optometry with secondary care data and images.
- **Circulatory:** Have 2 clinical champions in post working with primary care to improve earlier diagnosis and optimal management for hypertension and CVD
- **Diabetes:** we have invested £145k per annum from system development funds to support a new Community Consultant post and community team support. Some examples of new support include offering consultant level domiciliary support to patients who need it ensuring parity of access to care for people in care homes and housebound individuals, a new primary care education programme and instituted a home testing approach to ACR (albumin to creatintine ratio) to increase number of patients receiving 8 care processes and reducing complications – 48 practices are now live on this system with 9500 patients contacted and 52% uptake of testing
- **Mental Health:** Development of the complex emotional needs service and the use of co-production with inclusion Glos and embedding of experts by experience in the CPG**.**

Urgent and Emergency Care

The Urgent and Emergency Care (UEC) Clinical Programme Group launched this month. Our priorities are to:

Focus on delivery of Health and Care Services today

- Ensure improved performance across all of the domains of UEC and System Flow, for example by:
  - Delivering our performance improvement plan (The Sloman Plan) with actions now agreed for every system partner (including SWASFT) and monitored weekly through our tactical and strategic escalation groups
  - A review of quality and patient safety (Quality deep dive chaired by ICB NED, to take place in August)
  - Commissioning a peer review from the LGA (June) to gain insight into our system opportunities and challenges
  - Leading the development of our Winter Plan to ensure we are well prepared for Winter 22/23

Transforming for the future:

- Work together to set a vision for UEC for Gloucestershire that puts our patients at the heart of everything we do
- Commission external expertise and insight to support the development of a comprehensive strategy and transformation plan for UEC for our county (following a rapid procurement exercise Newton Europe started July 2022)
- Develop and deliver a programme of OD to develop our shared culture across our health and care system in response to the findings of the LGA Peer Review

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What are Newton here to support

Newton in partnership with our system will be commencing a diagnostic over the course of the next few months which will set the foundations for a full transformation programme. During this diagnostic Newton will be working closely with us to focus on:

- Prevention and supporting independence, improving long-term care, care assessments and embedding the principles of personalisation across our system
- Developing resilient capacity across social care to support the needs of our population, with a focus on maintaining independence and prioritising wellbeing
- Proposing a capacity model for our system which does not only consider beds but takes account of non-bedded capacity requirements, including EIO and Home First
- Improving community hospital and assessment / reablement bed flow
- Increasing the efficiency and effectiveness of reablement and rehabilitation
- The hospital front door, ambulance handovers and admission avoidance
- Care in hospital and making discharge outcomes more independent
- Considering the future model for integrated commissioning / shared system flow management arrangements in the ICB

Health & Wellbeing Partnership

FRAILTY STRATEGY for Gloucestershire

2022-2027

One Gloucestershire
Transforming Care, Transforming Communities

CONTENTS

EXECUTIVE SUMMARY

Gloucestershire Integrated Care System (ICS), working together with its partners, seeks to improve the health and wellbeing of Gloucestershire's residents. Through joint and collaborative effort, we can help people to remain as independent as possible, narrow any equality or inequities in the system and make the best use of resources.

The Frailty Strategy sets out a vision for the future and outlines a plan to achieve this. At its core is a transition from a reactive to a proactive model of support that is delivered in people's homes or community locations. It seeks to enable collaborative and integrated working to deliver positive outcomes. In simple terms we want to offer the right care, at the right time, in the right place, that improves the outcomes and resilience of people of all ages, right across Gloucestershire.

Reduced resistance to stressors and decreased reserves are features of "frailty". However it is not an inevitable part of ageing. With the right information, intervention and support to meet their physical, emotional and cognitive needs, people can live happy, healthy and fulfilling lives.

The Needs Assessment, Public Health Information, literature reviews, stakeholder and public engagement have increased the understanding of frailty in Gloucestershire and the current challenges and future needs. We know that some sections of the community are at greater risk of frailty, such as those living with a long-term condition, a Learning Disability, who are homeless or live with high levels of deprivation. One of the most significant frailty factors however is age.

Research suggests that 10% of people aged over 65 may have some degree of frailty, rising to between a quarter and half of those aged 85 years.[1]

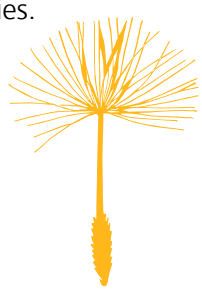
Gloucestershire has an ageing population with 21% aged 65+ years and this group is predicted to increase by 52% by 2043. The pandemic has also impacted on resilience, with individuals reporting increased levels of anxiety, loss of motivation, impacts on memory and loss of physical health.[2]

A frailty survey carried out in Gloucestershire in 2018/19 provided an insight into the views of the public. 81% of respondents thought that frailty could be prevented. They identified healthy diet and exercise as factors in keeping well. They also highlighted the need to raise awareness of frailty, the importance of information and knowing who to contact for advice.

Stakeholder workshops undertaken during the summer of 2021 brought together staff from across the statutory, voluntary and independent sectors. These events informed our understanding of frailty in Gloucestershire. They acknowledged challenges in the system and the impact of the pandemic. They also highlighted progress and developments, including the increased use of digital solutions, collaborative working and altered perspectives on community-based care.

This knowledge and understanding has informed the strategy and supported the development of four key priorities.

- Preventing frailty
- Identifying frailty
- Managing frailty
- Workforce



[1]Clegg A, Frailty in Older people Lancet 2013 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4098658/pdf/emss-59306.pdf

[2]Age UK https://www.ageuk.org.uk/latest-press/articles/2020/10/age-uk--research-into-the-effects-of-the-pandemic-on-the-older-populations-health/

The frailty strategy seeks to enable the delivery of a proactive community-based model of care that will increase resilience. It will prevent, halt, slow or reduce the impact of frailty, promoting healthy lifestyles that build resilience and help to anticipate and plan for change.

The strategy aims to ensure that regardless of where you live in Gloucestershire and regardless of your gender, socio economic status, ethnicity or age, you have access to information and support at or close to home that delivers positive outcomes for you, your family and carers. Our vision is for the people of Gloucestershire to live healthier, happier and longer lives.

OUR VISION

This strategy seeks to deliver the vision that:

The people of Gloucestershire live healthier, happier and longer lives.

Evidence gathered from the needs assessment, literature reviews and stakeholder engagement identified four key priorities:

- **Prevention of frailty**
- **Identification of frailty**
- **Management of frailty**
- **Workforce**

Promoting wellbeing and preventing ill health.

Develop workforce plans and initiatives to ensure staff are appropriately skilled and teams are fully staffed.

5

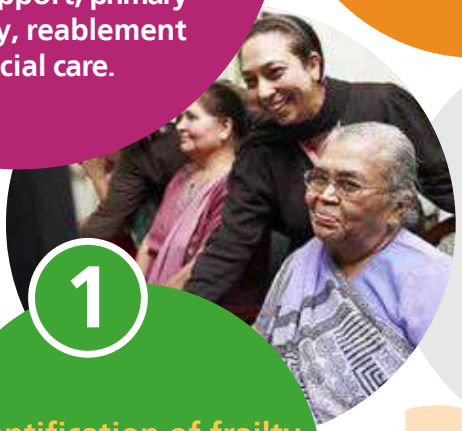
Transition to a proactive, holistic model of care that incorporates the components of emotional, physical and social care.

3

Management of frailty; supporting the development of a care pathway that focuses on care at home. Supported by a network of services that include same day emergency services, specialist support, primary care, therapy, reablement and social care.

4

Support statutory, independent and voluntary sector services to work collaboratively.



1

Identification of frailty.

Understanding of need and gaps to reduce inequalities and inequities.

2

Increased public understanding of frailty and how to build resilience.

6

10.2

Prevention of frailty

Build supportive neighbourhoods and communities. Work with transport and housing services to ensure safe housing that promotes independence and helps to reduce falls. Provide a range of wellbeing support to combat social isolation and loneliness. Run awareness raising campaigns and promote health to empower and inform.

Identification of frailty

Systematic screening and recording of frailty. Use of tools such as the Clinical Frailty Score, Comprehensive Geriatric Assessment and the Mental Health and Wellbeing assessment. Increased information sharing across systems.

Management of frailty

- Care and support at home providing alternatives to hospital admission: virtual wards, hospital at home, assistive technology, Same Day Emergency Care, (SDEC).
- Increased Multidisciplinary Team (MDT) working, Personalised care planning and coproduction.
- Medication optimisation.
- Falls prevention.
- Accessible information and resources. Reablement, rehabilitation and therapy. Adaptations and equipment.

Workforce

- Raising awareness, knowledge and understanding of frailty.
- Providing accessible information and resources.
- Recruiting and retaining staff.

Strategy development

The frailty strategy has been developed under the guidance of the Integrated Care System (ICS) Frailty and Dementia Clinical Programme Group (CPG). It has been informed by one to one, small group meetings and four larger stakeholder workshops held during the summer of 2021. At these events stakeholders from the statutory, third and voluntary sectors across the health and care landscape shared their experiences, ideas and views. This has provided a rich source of information that has been used to shape the development of the strategy, vision, principles and priorities. Views and feedback from experts by experience have been gathered from online surveys and informed by caseload reviews. Engagement with experts by experience, carers and wider stakeholders will be a key feature in the ongoing development, review and evaluation of the strategy.

The Vision

The vision for frailty is that the people of Gloucestershire live healthier, happier and longer lives. It reflects the principles set out in the NHS Long Term Plan[3], Ageing Well Programme and echoes the vision and ambitions detailed in the Gloucestershire Joint Health and Wellbeing Strategy[4].

The frailty strategy seeks to enable the development of a frailty pathway that will reduce variation, improve quality of care, support integrated working and deliver positive outcomes for the individual and their carers.

[3] The NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[4] Gloucestershire Joint Health and Wellbeing Strategy 2020-2030 https://www.gloucestershire.gov.uk/media/2106328/gc-c_2596-joint-health-and-wellbeing-strategy_dev12.pdf

AIMS AND PRINCIPLES

Aims

Over the next five years the strategy aims to:

- ➔ Improve the health and wellbeing of the people of Gloucestershire.
- ➔ Increase our understanding of inequity and inequalities and use this to improve access and support to all sectors of the community.
- ➔ Support a collaborative and integrated approach to managing frailty.
- ➔ Promote the delivery of personalised care.
- ➔ Raise awareness, knowledge and understanding of frailty.
- ➔ Build compassionate, supportive local communities and neighbourhoods.
- ➔ Provide a range of health and wellbeing support that meets individuals' physical, social and psychological needs.
- ➔ Provide care as close to home as possible.
- ➔ Proactively manage frailty, reducing the reliance and demand for urgent and emergency care services.
- ➔ Ensure there is a suitably skilled and competent workforce.

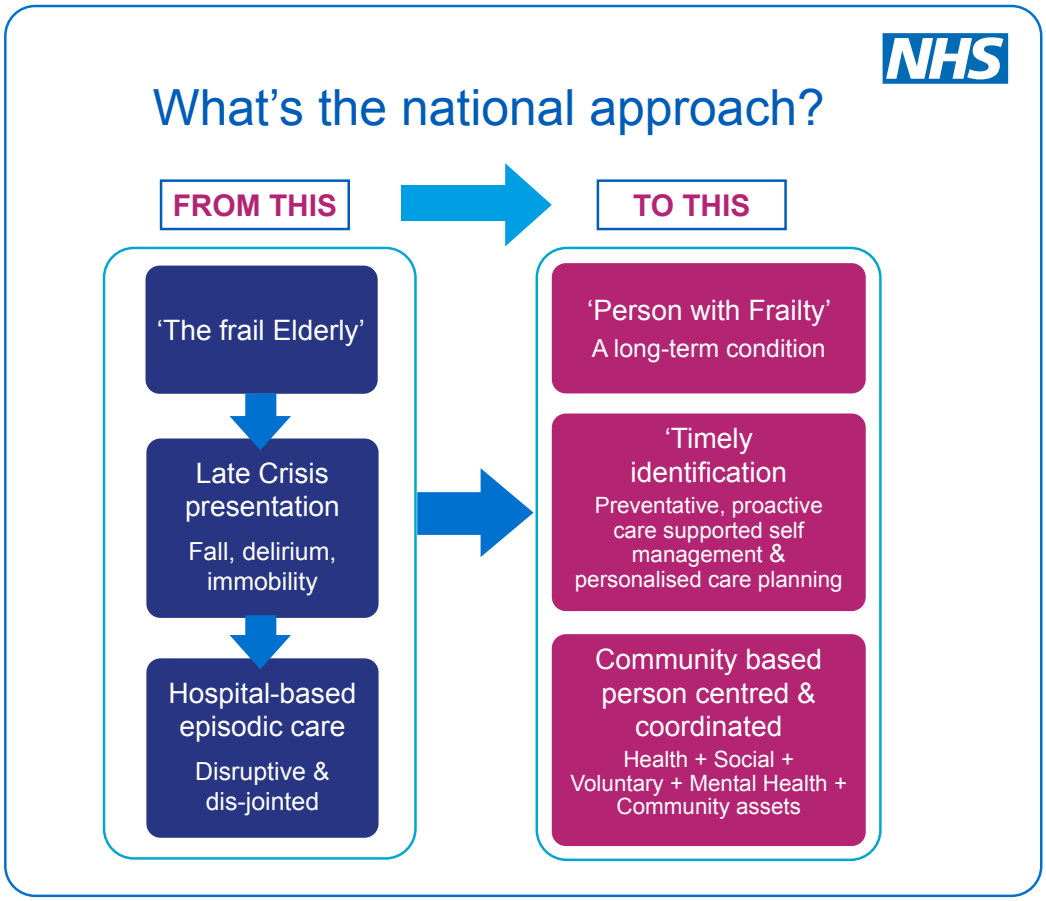
These aims will enable people to have a positive experience as they age. It will enable them to live as independently as possible, in a place of choice, connected to family, friends and community.

Principles

The principles that shape delivery of the strategy are:

- Population Health Management (PHM) approach to understand need, identify gaps, measure impact and outcomes.
- Health promotion, prevention and anticipatory approach to empower individuals to understand frailty. This will provide coping mechanisms and support to maintain independence and build resilience.
- Standardised screening, assessment, identification and recording of frailty.
- Care and support that is personalised, delivered in partnership with the individual and what matters to them.
- Collaborative working between the individual, carer and provider services.
- Information shared in an appropriate and timely way.
- Recognition and support to carers.
- Equitable access to services and inclusivity of all sections of the community.
- Embrace a positive view of ageing by promoting strategies and behaviour that promotes physical, social and psychological wellbeing.
- Enable the countywide workforce to have the right skills, knowledge and behaviours.
- A comprehensive system wide frailty pathway that is focused on 'home first'. Offering safe and effective alternatives to hospital admission as well as enabling timely supportive discharge.
- Utilise digital technology to enhance and support the delivery of care.
- Promote innovation and a process of continuous improvement to enhance outcomes, system flow, service redesign and redevelopment.

One of the key drivers within the strategy to improve health and wellbeing is to move from a reactive to proactive approach as outlined in fig 1. Proactive care means identifying individuals who will most benefit from services and support, stratifying risk (based on algorithms and assessment) then planning interventions with the individual that will reverse, reduce and slow the progression of frailty and help anticipate future needs.



(Fig 1)

10.2

SUMMARY OF STRATEGIC PRIORITIES

Based on the needs assessment and frailty workshops the following strategic priorities for 2022-2027 have been identified as:

- Prevention
- Identification
- Management
- Workforce

Prevention of frailty

Theme	Plans
To raise the awareness and knowledge of frailty (education, information and resources). To increase the countywide knowledge of frailty prevention specifically relating to: • Falls • Delirium • Social isolation To support neighbourhoods, accessible transport and housing that fosters independence. To ensure individuals receive psychological and social support. To better understand the needs of ethnic minority groups. To increase understanding of need of specific groups: Homelessness, Learning Disabilities, Dementia, Long Term Conditions and younger people.	To improve the health and wellbeing of the people of Gloucestershire. Increase understanding of frailty across the county in order to: • Reduce the number of people who become frail. • Increase awareness in order that individuals are able to build resilience through interventions such as strength and balance. • To reduce social isolation and loneliness. To build compassionate, supportive local communities and neighbourhoods. To identify provision of accessible local support utilising community resources. To increase use of holistic assessment of need that identifies social, psychological and physical needs. To ensure diversity is reflected in strategic plans, priorities and service provision. To develop strategic plans and priorities that reflect and meet the needs of people of all ages.

Identification of frailty

Theme	Plans
To make every contact count to proactively identify and manage frailty. To have an agreed approach to: • Identifying frailty. • Diagnosing frailty. • Assessment of frailty. • Recording of frailty. To understand the range of frailty service provision across the county. To gather data and information, utilising the frailty dashboard and measuring impact and outcomes.	To increase the number of people identified as frail. Target interventions based on assessed need and local provision. Through identification and diagnosis, co-create personalised plans of care. To systematically use assessment and screening tools such as the Comprehensive Geriatric Assessment (CGA) and the Clinical Frailty Score (CFS) across the county.

Management of frailty

Theme	Plans
To promote integrated working, information sharing and digital connectivity. To deliver personalised care planning. To offer care at home or close to home as alternatives to hospital admission. To enable access to reablement, rehabilitation and therapy. To engage and provide support for carers. To provide access to information to support independent living and adoption of a healthy lifestyle. To promote a holistic approach to frailty that incorporates mental health, wellbeing, social, environmental and physical health needs. To support individuals to plan and prepare for changes and the future.	To support services to work in an integrated way, with service criteria and pathways that facilitate timely and seamless transition between services and timely exchange of information. To promote the use of personalised care planning aimed at building resilience, increasing knowledge and understanding and support planning for the future. To reduce reliance and demand on urgent and emergency care services, offering alternatives to hospital-based care. To work to ensure individuals and their carer will get the right care, at the right time, in the right place. To empower and educate individuals in order that they can build resilience and manage their health and wellbeing. To ensure that social and environmental plans and priorities such as housing support individuals to live well and as independently as possible. To ensure that End of Life (EOL) treatment escalation plans are in place, shared and accessible.

Workforce	
Theme	**Plans**
To ensure workforce, consisting of both paid and unpaid individuals, is at a sufficient capacity and is equipped with the skills and knowledge to identify, prevent and manage frailty. To utilise and develop volunteer roles. To make education, information and resources accessible	To ensure links to workforce recruitment, development and retention plans across ICS partners. To engage and work with voluntary sector organisations. To promote use of approaches such as Motivational Interviewing training to enable change behaviour and personalised goal setting.

BACKGROUND

The British Geriatric Society define frailty as:

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.[5]

The loss of these in-built reserves can result in a seemly small insult having a catastrophic impact and outcome for the individual, which can be physical or psychological in nature.

Whilst frailty is more common in older people with around 10 per cent of people aged over 65 years having frailty, rising to between a quarter and a half of those aged over 85,[6] frailty is still prevalent in younger people, as well as other sections of the population, such as people with learning disabilities. Less is known about frailty in these groups and sections of society.

Some of the frailty identification tools are not validated for use with these individuals. Identifying and determining the requirements of these groups needs further engagement and analysis in order that needs can be fully identified and incorporated into strategic plans and workstreams.

Engagement and discussions have highlighted the challenges around the use of frailty as a descriptor. Whilst the term frailty is generally understood by health and social care professionals, its use as a descriptor can be a barrier to the wider population. Many people do not perceive or wish to see themselves as frail, as it is associated with increased vulnerability and dependency. Consideration needs to be given to positive language and descriptors that foster independence; enabling, rehabilitative and preventative approaches. Engagement with the public and key stakeholders is key to finding the right language that embodies positivity and empowerment.

[5] https://www.bgs.org.uk/resources/introduction-to-frailty
[6] https://www.bgs.org.uk/resources/introduction-to-frailty

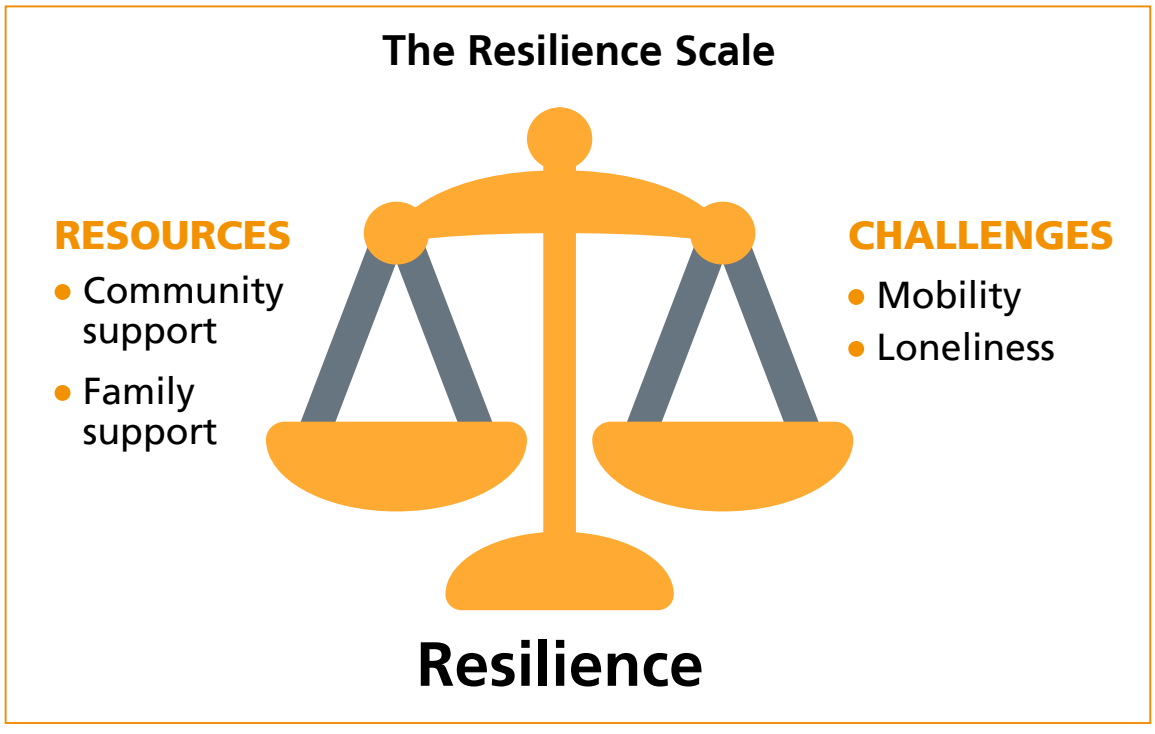
Case for change

Frailty is not an inevitable part of growing old or living with a long-term condition or disability. The countenance to frailty is resilience. This is an ability to adapt in the face of adversity, trauma, tragedy or threats. It can also be a response to stressors which can be physical, mental or social in nature. Active intervention can halt, slow or reverse the impact of frailty. Risks and harm can be mitigated, changes can be anticipated and the impact of stressors can be reduced.

There is significant evidence as to the benefits of this anticipatory care approach. It does however require a fundamental shift in behaviour and approach. It seeks to move away from a reactive model of care, where people are presenting in crisis, where the perceived 'safe' choice is hospital-based assessment and care.

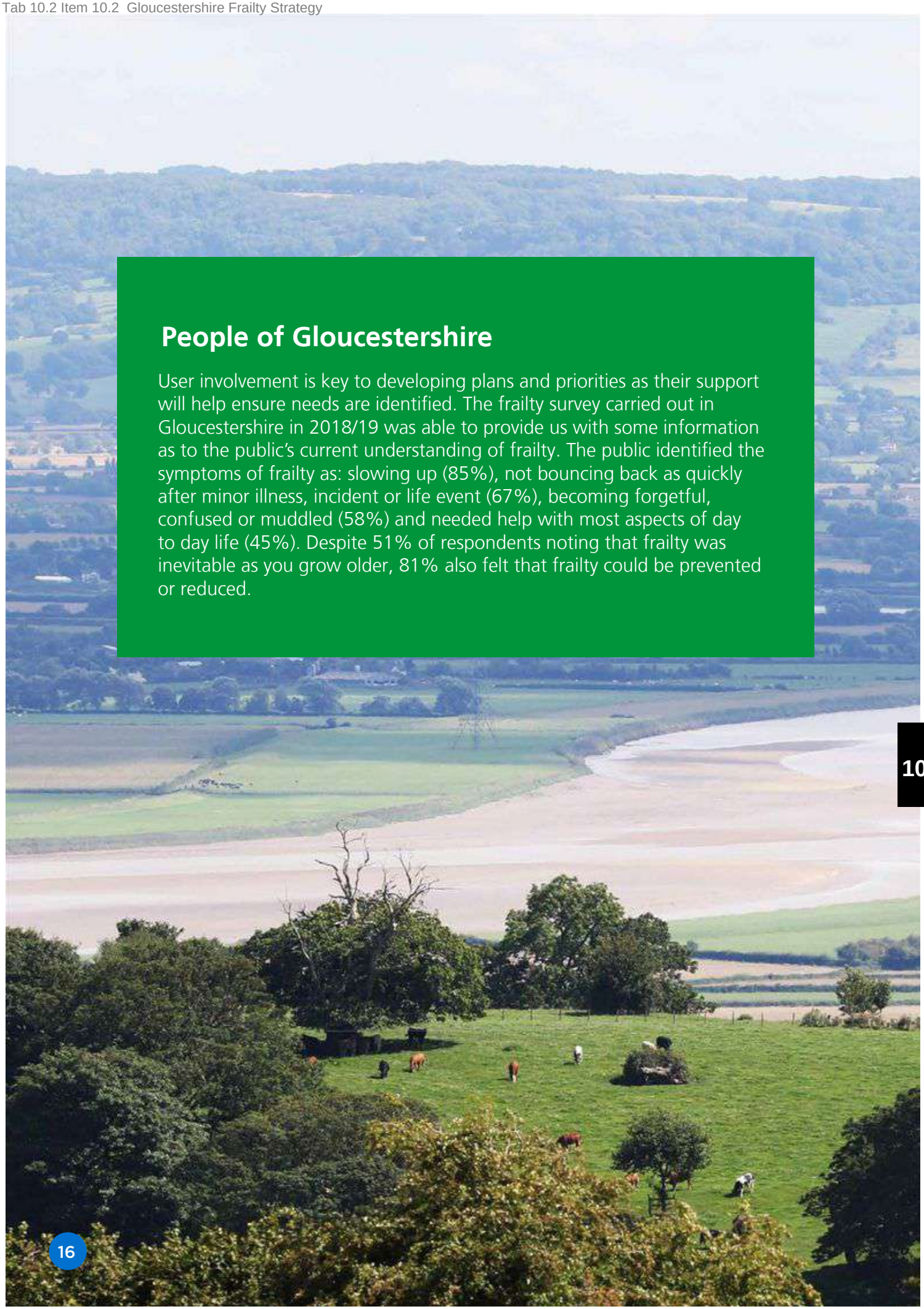
Anticipatory care makes a transition to a focus on "upstream" and the wider determinants of health. Screening helps early identification of need and personalised plans are co-created that seek to build resilience. Additionally there is a fundamental shift to community-based intervention and support.

The combination of the pandemic and its impact on physical and psychological health, along with growth year on year of the number of older people in Gloucestershire, have the potential to significantly increase demands. Many services are already struggling to remain responsive. A case for change is to ensure that Gloucestershire's strategic approach will manage demand, ensuring that systems and services are working effectively together to deliver positive outcomes for the individual and their carer, whilst making the most effective use of resources.



The above figure shows the resilience scale.

Our aim is for the scales between Resources and Challenges to be equally balanced.
In the example presented in the above figure, the individual has mobility issues and lives alone. These are their challenges. The available resources of community support and family support balance out these challenges and enable the individual to have resilience.



People of Gloucestershire

User involvement is key to developing plans and priorities as their support will help ensure needs are identified. The frailty survey carried out in Gloucestershire in 2018/19 was able to provide us with some information as to the public's current understanding of frailty. The public identified the symptoms of frailty as: slowing up (85%), not bouncing back as quickly after minor illness, incident or life event (67%), becoming forgetful, confused or muddled (58%) and needed help with most aspects of day to day life (45%). Despite 51% of respondents noting that frailty was inevitable as you grow older, 81% also felt that frailty could be prevented or reduced.

As part of the 2018/19 frailty survey people were asked who they would contact if they or a family member had symptoms of frailty. The majority (79%) said their GP, followed by family and friends (56%) and practice nurse (42%)

Who would you contact initially if you or a family member had symptoms of frailty?			
			Response Percent
1	I wouldn't want to trouble anyone		6.06%
2	Your GP		78.79%
3	Practice Nurse at Doctors Surgery		42.42%
4	local community group or voluntary organisation e.g. Age UK		24.24%
5	Search the internet for advice e.g. Your Circle		15.15%
6	Family or friends		57.58%
7	Social Prescribers / Wellbeing Coordinators / Community Wellbeing Agents		18.18%
8	Local County Council/Social Services		21.21%

Whist the survey results suggested that GP surgery was the most likely point of contact for people looking for help or advice on frailty, the survey respondents also highlighted the need for good quality information that was easy to access. Further and on-going engagement with people with lived experience, their carers and the general public will be part of the on-going development and review of the strategy.

Population Health Management

Population Health Management (PHM) is an approach that aims to improve the physical and mental health outcomes and wellbeing whilst reducing inequalities across a defined population. It includes actions to reduce the occurrence of ill health and reflects the wider determents of health such as social or economic factors, health behaviours and physical environment.

Utilisation of a PHM approach aims to improve health through data driven planning and the delivery of care to achieve maximum impact. Whilst frailty exists across the whole of the county, there are local variations and inequalities. The use of PHM enables the sub division and risk stratification of a given population. This helps ensure that interventions or services to prevent frailty and improve the health and care of those people living with frailty are targeted appropriately. PHM can also help support a common and shared understanding which can help communities identify how they can best work together to meet these needs.

Equality

Inequality can be due to a number of factors. These include health behaviours such as smoking, diet and alcohol, as well as psychosocial factors, isolation, social support, social networks and self-esteem/self-worth. There are also wider determinates of health such as income and debt, employment, education and skills and environmental factors such as housing, air quality and pollution. Understanding and identifying these factors will help ensure these are addressed in the strategic plans, priorities and workstreams.

Carers

Carers play a vital role in reducing risks, building resilience, maintaining independence and providing companionship and care. They need to be engaged, involved and listened to. Whilst often a rewarding role, it can also go unacknowledged and can impact on the carers' own physical and emotional health and wellbeing. Caring responsibilities can have an economic impact, with many reducing work commitments in order to fulfil their caring role. For some this results in financial hardship. The frailty strategy and supporting workstreams acknowledge the significant contribution carers make and seeks to make provision for them.

Care Homes

Many of the individuals who live in a residential, nursing or specialist residential care setting have complex care needs and are frail. Engagement with these individuals and the staff that support them, is vital to understand their needs and how best to meet them. These can then be translated into strategic plans, priorities and workstreams.

THE PICTURE IN GLOUCESTERSHIRE

Frailty in Gloucestershire – *"there's a lot of it about"*

Information based on Electronic Frailty Index (EFI) data indicates that in Gloucestershire there are approximately 90,000 people classified as living with mild, moderate or severe frailty. Age standardisation rates by localities demonstrate that across Gloucestershire between 104 – 157 per thousand of the population have some degree of frailty. (Fig 2) This locality data illustrates the spread of frailty and is informing our understanding of frailty.

Frailty Rates by Locality

Locality	Cohort_Size	Frailty Population	Prevalence_1k	Standardised Rate_1k
Gloucester City	190,501	26,578	139.52	157.04
The Forest of Dean	66,726	10,302	154.39	138.79
Tewkesbury Newent and Staunton	46,598	6,699	143.76	132.87
North Cotswolds	34,582	4,910	141.98	119.5
Cheltenham	176,420	19,660	111.44	118.07
South Cotswolds	65,448	7,424	113.43	104.73
Stroud and Berkeley Vale	130,281	14,576	111.88	104.3

(Fig 2)

There is a wide range of statutory service provision in Gloucestershire. Alongside this is a wealth of independent sector organisations. These provide a variety of services such as volunteer driving, lunch clubs, Men's Sheds, Faith Groups and befriending services. A baseline assessment of services currently underway will help enhance our understanding of the local landscape, inequalities and factors that impact on resilience.

The stakeholder engagement events that took place in summer 2021 demonstrated a commitment to working together. The workshops captured passion, ideas and learning and showcased some of the innovative person-centred developments in the county.

Summary and themes from workshops are noted in Appendix A. The workshops also highlighted some of the variations and challenges, which are outlined below:

- Some services operate in specific geographical areas.
- There is not a standardised approach in the use of assessment and screening tools, such as the Comprehensive Geriatric Assessment (CGA), Clinical Frailty Score (CFS), PiNCH ME and SQUiD (Single Question in Delirium).
- There is variation in the recording and coding of frailty.
- There are workforce vacancies across the system.
- Access to training can vary in services and sectors.

Along with the county variations, the needs assessment also identified some of the key challenges. These included:

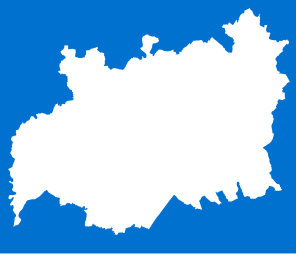
- Impact of the pandemic on people physically, mentally and socially; e.g. deconditioning, loneliness, isolation.
- Increasing number of people aged 65+, resulting in increased disease prevalence in Falls, Delirium, Long Term Conditions, Dementia etc.
- Increasing complexity of care needs.
- Inequity and inequalities across the county in some areas and for some sections of the population.
- Increased volume and workload for carers.
- Workforce impacted by vacancies, high staff turnover, needing to release staff for training and development, contractual arrangements and Brexit.
- Issues with system capacity in health and social care are resulting in people experiencing delays, experiencing longer length of hospital stays and not being able to access the right care, at the right time, in the right place.
- Digital connectivity: Systems and processes mean information is not shared in a timely way.

These challenges are set against the context of a protracted pandemic, with services seeking to restore, recover and meet the demands of winter pressures and business as usual. No one service or organisation can resolve these challenges. Collaborative working and agreeing priorities and plans will help ensure that collectively we can begin to address these and work to reduce variations.

Co-production and the active involvement and participation from the public and all sections of society is central to frailty planning, priorities, management and measuring impact. On-going engagement is required to ensure any plans, priorities and workstreams reflect local need and deliver on desired outcomes. This will form part of the overall strategic work plan.

LOCAL CONTEXT

Across Gloucestershire there are people who are at risk or who have frailty. Two main factors will impact on frailty in Gloucestershire over the next **2-5 years.**



1

An **older population** - The number of people in Gloucestershire aged **65+** is forecast to rise faster than nationally in the next **25 years**, rising from **135,000** to **205,900** people between 2018 and 2043. This is equivalent to an average increase of **2,800 people** per year.[7]

2

Pandemic impact - Changes implemented as part of the response to the global pandemic have impacted in a number of ways. Social isolation and shielding have led to physical deconditioning. These physiological changes, following a period of inactivity, may impact on the body in several ways including loss of muscle mass and muscle strength. These physical changes are linked to an increased risk of falls, functional decline, reduced inability to undertake usual activities of daily living and reduced mobility. Alongside the physical impact there has been a psychological effect, which includes loss of support networks, increased levels of anxiety and depression, insomnia and loneliness. These have all impacted on mental health and wellbeing.

Facts and Figures

In Gloucestershire **21.3%** of the GP registered population are **65** and over.

Based on the eFI data for the population aged 65 and over **41.7%** are living with some level of frailty. This can be broken down to **27.8%** with mild frailty, **11.1%** with moderate frailty and **2.8%** with severe frailty.

82% of people thought that frailty could be prevented or improved.[8]

[7] Inform Gloucestershire 2020 https://inform.gloucestershire.gov.uk/media/2099482/op_prevalance_of_need_2020_final.pdf

[8] Gloucestershire Frailty Survey 2018/19

ENABLERS

There is a range of enabling workstreams that will help and support the delivery of the strategy and improvements in care. These include:

Digital

In the last few years our use of digital technology in the form of Telehealth, virtual wards and remote consultations have significantly changed the way care is delivered. Despite these digital advances the current health and social care digital architecture means that many IT systems are not connected. Information does not flow through the system. As a result, there is duplication of effort and staff don't have access to all relevant information to support assessment and planning for patients and families. This often results in repeated questioning and information gathering. A key enabler in the delivery of the strategy is to maximise the use of digital developments to enable timely access to information, as well as continuing to transform the way care is delivered.

Recording & data collection

Systematic recording of frailty will help identify need at a micro and macro level. It will enable the incidence and levels of frailty across the county to be identified. It will provide a benchmark to measure impact, outcomes and performance along with informing service development and prioritisation of investment.

Screening and Assessment tools

There is a variety of tools to support identification, assessment, planning and delivery of care. These include: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), the Comprehensive Geriatric Assessment (CGA) and the Clinical Frailty score. To be effective they need to be part of the frailty pathway, used consistently by staff who are trained and skilled in their use. The consistent use of these tools can have many benefits, providing a common language and understanding of need between services. It can also inform decision making and help ensure resources or interventions are targeting appropriately.

Education and Resources

Training and education aims to ensure that staff have the right skills and competencies. Within the county is a wealth of expertise and experience along with a wide range of educational resources. The development of an Education and Training Strategy will bring these resources and information together in a structured way. Access to good quality information will support the general public and staff. This needs to be provided in a variety of ways to ensure accessibility by all sectors of the community.

Personalisation

Individuals having choice and control has been a central tenant of legislation, policy and guidance for several years. The personalised care agenda, What Matters to Me and Me at my Best progress this approach further. This partnership approach where interventions and resilience plans are coproduced will help ensure care is tailored to individual need and help transform the relationships between professionals and the individual from fixer to facilitator.

Experts by experience

The voice, views and involvement of people with lived experience is vital. Whilst staff are powerful advocates for the people they support, it is vital that the voice of the public is heard directly. There are some key questions that only experts by experience can answer, such as:

- What do you need to live happier, healthier and longer lives?
- How best we can reduce inequalities?
- Did the intervention provided make a difference?

Continuous engagement and public involvement will help shape continuous improvement, define priorities and inform services in the future.

High Impact Change Model

The High Impact Change Model was developed by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), national partners. Updated in 2020 it supports the ambitions in the NHS Long Term Plan. The model offers a practical approach to managing patient flow and hospital discharge. The model identifies system changes that include a workstream which will focus on:

- Early discharge.
- Monitoring patient flow.
- Discharge teams.
- Home first and discharge to assess.
- Seven day a week services.
- Trusted assessors.
- Enhanced health in care homes.

Interdependencies

Frailty is complex, it is not an illness but the combination of a range of factors which may include the natural process of ageing or the impact of a long-term condition or disability. It encompasses the domains of physical, psychological and social health. As a result, it creates interdependences across a range of statutory, third sector and health and social care services who need to work collaboratively if they are to meet the holistic needs of the individual and their carer. The construction of a frailty pathway that spans across all organisations and systems will map these interdependencies, identify gaps and support the development of integrated, seamless and co-ordinated care pathways.

Strategy context and implementation workstreams

The Frailty Strategy is integral to two wider programmes, Gloucestershire County Council (GCC) Transformational Programme for Adult Social Care and the ICS Ageing Well Programme. GCC, through the Adult Single Programme, has transformed the way in which it works. Reflecting the requirements of the Care Act, it seeks to:

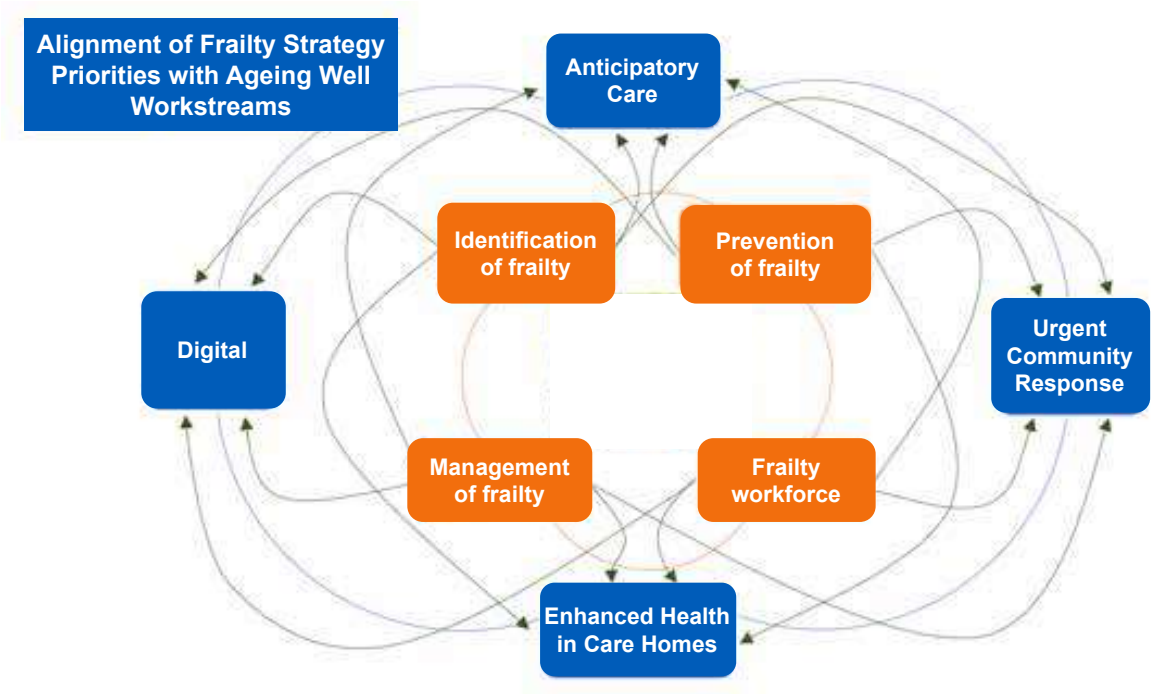
- Support early intervention and prevention and work collaboratively across the Adult Social Care System and with partners.
- Improve the impact of short-term help to make sure people regain their confidence and independence whenever possible.
- Explore the potential of technology to support carers and improve the quality of care that people receive.
- Work with independent care providers to address capacity gaps and over provision to improve the terms and conditions of care sector staff.
- Respond to further guidance or legislation.

The Ageing Well Programme is the delivery mechanism for realising the objectives of the NHS Long Term Plan. The Ageing Well Programme seeks to:

- Support people to stay well and independent at home for as long as possible, wherever they call home.
- Prevent unnecessary admissions to hospitals and residential care and accelerate the treatment of people's urgent care needs.
- Ensure people can return home safely and timely after being in hospital with assessment and on-going care and support in the community.

Ageing Well key workstreams:

1) Anticipatory Care aims to proactively manage health and care intervention at individual and population level. It adopts a population health management approach identifying cohorts of people through risk stratification.
2) Urgent Community Response aims to avoid unnecessary hospital admission and support discharge by ensuring that everyone who requires a two-hour crisis response receives one, regardless of where they live. It also aims to provide reablement care for people who need it within a maximum of two days.
3) Enhanced Health in Care Homes aims to ensure that people living in care homes receive the same level of care and support as those living in their own homes. This is done by providing proactive and preventative care centred on the needs of individual residents, their families and care home staff.
4) Digital aims to ensure community health services, as part of local systems, provide a comprehensive digitally enabled service that aspires to the highest standards of excellence and professionalism. It will be available to all based on clinical need and will deliver the best value for public money. It includes data, IT and technology.



(Fig 3)

Figure 3 outlines the independencies and connections with the Ageing Well Programme and the frailty strategy.

10.2

FRAILTY WORKSTREAMS

There are key themes that emerge in the Transformation Programme and the Ageing Well Programme. These include early and proactive intervention, care at home, reducing crisis, increasing independence and resilience.

Frailty Workstreams

The function of any strategy is to describe the vision, aims and objectives will be realised. The frailty strategic priorities are be underpinned by five workstreams. Whilst there are interdependencies between the workstreams, as well as the wider Ageing Well and Transformation Programme, each will have its own scope of work, action plans, milestones and measurable targets. The workstreams are structured around the frailty well pathway of:

- Preventing Well.
- Diagnosing Well.
- Supporting Well.
- Living Well.
- Dying Well.

The model is adapted from the Dementia Well Pathway[9] It aims to provide a simple but comprehensive structure on which to outline the way forward. The ICS Frailty and Dementia Clinical Programme Group will play a key role in providing strong leadership, collaborative working, aligning workstreams and monitoring strategic progress. The overall governance structure is outlined on page 35.

10.2

[9] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Preventing

- I understand my medication.
- I don't feel so isolated or lonely.
- I know where to go to get help.

Strategic Aim #1: Preventing Well

Prevention is key to improving the quality of life. This aim is to reduce the number of people who become frail and to halt, slow or reduce the impact of frailty through early identification and the development of plans and interventions. These will build resilience, anticipate changes and identify and mitigate risks.

The outcomes of this strategic aim are to:

- Reduce the number of people who become frail.
- Halt, slow or reduce the impact of frailty.
- Gain a deeper understanding and overview of frailty in the county.
- Raise awareness and increase understanding of frailty by promoting and encouraging healthy lifestyles and behaviours across all ages and sections of society.
- Develop/provide proactive health and care interventions aimed at reducing risks and building resilience.
- Develop a range of services and interventions that support care at home and ageing well.

We will do this through health education, risk stratification and anticipatory care interventions. We will undertake a baseline assessment of frailty services. We will gain involvement and feedback from experts by experience and their carers. We will support the delivery and development of anticipatory care services that reduce frailty risks and build resilience through education and health promotion.

Mr Osmanski

Mr Osmanski is 80. He has recently had a fall. He mentions this to the pharmacist when he pops in to collect his routine prescription. The pharmacist takes some time and talks to Mr Osmanski about the fall. She makes some suggestions as to steps he might take to reduce the risk of further falls. She records her conversation and actions on a shared care record. When Mr Osmanski visits the practice nurse for routine health screening and blood test she is able to check with him what steps he has taken and whether he needs further information, support or referral.

Diagnosing

- **I have regular check-ups and understand why they are important to detect problems or issues early.**
- **I have information and support that reduces my risk of frailty and helped me to build my resilience.**

Strategic Aim #2: Diagnosing Well

Diagnosing well will identify those at risk or those who are frail. The aim is to work with individuals and their families to plan a programme of care that increases resilience whilst reducing frailty progression. It will help to avoid unnecessary harm whilst empowering the individual to make informed choices enable them to plan for expected and emergency situations.

The outcomes of the strategic aims are to:

- Increase the number of people who are screened and assessed for frailty.
- Increase the number of people who have personalised plans aimed at increasing resilience, reducing risks and anticipating changes.
- Identify the levels of frailty within the population across the county to a level of Integrated Locality Partnership (ILP), Primary Care network (PCN) and neighbourhood detection. We will utilise this information to increase understanding of need and demand whilst informing capacity planning and supporting the measuring of impact of interventions.
- Increasing individuals' understanding of how to build resilience.

We will do this by consistently and systematically identifying frailty and sharing this information across systems and services. We will develop shared care plans and actions to build resilience. We will use a Population Health Management approach to understand frailty at local and countywide level. We will help individuals build resilience and reduce the impact of frailty by providing accessible information

10.2

Mrs Smith

Mrs Smith is 78 and her husband has noticed that she is more muddled than usual. He mentions this to one of the care staff who visit daily. The staff are aware of the risk of delirium and gather more information from Mr and Mrs Smith. Based on this they make contact with the primary care team. Prompt intervention and two nights of overnight care mean Mr Smith is supported and able to care for his wife at home. The cause of the delirium is identified and a plan of action put in place involving Mr and Mrs Smith and the care staff to avoid recurrence. A flag relating to delirium risk is placed on Mrs Smith's notes to alert any agency or service involved in her care.

Supporting

- **I receive care that is coordinated, teams share information and know about my preference and choices.**
- **I have a personalised plan of care that also recognises the role and needs of my carer.**
- **I have the treatment and support I need at or as close to home as possible.**
- **My home is adapted to meet my needs.**

Strategic Aim #3: Supporting Well

This strategic aim will ensure that people who are at risk or have frailty are enabled to live as well as possible. It will ensure that emotional, social and psychological needs are met in a timely and coordinated way. It will ensure that individuals get the right care, provided at the right time, in the right place with support equitably available across the county but reflective of local diversity, provision and need. It will ensure that care is delivered as close to home as possible.

The outcomes of this strategic aim are to:

- Increase the number of people reporting positive outcomes from interventions and support.
- Improve equity of access to support and services across the county.
- Ensure the timely provision of support and the seamless transition between services.
- Understand the needs of younger people and other groups at risk of frailty and ensure these are identified and met.
- Reduce reliance and demand on urgent and emergency care services.
- Increase the range of anticipatory care responsive same day or community-based services.
- Improve communication and reduce duplication through information sharing.
- Increase the use of digital and assistive technology to support people to live well.
- Increase public awareness of frailty and understanding of how to build resilience.
- To engage, empower and support carers.
- To support medication optimisation.
- Ensure workforce has the right skills and competencies.

We will do this through co-production with the individual and what matters to them and their family. The skills and contribution of carer will be integral to the support system. The frailty pathway will be focused on 'home first' with services at or close to home, that will proactively meet the physical, psychological and social need. Stakeholders will work together to agree an integrated model of care that is responsive, impactful and maximises the resources in local communities.

Ms Jones

Ms Jones is 77, lives alone following the death of her partner 11 months ago and has become more anxious and socially isolated. Ms Jones is helped to explore and understand her feelings and to develop a plan of action that will help alleviate these anxieties. She is introduced to a local photography group. Through the group she starts to reconnect with her local community, makes new friends and builds confidence. Mrs Jones reports that her confidence has improved along with her sense of wellbeing.

Living

- **I have access to information and support, that helps me live independently and keep me well.**
- **I am supported to be part of my local. community and contact with people that matter to me.**

Strategic Aim #4: Living Well

The aim is for people to have a positive sense of wellbeing, feel fulfilled and engaged in the community in which they live. Having an understanding of the factors that contribute to wellbeing and overall health will enable people to live well for longer. This can be achieved by enabling access to information and developing a network of support for the individual to ensure their physical, social and psychological needs are met.

The outcomes of this strategic aim are to:

- Individuals and their carer get the right care, at the right time, in the right place.
- Ensure that personalised care focuses on what is important to the individual.
- Increase proactive identification of risks and plans to reduce these whilst building resilience.
- Reduce loneliness and social isolation through meaningful social engagement and role/ place within the community.
- Enable access to housing and improved environmental factors that support people to live as independently at home for as long as possible.
- Enable access to information on benefits and financial support that enables individuals to live well.
- Increase range and access to information, resources and support to enable individuals to live well and build resilience.

We will do this through the provision of a range of information and a network of support that meets the individuals' social, physical and psychological needs. Services will be delivered in a planned and coordinated way.

Mr Patel

Mr Patel is 65 and planning to retire. He has non-insulin dependent diabetes and some visual impairment. Being independent and being an active member of the community is very important to him. He joins a pre-retirement course that gives him lots of information and resources. This helps him understand what aids and adaptations may help him at home to live more independently. He identifies some volunteering roles that will utilise his knowledge and expertise. He enrols on an online course on living with and looking after yourself with diabetes. Mr Patel reports feeling positive about the future and is glad that he can use the skills he has gained during his working life to help others.

Dying

- I am prepared for the future; I know what to do if my heath changes.
- I have made my wishes known, so that I can have a good death, in a place of my choosing and that my wishes are respected.

Strategic Aim #5: Dying

The aim is for palliative and end of life needs to be identified as earlier as possible. The individual and their carers are made aware and are prepared for death. Plans are in place that detail preferences and choices along with treatment escalation plans and anticipatory prescribing. Care is supported by open and honest conversations that enable the individual to live well and have a good death, in their place of choice. The outcomes of this strategic aim are to:

- Increase the identification in the number of people who are nearing end of life, helping to ensure their choices and wishes are recorded, regularly reviewed and shared with those that need to know so their preferences can be met.
- Increase the number of people who are cared for and die in place of choice.
- Increase the information and support for carers pre and post bereavement.

We will do this by supporting the Palliative and End of life Strategy and workstreams to ensure these reflect the needs of people who are frail.

Vision – Providing care close to home that is proactive, preventive, personalised, enabling and equitable

The vision for frailty that was adopted and endorsed by participants at the frailty workshops and the ICS Frailty and Dementia Clinical Programme Group was:

> *"The people of Gloucestershire living healthier, happier and longer lives."*

Encapsulated in this vision is a model of care that is focused on prevention and building resilience. It delivers care that is personalised, with services provided close to home that meet the physical, social and psychological needs of the individual.

When required, access to specialist support is provided in a timely way and transition and transfers between services happens in a seamless way, including the exchange of relevant information. Plans are in place to reflect changing need and these include treatment escalation plans where preferences and wishes are recorded. These ensure the intervention is in the best interests of the individual and reflect the preferences of the individual and deliver positive outcomes. Care is provided by a workforce (both paid and unpaid) who have access to training, resources and support with the right tools, skills and competence requisite to their role.

Within Gloucestershire the aim is to have a proactive and preventative approach. This will be one that helps individuals understand what is needed to build resilience that will support their health and wellbeing.

This proactive model of care will consist of screening individuals to identify their risk of frailty through the use of tools such as the Comprehensive Geriatric Assessment (CGA) and Clinical Frailty Scale (CFS). This information would be used to co-produce a personalised care plan that would seek to build resilience, maintain good health and help the individual understand warning signs or triggers that may indicate changes in health that may alter or increase frailty risks.

Improving access to care is vital to the delivery of positive outcomes and address inequalities. This will include access to specialist intervention and may be delivered in the community or in a hospital setting. It is vital that individuals can move in and out of these services in a timely way. This helps ensure that these services remain responsive and that the resource and skills of the staff are utilised appropriately.

Service design needs to reflect cultural, socioeconomic factors and local demographics, utilising the wealth of experience in statutory, independent and third sectors organisations. It needs to be sustainable and coproduced with experts by experience and their carers.

NATIONAL CONTEXT AND DRIVERS

White Paper "Integration and Innovation: working together to improve health and social care for all (February 2021)

The proposals within this legislation are recommendations built within the NHS Long Term Plan. The legislation is guided by 3 main principles.

1) To increase integration within the NHS in England and between the NHS, local government and other health system partners.
2) To reduce bureaucracy and remove barriers to integrated working that benefits service users.
3) To improve accountability and enhance public confidence.

NHS Long Term Plan 2019

This outlines how people who have frailty or who are at risk will be offered targeted support for both their physical and mental health needs. The Ageing Well programme is one of the vehicles to support these ambitions/targets.

Shifting the Centre of Gravity – Making placed based, person-centred health care a reality Local Government Association (November 2018)

Dementia Challenge

In 2015, the Dementia 2020 Challenge was launched. It aimed to make England, by 2020, the best country in the world for dementia care, support, research and awareness. The Challenge identified 18 key commitments under four themes: Dementia Awareness; Health and Care Delivery; Risk Reduction; and Research and Funding. There were a number of commitments made to support dementia. These included increasing the rates of dementia diagnosis, creating dementia friendly communities, raising awareness of dementia, risk reduction strategies and increased dementia research. (February 2015)

Five Years Forward View 2014

This sets out a shared strategic vision for the future of the NHS. It plans to address inequalities and gaps in services and it proposes a remodelling of services. Amongst these are urgent and emergency care, mental health, primary and acute care services. (October 2014)

NICE guidance quality standards, statements and supporting reports

Much of the National Institute of Excellence's (NICE) guidance includes reference to frailty for example, dementia disability and frailty in later life, (NG 16, October 2015) Multimorbidity clinical assessment and management (NG56 September 2016), Multimorbidity and polypharmacy.

The Care Act 2014

This brought together a range of legislation, reports and reviews with the aim of consolidating and modernising the framework of adult social care in England. The Act placed the individual in the centre of care, giving them new rights, along with recognising the key role and needs of carers, whilst placing a focus on prevention and promoting wellbeing.

Measures and Indicators

Measuring outcomes is key to assessing the impact of the strategy. Each of the individual workstreams will develop a set of outcomes measures. These will help determine if the intended benefits have been delivered. The overarching indicators that will demonstrate success are:

- Earlier identification of people who are frail.
- Self-reported outcomes that demonstrate improvements in quality of life for the individual and their carer.
- Recording of frailty score.
- Increasing the number of people with personalised plans of care.
- Reducing the demand on urgent and emergency care and preventing unnecessary hospital admissions.
- Increasing the frailty provision in the community.
- Increasing provision of services and opportunities to build resilience.
- Enabling a workforce that has access to a range of frailty education, training and development.
- Increasing awareness of frailty.

Governance

A governance structure will support the development and implementation of the strategy. It will monitor if the strategic aims have been achieved and evaluate if it has been delivered in line with the strategic principles. The governance structure is outlined below.

ACKNOWLEDGMENTS

Many thanks to everyone who has contributed to the development of this strategy, either through the provision of data, insight, views or experience. This strategy aims to capture this knowledge and develop it into a shared vision with priorities, aims and a road map that ultimately seek to improve the lives of the people of Gloucestershire.

APPENDIX A

Key findings from the frailty workshops – key themes

Frailty workshops

In summer 2021 a set of four stakeholder workshops were held. These sessions provided valuable insight into the challenges and demands facing services across the county. It identified the need to join up systems, share information in a timely way and enable consistent reporting and recording of frailty.

Workshop participants highlighted that many services were struggling to remain responsive and meet demand. There are gaps and delays in systems, which meant people were sometimes cared for in the wrong setting and this can have a negative impact on the individual.

A resounding message from the workshop is that significant and sustained inroads into managing/ supporting people with frailty can be made through a collaborative and integrated approach. The ICS is ideally placed to support this ambition.

Some of the issues identified during the workshop and through individual and group meetings have included:

a. Inequity and inequalities in access to frailty support /service provision.

b. A shared IT system is needed to help information exchange, reduce duplication and assist decision making.

c. Gaining a clear overview of the challenge of frailty is difficult due to code variations and processes for data collection.

d. The impact of the pandemic has led to deconditioning and poorer disease management.

e. Hospital admission is seen as safe option and default position. We need to reduce reliance on this and increase community resources, change behaviour and attitudes.

f. Importance of trusted relationships in driving forward developments and enabling shared decision making and shared risk taking.

g. Concerns for patient welfare and the risk of further deconditioning due to extended hospital stays whilst waiting for discharge.

h. Current service demands coupled with the need to implement recovery plans and respond to 'winter pressures'.

GLOSSARY

Association of Directors of Adult Social Services (ADASS)	A charity and membership organisation which aims to be a leading voice of adult social care, working in partnership with people to help transform their experience of care and support.
British Geriatrics Society (BGS)	The professional body of specialists in the healthcare of older people in the UK.
Clinical Frailty Score (CFS)	Clinical Frailty Score is a judgement-based frailty tool that evaluates specific domains including comorbidity, function and cognition to generate a frailty score ranging from 1 (very fit) to 9 (terminally ill).
Clinical Programme Group (CPG)	Clinical Programme Groups are a partnership group of individuals who meet on a bi-monthly basis to provide oversight of their particular clinical programme area. For example, the Frailty and Dementia CPG in Gloucestershire oversees the implementation of the Frailty and Dementia strategies in Gloucestershire. CPGs are made up of service leads, experts by lived experience and senior stakeholders.
Comprehensive Geriatric Assessment (CGA)	Comprehensive Geriatric Assessment is a process used by healthcare practitioners to assess the status of people who are frail and older in order to optimise their subsequent management.
Delirium	A serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment. Also known as sudden confusion.
Dementia	Term used to describe a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life. It isn't a specific disease, but several diseases can cause dementia.
Electronic Frailty Index (eFI)	Electronic Frailty Index – the eFI is based on 36 physical, mental and social deficits, the presence/ absence of each of these are combined to provide an overall score. The score is then used to classify the population into fit, mild, moderate or severe frailty levels.
End of Life (EOL)	End of life care includes physical, emotional, social and spiritual support for patients and their families. The goal of end of life care is to control pain and other symptoms so the patient can be as comfortable as possible. End of life care may include palliative care, supportive care, and hospice care.

Frailty	A person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury.
Gloucestershire Health and Care NHS Foundation Trust (GHC	An NHS Foundation Trust which provides physical health, mental health and learning disability services throughout Gloucestershire.
Gloucestershire Joint Health and Wellbeing Strategy	A strategy that aims to improve the health and wellbeing of people in Gloucestershire. It articulates Gloucestershire's Health and Wellbeing Board's response to the Prevention System Peer Challenge and sets out a clear vision and priorities.
Home First	The 'Home First' model aims to stop patients being stranded on hospital wards. Planning for the future and long term decisions are taken following recovery and an assessment at home rather than in hospital.
Integrated Care Board (ICB)	A new organisation responsible for providing oversight of the implementation of an Integrated Care System across Gloucestershire.
Integrated Care System (ICS)	New partnerships between the organisations that meet health and care needs across an area, to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
Integrated Locality Partnerships (ILP)	Partnerships made up of senior leaders of health and social care providers and local government. They work with each other to bring services together and plan how they are delivered to their local populations.
Local Authority (LA)	Local government is responsible for a range of public services for people and businesses in defined areas. These include services such as social care, schools and housing. There are three tiers of local government in Gloucestershire and responsibility for services is divided between the county council, six district councils and 264 parish and town councils.
Local Government Association (LGA)	The national membership body for local authorities.
Long Term Conditions (LTC)	A long-term condition is an illness that cannot be cured but can usually be controlled with medicines or other treatments.
Me at My Best	A Care Plan that aims to support people with a long-term condition, including living with frailty and dementia. It is a record of what is usual for an individual and how they live at home with their health condition.
MYCaW (Measure Yourself Concerns and Wellbeing)	An individualised outcome measure used for evaluating holistic and person-centred approaches to supporting people. It is a short, validated tool that can be routinely incorporated into a consultation to see where a person most wants support or used in an organisation to improve workplace wellbeing.

NHS Long Term Plan (LTP)	The Long Term Plan sets out action to ensure patients get the care they need fast and to relieve pressure on A&Es. It sets out key ambitions for the NHS over the next 10 years (2019-2029).
Pain, Infection, Constipation, dehydration, Medication, Environment (PiNCH ME)	PiNCH ME is a tool used to help assess the potential cause of delirium.
Plan-Do-Study-Act (PDSA)	A scientific method used to test a change, by planning it, trying it, observing the results and acting on what is learned.
Population Health Management (PHM)	The process of improving clinical health outcomes for a defined group of individuals (for the purposes of this Strategy individuals with Frailty) through improved care co-ordination with partners and patient engagement.
Primary Care Network (PCN)	Groups of GP practices that work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices which are known as PCNs. They build on existing primary care services to enable greater provision of personalised and integrated health and social care for people within their local communities.
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	ReSPECT is a national patient held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.
Rockwood Clinical Frailty Score	Rockwood is the Clinical Frailty Scale (CFS) being used by the NHS to help decide which people are most likely to recover, ranking frailty from one to nine.
Same Day Emergency Care (SDEC).	Same day emergency care is the provision of same day emergency care for patients being considered for emergency admission.
Single Question in Delirium (SQiD)	SQiD is a single question used to identify delirium. This is a simple prompt question which asks "Is the patient more confused than before?'
South Cotswolds Frailty Service	South Cotswolds Frailty Service is an anticipatory care community service embedded in and delivered by the South Cotswolds PCN.
Telehealth	Providing health care at a distance rather than face-to-face.
What Matters to Me	Everyone will have their own 'What Matters to Me' orange folder, which is owned by the individual and contains their personalised care and support plans, which are co-produced by staff and the individual. By holding the folder themselves, the individual will be able to share their information with other health and social care professionals and voluntary community sector colleagues during routine assessments or an emergency situation, in which guidance in the folder will provide instructions on what actions should be taken.

Version	Date	Author/Reviewer	Comment
1.0	29/06/2022	Sian Cole/Tom Orpin	Completed Strategy marked as final version following consultation with stakeholders

Review Date:

The programme of work which sits under this Strategy will be regularly reviewed by the Project Team. A review of this Strategy's programme of work will be undertaken on an annual basis by the Frailty & Dementia Clinical Programme Group.

The overall Strategy will then be formally reviewed in 2026.

For more information on the Frailty Strategy for Gloucestershire please contact **glccg.ageingwell@nhs.net.**

Agenda Item 11

Integrated Care Board Meeting

27 July 2022

Report Title	**Proposals for the Delegated Accountability for the Community Mental Health Transformation Programme**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
					X	
Route to this meeting	The principles within the paper have been discussed with • CMHT Programme Board and respective VCS Partners • ICS Executive colleagues The paper has been through the GHC executive group meeting					
	ICB Internal	**Date**	**System Partner**		**Date**	
			CMHT Programme Board		29/06/2022	
Executive Summary	To outline the proposed approach to enable Gloucestershire Health & Care NHS Foundation Trust to take on the devolved accountability for the budget (circa £2.8m for 22/23), delivery and tactical commissioning of VCS partners to complete the delivery of the Community Mental Health Transformation programme. The emphasis is to develop a strong partnership approach although a contractual mechanism will need to be wrapped around the arrangement which would take the form of a Lead Provider contract. It would see the secondment of the existing project team sitting within the commissioner over to GHC and the creation of an integrated CMHT implementation team within the Strategy & Partnerships directorate team.					
Key Issues to note	The key issues that the proposal is aiming to address are; • Delays to the programme to date through NHSE business case approvals and release of funding and therefore inability to recruit in a timely manner into posts • Increased collaborative working by joining together the programme resources in GHC as the main provider and the ICB into a single delivery team hosted within GHC • Timely and streamlined delivery of the CMHT programme with providers taking collaborative accountability for the delivery of the transformation outcomes. There have been no issues in the production of the paper and the concept is supported by wider VCS partners as a key stakeholder to this work.					

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Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Failure to deliver the transformation outcomes to time and budget: (4x4) 16 (4x2) 8 Mitigations; Clear programme structure and workstreams developed, overseen by the programme board with clear outcomes and milestones Failure to undertake true co-production of the new models of care with our partners including the people who use our services and the third sector (4x4) 16 (4x2) 8 Mitigations: Peoples Representation Action Board now in place with Chair and Co-Chair members of the Partnership Board. VCSE Alliance fully engaged and Inclusion Gloucester and Barnwood Trust running a number of engagement workshops and a strong recruitment programme of Experts by Experience.			
Management of Conflicts of Interest	No Known Conflicts of Interest			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	
	Human Resource	X	**Buildings**	
Financial Impact	There are no additional financial requirements. The proposal requests the devolving of the existing CMHT budget to GHC under a lead provider model			
Regulatory and Legal Issues (including NHS Constitution)	The proposal requires the ICB to appoint GHC in a lead provider role for the onward tactical commissioning of additional providers once the pathway has been confirmed.			
Impact on Health Inequalities	The CMHT programme is fully aligned with the inequalities agenda across Gloucestershire. The first area of transformation work is proposed to be within the Forest of Dean.			
Impact on Equality and Diversity	This proposal itself has no equality and diversity implications. Wider transformation work once underway will be subject to appropriate EDI impact assessments.			
Impact on Sustainable Development	N/A			
Patient and Public Involvement	The CMHT People's Representative Action Group are supported of the proposed way forward.			
Recommendation	The Board is requested to: • Approve the delegation of the budget and accountability for the delivery of the Community Mental Health Transformation Programme to Gloucestershire Health & Care NHS FT (GHC)			
Author	Angela Potter	**Role Title**	Director of Strategy & Partnerships - Gloucestershire Health & Care NHS FT	

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Sponsoring Director (if not author)	Mary Hutton, Chief Executive Officer, Gloucestershire ICB Paul Roberts, Chief Executive & ICS Executive Lead for CMHT Transformation.

Glossary of Terms	**Explanation or clarification of abbreviations used in the paper**
CMHT	Community Mental Health Transformation
EDI	Equality, Diversity and Inclusion
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

Community Mental Health Transformation Programme

1.0 Introduction

As we move closer to the halfway point in the three-year funding allocation for the CMHT programme we bring to the ICB Board a proposal for full delegation of the remaining delivery (implementation management, funding, and resources) to Gloucestershire Health & Care NHSFT to ensure that One Gloucestershire can optimise the transition to the implementation of the Transformation of Community Mental Health services across the county. The purpose of this paper is to:

- Set out the rationale for this change, at this point in the programme lifecycle
- Define proposed governance and reporting structures to provide ongoing assurance to the ICB Board of pace and progress of delivery
- Confirm key deliverables and milestones against which programme success and expected benefits may be measured.
- It should be noted that the recommendations apply to the devolution of the CMHT budget and do not apply to other Mental Health funding streams (MHIS etc) at this stage, although we recognise that this approach and principle may be one that the ICB Board considers for future tactical commissioning arrangements moving forward.

The proposal has been discussed, and fully endorsed by the members of the CMHT Programme Board and will ensure the continued development of the strong partnership working across Voluntary & Community providers as we drive forward the transformation of our community mental health services.

2.0 Background

National Context:

The Community Mental Health Transformation (CMHT) programme, in line with the ambitions set out in the LTP and Mental Health Implementation Plan, will design and develop new and integrated models of primary and community mental health care. This new community-based offer spans both community provision and dedicated core services and is built around Primary Care Networks (PCNs) that will utilise and expand our local Voluntary, Community & Social Enterprise Sector (VCSE) offers to support new and sustained ways of working to deliver improved health outcomes and reduce health inequalities.

As set out in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, all ICSs in England received their 'fair share' of central transformation funding to deliver new models of integrated primary and community mental health care for adults and older adults with Serious Mental Illness (SMI). ICB baseline funding uplifts should then enable the continued delivery of the new models for community mental health.

This paper sets out a proposal for full delegation of the delivery, budget, and resourcing of this programme to GHC to give our System the best possible opportunity to realise the potential for this transformation and to mitigate the current delivery risks.

3.0 CMHT Programme Status and Funding Overview

Year 1 funding for 2021/2022 was confirmed to support the following agreed priorities:

- Continued development and implementation of existing/'in train' schemes:
  - Complex Emotional Needs – Gloucester City roll out and Open Access Therapy (OATs) implementation
  - Eating Disorders – responding to demand and recovering waiting times and exploring alternative provision with VCSE partners – NOTE: this has now been scoped as an ICS programme due to the requirement for system wide transformation to be able to effectively address demand. ICS have previously supported the connection of this work with the CMHT governance structure in terms of both Delivery and Partnership structures and this proposal will not impact on this.
  - Physical Health Checks (PHC) for SMI – ensuring all eligible people receive a PHC, supporting primary care and exploring alternative community and VCSE provision to support recovery of the performance trajectory.
  - Additional Roles Reimbursement Scheme (ARRS) – roll out of additional Metal Health practitioner roles across PCNs as per national guidance.

  - Individual Placement and Support (IPS) delivery
- Developing the programme infrastructure and governance arrangements including commissioning VCSE partners to provide Expert by Experience voices and public engagement.
- Engaging with our local VCS MH Alliance and wider partners to promote the programme and encourage participation, representation, and membership within the programme, whilst exploring options to develop a local framework for VCSE provision within new models.

Key workstreams and deliverables for the 22/23 funding year and beyond into 23/24, are summarised in the Appendix to this paper.

Subject to some final points of clarification, the CMHT Finance Working Group has now agreed a budget of c£2.8m for 22/23. In light of the increased pace required in delivery there needs to be an accelerated process for draw down of agreed funding and full delegation of that budget to GHC will facilitate this.

The 22/23 plan will continue to support delivery of the Y1 priorities outlined above, but in addition will also include investment to support co-production and testing of the new Community Mental Health Team (CMHT) models in 2 PCNs, implementation of a new model for rehabilitation and increased resource working differently with primary care, existing community teams along with enhanced infrastructure to enable increased VCSE participation and delivery.

4.0 Key Challenges to Date

The programme to date has suffered from a number of challenges that have been a barrier to progress and our ability to start to move at pace through this transformation.

Delays with NHSE sign off of our original proposal have added time pressure to the programme and agreement around budgetary releases have delayed the recruitment of the implementation team meaning an accelerated transformation approach is now required to meet key milestones. The current commissioning team have multiple priorities to continue to address and therefore the level of resource requirement to service this programme has been a significant drain on their capacity.

Engagement with multiple PCNs whilst maintaining consistency and scalability of the transformed model is a risk to the programme and one that requires a tightly integrated implementation approach to drive forward successfully.

5.0 Opportunities

- As we move into Year 2, the need to reshape our community teams and interlock them with primary care and the third sector through operational delivery is paramount. This is a significant change programme for our staff and one that will be managed most effectively from within GHC.

- Improve the GP connectedness with the programme through direct relationships and involvement of Mala Ubhi as the ICS's GP lead for Mental Health, and clear linkage with the CMHT CPG.

- GHC can host a fully integrated Programme Team and we have agreed in principle to extend this to include seconded ICS programme resources within the Strategy and Partnerships Directorate to ensure that the programme is well managed. Angela Potter as our Executive Director with senior responsibility for delivering this programme will oversee these resources (see section 8.0 for an outline of the proposed programme governance).

- Delegating the responsibility and accountability for delivering CMHT is absolutely in line with the principles of developing strategic commissioning in the ICB. This encompasses the delegation of service delivery and tactical commissioning to providers.

- CMHT programme delivery and assurance being provided by GHC through a consolidated programme implementation team will enable greater clarity for the ICB as the strategic commissioner.

6.0 Proposed Contracting mechanism

Whilst the overall culture of the Programme remains one of strong partnership, co-production and collaboration across the System and with multiple VCSE providers in Gloucestershire, to ensure effective delivery of specific elements of the Programme there will need to be a formal contracting mechanism in place and we recognise that sub-contracting can take a number of different forms.

We would propose a Lead Provider commissioning model as this does not compromise the opportunity for partnership and strategic collaboration which will continue to be fostered through the proposed and re-invigorated CMHT Partnership Board. The Partnership Board has an important role to play in providing equity of relationships and mutually holding each other to account for delivery. The VCSE partners have an important role to play in holding GHC to account for delivery as much as GHC as Lead Provider have a responsibility for delivery of the overall contract. The People's Representation Action Board also has a key governance role in the CMHT Partnership in ensuring that we develop our news models and deliver through strong co-production and engagement.

GHC currently manages a broad portfolio of subcontracts across a range of clinical services. The value of individual subcontracts ranges from £5k to over £1m. More recently, we have established a partnership approach with a VCS organisation for the delivery of our Sexual Health services (First Light) under a Lead Provider model with sub-contracts to enhance the working relationship and focus on supporting our patients to reduce health inequalities.

The contract management process, and oversight of clinical sub-contracts is embedded within the Trust infrastructure and the level of Contract Management is dependent on the outcomes of the contract and the relationship with the provider e.g., whether a sub-contractor and/or partner. The reporting and escalation of this lead provider contract would be undertaken in the same manner as all GHC contracts through to the Contract Management Board.

Whilst the design and scoping of VCSE services will be developed within the CMHT Programme Governance structure and as mentioned previously, the Partnership Board has an important role in collective governance and delivery. This will sit alongside the oversight of delivery of all clinical subcontracts which will be provided by the GHC Contract Management Group which providers senior oversight of all clinical sub-contracts including:

- Financial monitoring
- Performance monitoring
- Quality and Compliance monitoring
- Risk management
- Service Development and Improvement
- Resource management

The Contract Management Group will ensure the clinical subcontracts are awarded appropriately and the terms and conditions are robust and achievable. The group will also monitor compliance against the Lead Provider contract and co-ordinate the reporting and assurance requirements for the GHC CMHT Oversight Group.

7.0 Budget devolution and funding flow

To effectively control the delivery of the Programme, GHC proposes full devolution of the Programme Budget. Elements of this are clearly already committed, however, there needs to be an unrestricted flow of funding to underpin the pace of change that is now required.

The financial principles that underpin the management of the devolved budget includes:

- Ensuring delegated budget management is open and transparent.
- Producing finance information to support mandatory reporting requirements of partners
- Managing delegated resource responsibilities for agreed pathways
- Supporting financial decision making, contracts and planning to ensure provider incentives are aligned
- Facilitating collaborative and proactive working across organisations to deliver the best value and maximise the best use of assets across the pathway.
- Ensuring delivering value and benefits realisation form part of the decision-making process for investments and will be part of a continuous process to maximise quality and value for money.

- Enabling processes for invoicing and cash flow that support the financial planning needs of small organisations

The CMHT Finance Group will be responsible for ensuring these principles are met. Although the majority of the CMHT budget is already allocated across key Programme workstreams, any material deviation will need to be confirmed by the Finance Group and ratified by the Partnership Board.

8.0 Proposed Governance and reporting arrangements

The proposed governance structure includes the following key features:

CMHT Partnership Board – this group is an evolution of the current ICS CMHT Programme Board, and its focus is on maintaining a clear partnership approach across providers (NHS and VCSE for the delivery of the programme. Terms of Reference will be reviewed to give the Partnership Board collective oversight and assurance responsibilities, so that all partners mutually hold each other to account for delivery.

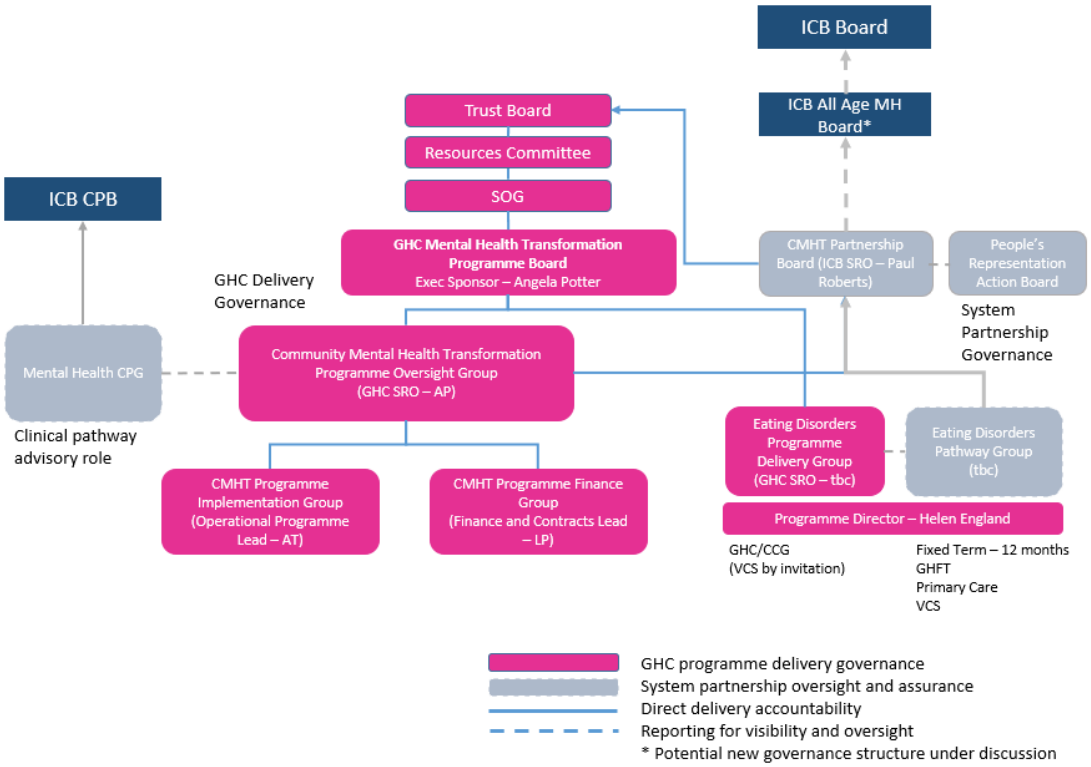
There is already a People's Representation Action Board who will hold the partnerships to account in terms of the required focus on co-production of the CMHT model.

Reporting; As the lead contract holder there is a formal line of accountability to the GHC Trust Board. The potential of an ICS wide All Age Mental Health Board is also being explored to bring together all of the current groups into a single governance structure which would then have oversight of the transformation work on behalf of the ICB, the exact scope and reporting of this is currently being developed and the Terms of Reference will be referred back to a future ICB once confirmed. Should this be confirmed, we would propose formal reporting into it on a quarterly basis from the CMHT Partnership Board with escalation to the ICB on an exception basis as needed. This will allow clear oversight against the programme objectives and delivery of the agreed work plan to ensure that the transformation programme continues to meet its objectives. This is identified in the indicative governance diagram below.

This approach enables partnership collaboration with the ICS, Primary Care and VCSE colleagues around matters of the strategic direction and prioritisation within the programme as the CMHT model develops whilst giving delegated authority to GHC for programme oversight for time, cost and delivery parameters which will be overseen by the CMHT Programme Oversight Group.

Community Mental Health Transformation Programme Finance Group – provides the detailed financial management and tracking against allocations of the Programme Budget. It reports to the Oversight Group around any overspend or underspend that may need to be addressed within the delivery of the Programme.

Funding returns to NHSE will continue to be submitted by the ICS Finance team based upon reporting from GHC.



9.0 Programme Resources

Designated resource is now in place to provide the Programme infrastructure and capacity to deliver this complex Transformational Programme at place level and to enable partnership working with VCSE organisations across the county.

There has been agreement in principle that the staff will be managed as a single team within GHC, with the current CCG roles being seconded across. This would include the CMHT Programme Lead (Band 8B role) on a full time basis and a CMHT Project Manager (B6 role) whose role is split with 3 days per week focused into CMHT and eating disorders and the remainder on taking forward the MH Clinical Programme Group (CPG) and continued personal development. The secondment process and best approach to achieve a single team is currently being confirmed with human resources advice and input. VCSE support is also funded and supported through the Programme to the VCS Alliance, Barnwood Trust, and Inclusion Gloucestershire.

Collaborative working will continue between GHC Contracts (Lisa Proctor) and CCG contract lead (David Porter) around the specialist clinical commissioning/contracting elements of the provision.

10.0 Deliverables

A high-level milestone plan for 2022-2024 is included at Appendix 1. Key deliverables of the Programme in 22/23 are as follows and these will be reported against on a quarterly basis as outlined in section 8.0:

Deliverable	Measurement/reporting	22/23
ARRS recruitment	in line with annual targets	9.2 fte
CEN	Fully operationalised and rolled out. Review of county wide expansion with commissioners	Q3
Annual Physical Health Checks	• additional scoping for SMI physical health interventions • target 65%	Q3 Q4

Deliverable	Measurement/reporting	22/23
Eating Disorders	Being developed through separate ED programme	
VCSE • advisory support • developing capacity and infrastructure (training, project management etc etc)	• Overarching contract in place Rethink/Mind • tangible partnership working on service delivery – combined offer • Continued delivery of Trauma Informed Care by Nelson Trust	Q3 Q4
CMHT phase 1 • FoD • Cheltenham	• Place based service incorporating secondary, primary and VCSE services and operational links with social care and housing. • Comprehensive offer and easy access	April 23
CMHT roll out	• Above model – tailored to local requirements across all PCNs. • Incorporating processes developed in Phase 1 such as assessment format, VCSE contracting and engagement principles	
Accommodation options for SMI	To be developed with the countywide Strategic Housing Group	Jan 23
Rehabilitation Workstream	To be defined in conjunction with National CMHT Development	March 23

11.0 Recommendations

It is recommended that:

- The ICB Board approves the delegation of the full Programme Management, Resources and Budget to GHC through a Lead Provider contracting arrangement enabling GHC to operationally commission VCSE providers as required to support and deliver the Programme.
- As an element of this delegation the ICB Board endorses the secondment of ICS Programme Resources to GHC (1.0 Band 8b Programme Lead and 0.6 Band 6 Project Manager).
- The ICB Board approves the refocussing of the current CMHT Programme Board into a Partnership Board – a dotted reporting line to the ICB Board will continue to provide good visibility and assurance around the strategic partnership working aspects of the Programme as well as progress reporting to NHSE.
- Receive progress reports on a quarterly basis from the Partnership Board to maintain oversight of the programme's delivery.

Appendix 1 - Overview of Priority Workstreams 2022-2024

Deliverable/Activity Implementation Score out of 100 IS = complexity x resource required	IS Score	Q1 22	Q2	Q3	Q4	Q1 23	Q2	Q3
Priority Workstreams								
CMH New Model	81	Deploy across 3 PCNs then all PCNs through 2023						
VCSE Contracts	40	Recruit a National Provider as Programme Advisor						
Communication and Engagement	40	Internal CMHT team engagement. VCSE via Barnwood and Inclusion Gloucestershire. PCNs						
Access and Assessment Process	72	Replace CPA and identify Outcome Measures						
Workforce Modelling	48			To fill gaps identified in CMHT Model				

Deliverable/Activity Implementation score out of 100 IS = complexity x resource required	IS Score	Q1 22	Q2	Q3	Q4	Q1 23	Q2	Q3
Component Workstreams								
SMI Health checks	24	Requires achievement of 65% compliance across PCN and GHC, requires further development of interventions to improve outcomes where a need is identified						
Eating Disorders	32	Ongoing ICS programme. Still requires funding and reporting to NHSEI via CMHT Transformation Board						
Personality Disorder	16				Countywide expansion (current funding was based on Gloucester City deployment)			
Additional Responsibility Reimbursement Practitioners	36	Recruit 3 x per quarter			Review banding options and roles available under new national ARRs guidance			
Housing and Accommodation for SMI	40	Integrate with Strategic Housing Group and focus on SMI/MH specific provision. Integrate strategic options with GHC site disposals to maximise social benefits						
Rehabilitation	16			Identify workstream and start co-design. Requires pathway review for specialist placements and locked Rehab				

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Agenda Item 12

Integrated Care Board meeting

27 July 2022

Report Title	**EPRR transition to the ICB v.1**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X						
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Request to provide information on EPRR responsibilities to the ICB	13/06/2022	NHSE readiness Assurance assessment process	8/6/2022			
Executive Summary	This paper outlines to the ICB Board their responsibilities with respect to EPRR. It further describes the assurance process undertaken by NHSE to permit the NHS Gloucestershire ICB to take on the role of Category 1 responder. It also provides assurance to the board that the ICB has robust systems and processes in place to effectively manage the role of system leader for EPRR.						
Key Issues to note	To note the Category 1 responder responsibility of the ICB and the positive outcome of the assurance process by NHSE.						

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Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	That the ICB EPRR function will not be effective and unable to meet the duties of the Civil Contingencies act 2004.			
Management of Conflicts of Interest	None			
Resource Impact (X)				
Financial Impact	None			
Regulatory and Legal Issues (including NHS Constitution)	We need to comply with the Civil Contingencies Act 2004 as a Category One responder. We need to comply with ISO 22301 in respect of Business Continuity. There are two members of staff working in EPRR that hold this qualification. Other legislation includes: The NHS Act 2006, The Health and Care Act 2022 and the NHS Standard Contract including the Framework and Core Standards.			
Impact on Health Inequalities	None			
Impact on Equality and Diversity	None			
Impact on Sustainable Development	None			
Patient and Public Involvement	None			

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Recommendation	The Integrated Care Board is asked to note the content of this report with regards to the ICB duties in respect of EPRR.		
Author	Andy Ewens	**Role Title**	Senior EPRR and Business Continuity Manager
Sponsoring Director (if not author)	Dr Marion Andrews-Evans - Accountable Emergency Officer		

Glossary of Terms	**Explanation or clarification of abbreviations used in the paper**
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise
EPRR	Emergency Preparedness Resilience and Response
CCA	Civil Contingencies Act 2004
LRF	Local Resilience Forum

1. Introduction

1.1. With the establishment of the Integrated Care Board (ICB) on 1st of July, the Board became a category 1 responder as defined by the Civil Contingencies Act 2004 and as part of the NHS Emergency Preparedness Resilience and Response (EPRR) arrangements. Category 1 responder are those organisations at the core of emergency response (e.g. emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties. NHSE will also continue to offer support to the ICB as a Category 1 responder should the need arise.

1.2. Though the Category 1 designation formally commenced on 1st July 2022, the CCG had been operating at this level for several years with agreement of NHSE due to the robust EPRR arrangements that were in place. The CCG has been a full member of the Local Resilience Forum (LRF) and has been an active participant in Strategic Co-ordinating Groups called to manage serious untoward events such as the Covid pandemic.

2. Purpose and Executive Summary

2.1. This paper outlines to the ICB Board their responsibilities with respect to EPRR. It further describes the assurance process undertaken by NHSE to permit the NHS Gloucestershire ICB to take on the role of Category 1 responder. It also provides assurance to the board that the ICB has robust systems and processes in place to effectively manage the role of system leader for EPRR.

3. ICB Emergency Preparedness Resilience and Response Duties

3.1. The 1st July saw significant changes to the way that healthcare services are delivered to our local, regional and national audience. Along with that came a significant change in the way Emergency Preparedness, Resilience and Response (EPRR) is provided within the NHS with additional responsibilities placed on the Integrated Care Board (ICB).

3.2. Appendix 1 to this paper is the NHS EPRR Framework that has been revised to reflect the introduction of the Health and Care Act 2022, including the change of status of an ICB to include that organisation as a Category 1

responder under the Civil Contingencies Act 2004. This introduces changes to the responsibilities of the ICB EPRR duties .

3.3. The role of Category 1 responder is:

- To assess the risk of emergencies occurring and use this to inform contingency planning in the form of a Community Risk Register;
- Put in place emergency plans;
- Create business continuity plans to ensure that they can continue to exercise critical functions in the event of an emergency;
- Make information available to the public about civil protection matters, and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance coordination and efficiency;
- Provide advice and assistance to other NHS organisation.

3.4. As indicated above, NHS Gloucestershire CCG undertook these functions on behalf of NHSE and therefore the transfer to a Category 1 responder as an ICB is straight forward. As part of the transfer to a Category 1 responder NHSE undertook an assurance process of the CCG / ICB. A letter from NHSE is attached following that process indicating that they are fully assured that the ICB is able to take on this new function. Appendix 2.

3.5. Little change is required at present as to how our EPRR processes function and how we respond should there be an emergency situation. The demonstration of the CCG acting as a Category 1 responder was evidenced by our system leadership of the response to the Covid pandemic.

3.6. The content of the new EPRR Framework document and it's supporting paper regarding Minimum Occupational Standards for EPRR, does indicate a need for some changes in the way we will function going forward and the EPRR teams across the system are currently exploring what the implications of the new framework are and what changes need to take place.

4. EPRR Assurance and Exercises / Training

4.1. Annually the CCG had to undertake an EPRR Core Standards Assurance process as determined by NHSE. In recent years the CCG has attained assurance levels of either substantially compliant or fully compliant which was the standard for this last year (2020/21). Appendix 2. This year's process will start in August with the ICB undertaking an assurance of the EPRR

arrangements of our main service providers. Subsequently the ICB EPRR process will also be assured by NHSE in the Autumn.

4.2. Based on the previous assurance process the ICB and partner organisations have commenced a training programme based on the gaps that were identified. The recent appointment of a joint training officer between the ICB, GHC and GHT will further strengthen our shared approach to EPRR.

4.3. Recent emergency planning exercises (Lemur, Cypress and Orient) have taken place that have clearly evidenced the benefit of Multi Agency / discipline working. Within EPRR in the county there is a commitment to continued working in this way not just in the NHS but with the Local Authority, other statutory bodies, and voluntary sector partners.

5. System-wide working

5.1. The ICB have commenced work with GHT and GHC EPRR managers to develop further joint working arrangements.

5.2. Some of the key EPRR plans have been reviewed and amended to reflect the ICB / ICS, this includes the Incident Response Plan, Business Continuity Strategy and Business Continuity Plan.

5.3. In addition, the Health Community Response Plan has been thoroughly updated to allow for the change in statute of the ICB to Category 1 and recognise the collaborative arrangements of the ICS. A new version of the Countywide Mass Casualty Response plan is also in the process of being updated.

6. Recommendations

The Integrated Care Board is asked to note the content of this report with regards to the ICB duties in respect of EPRR.

Classification: Official

Publication approval reference: B1568

Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR)

Version 1.0, June 2022

12.1

Contents

1 Introduction

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA), the Civil Contingencies Act 2004 (Contingency Planning Regulations) 2005, the NHS Act 2006 and the Health and Care Act 2022.

This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

The day-to-day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident; however, these events can lead to greater public and legal scrutiny. If staff are planning for or responding to an incident, they need to have the tools and skills to do so in line with their assigned NHS command and/or incident response role.

2 Purpose

This document sets out the minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve in order to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD), maintaining personal development portfolios (PDPs) in accordance with NHS Core Standards for EPRR. Regional EPRR teams can provide good practice examples of PDPs on request.

As part of ongoing CPD, the Skills for Justice National Occupational Standards (NOS) Framework should be evidenced in addition to these minimum standards. Suggestions as to the NOS aligned to roles are provided in Appendix 1. In addition, there may be a need for specific specialist training for roles required.

This guidance must be used in conjunction with the NHS Emergency Preparedness, Resilience and Response Framework which sets out requirements for EPRR, including definitions of strategic, tactical and operational command.

The standards apply to all commissioners and providers of NHS-funded services where the NHS Core Standards for EPRR apply. These occupational standards are provided as EPRR Guidance as defined in the NHS Standard Contract.

3 Achievement and recording of competence and training

Training should be focused on the specific roles and requirements assigned to an individual, aligned to a training needs analysis. In addition to covering all aspects of the response role, training should also highlight wider organisational and multi-agency response structures.

Organisations will need to adapt the roles specified in Appendix 1 to match them to the roles they use in their Incident Response Plans.

In order to provide evidence of competence, it is essential that all training objectives and outcomes are met and recorded. Trained individuals must have protected time and the opportunity to practice their skills and increase their confidence, knowledge and skill base through regular exercises. Individuals who have a role within the planning for and/or response to an incident or emergency must demonstrate competence against the required standards every three years as a minimum. Individual organisations may set more frequent periods depending on the assessed risks.

4 Roles covered by this document

4.1 Roles with specified NOS

The following roles have specified NOS, as outlined in Appendix 1, as the expected minimum standards for the role:

- EPRR Specialist/Adviser
- Business Continuity Lead
- NHS Emergency Ambulance Commanders (Strategic, Tactical and Operational)

4.2 Other roles

The following list is provided as examples of the roles in use across the NHS and should be used as a guide in determining the applicable standards for the role in individual organisations. Where minimum occupational standards are not specified then the appropriate NOS must be used, as described in Appendix 1:

- Chief Executive Officer (Strategic)
- Accountable Emergency Officer (Strategic)
- NHS Strategic Commander
- NHS Tactical Commander
- NHS Operational Commander
- EPRR Strategic Advisor (these cover such incidents as chemical, biological, radiological, and nuclear (CBRN) etc)
- EPRR Tactical Advisor
- Loggist
- Communications Officer
- Command Support.

NHS Decontamination Operatives/Practitioners are aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by a chemical, biological, radiological or nuclear incident.

Appendix 2 provides examples of roles within NHS England and NHS provider organisations and how these may be matched to the roles specified above.

5 Respond to incidents and emergencies at the Strategic level

The NHS Strategic Commander has overall command of the organisation's resources. They are responsible for liaising with partners to develop the strategy, policies and objectives and to allocate the funding which will be required to manage the incident. They will also ensure arrangements are in place to support the recovery from an incident.

5.1 Performance criteria

The NHS Strategic Commander must be able to:

1. develop and review response and communications strategies for your organisation with appropriate stakeholders and multi-agency partners
2. coordinate and communicate effectively at tactical and strategic level, across health and with multi-agency partners
3. gather and share information and intelligence to inform effective decision-making
4. make effective decisions based on the best available information (e.g. through use of the Joint Decision Model)
5. brief the strategic plan, appropriately delegate to tactical level and regularly review
6. ensure sufficient, appropriate resources are available to support the response
7. identify the long-term and medium-term recovery priorities
8. ensure effective and timely handover of command
9. fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

5.2 Knowledge and understanding

The NHS Strategic Commander must know and understand:

1. the legal basis of their authority and the powers that derive from this (e.g. statute, contract, policy etc)
2. the principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'
3. the command and control structures for health and multi-agency emergency response
4. the roles and responsibilities of key emergency response partners (i.e. emergency services, local authorities and other health partners)
5. the key elements of organisational and multi-agency incident and emergency plans
6. the factors relevant to setting and reviewing the response strategy, identified in point 1 of the Performance Criteria (e.g. risk assessment, community impact, environmental impact and the longer-term recovery process)
7. the financial arrangements that are needed to enable an emergency response
8. how to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups

9. how to ensure the provision of continued support for individuals affected by an incident or emergency
10. how to access sources of technical and professional advice
11. the information needs of the various organisations involved in the response
12. the Joint Services Interoperability Principles (JESIP) joint doctrine.

6 Respond to incidents and emergencies at the Tactical level

The NHS Tactical Commander is responsible for directly managing their organisation's response to an incident. They will interpret strategic direction and develop the tactical plan to achieve the objectives set by strategic command.

6.1 Performance criteria

The NHS Tactical Commander must be able to:

1. work in co-operation with and communicate effectively with other health and multi-agency partners at the tactical level
2. gather and share information and intelligence to inform effective decision-making
3. make effective decisions (e.g. through use of the Joint Decision Model)
4. undertake an ongoing assessment of the risks to the health of the community and to the delivery of healthcare to the community
5. develop tactical plans, aligned to the strategic plan, based upon available information, incident and emergency plans and the assessed risks
6. implement and brief tactical plans, reviewing them on an ongoing basis, in consultation with key staff and partners
7. determine and prioritise the resources required for the response in both the short and longer term
8. provide accurate and timely information to inform and protect the community, working with the media where relevant, and within the agreed organisational communication strategy
9. coordinate responses from the operational level
10. identify where circumstances warrant a strategic level of management and ensure fully briefed as required
11. ensure effective and timely handover of command
12. maintain the health, safety and welfare of individuals during the response
13. fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

6.2 Knowledge and understanding

The NHS Tactical Commander must know and understand:

1. the legal basis of their authority and the powers that derive from this (e.g. statute, contract, policy etc)

2. the principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'
3. the command and control structures for health and multi-agency emergency response
4. how to undertake an ongoing risk assessment
5. the roles and responsibilities of key emergency response partners (i.e. emergency services, local authorities and other health partners)
6. the key elements of organisational and multi-agency emergency plans (i.e. aim & objectives, activation process and roles and responsibilities of responding agencies)
7. the range of tactical options available and how they should be communicated
8. how to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups
9. the information needs of the various organisations involved in the response
10. the Joint Services Interoperability Principles (JESIP) joint doctrine.

7 Respond to incidents and emergencies at the Operational level

The NHS Operational Commander is responsible for managing the main working elements of the response to an incident, by ensuring rapid and effective actions are taken, and implementing the tactical plan.

7.1 Performance criteria

NHS Operational Commander must be able to:

1. assess the situation and report to other responders and to tactical level
2. conduct a dynamic risk assessment
3. prepare, implement and review a plan of action based upon the dynamic risk assessment and tactical plan, within own operational area of responsibility
4. ensure that any individuals under your command are fully briefed and de-briefed
5. work in co-operation with, and communicate effectively with, other responders
6. assess resources required and deploy them to meet the needs of the response
7. identify resource constraints and communicate to tactical level
8. monitor and protect the health, safety and welfare of individuals during the response
9. identify where circumstance warrant a tactical level of management
10. make effective decisions (e.g. through use of Joint Decision Model)
11. ensure effective and timely handover of command
12. fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

7.2 Knowledge and understanding

NHS Operational Commander must know and understand:

1. current legislation, policy and procedures relevant to the response role being undertaken, including that relating to health, safety and welfare
2. their relevant organisational incident and emergency plans and arrangements
3. how they fit into the wider command and control structure (organisational & multi-agency)
4. the communication channels to be used to liaise with other responders and the chain of command
5. the organisational policy on dealing with the media
6. the correct procedures for handing over responsibility
7. the purpose of recording information and the types of records that must be kept.

8 Record decisions (Loggist)

The Loggist is responsible for ensuring that appropriate decision logs are recorded for a specified Decision Maker.

8.1 Performance criteria

The Loggist must be able to:

1. Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation as specified by nominated Decision Maker
2. Ensure effective and timely handover of Logging.

8.2 Knowledge and understanding

The Loggist must know and understand:

1. Current legislation, policy and procedures relevant to the role of the Loggist
2. Log keeping requirements including ways of working with the decision maker and the purpose of decision logs.

Appendix 1 – NOS aligned to roles

The minimum standards are outlined in the body of this document. CPD should take place to develop the role where 'optional for role' is indicated, with ongoing CPD to achieve all other NOS.

M - Mandatory for Role, O – Optional for Role

Skills for Justice NOS	Chief Executive Officer	Accountable Emergency Officer	NHS			NHS Emergency Ambulance Service			EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Roles	On Call staff	Loggist
			Strategic Commander	Tactical Commander	Operational Commander	Strategic Commander	Tactical Commander	Operational Commander						
SFJ CCA A1 Work in cooperation with other organisations	O	O	M	M	M	M	M	M	M	M	M	O	M	
SFJ CCA A2 Share information with other organisations	O	O	M	M	M	M	M	M	M	O	M	O	M	
SFJ CCA A3 Manage information to support civil protection decision making			M	M	M	M	M	M	M		O	O	M	O
SFJ CCA B1 Anticipate and assess the risk of emergencies		O	M	M	M	M	M	M	M					
SFJ CCA C1 Develop, maintain and evaluate emergency plans and arrangements			O	O		O	O		M		O			
SFJ CCA D1 Develop, maintain and evaluate business continuity plans and arrangements		O	O	O	O	O	O	O	M	M				
SFJ CCA D2 Promote business continuity management		M							M	M	O			
SFJ CCA E1 Create exercises to practice or validate emergency or business continuity arrangements									M	M				

Skills for Justice NOS	Chief Executive Officer	Accountable Emergency Officer	NHS			NHS Emergency Ambulance Service			EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Roles	On Call staff	Loggist
			Strategic Commander	Tactical Commander	Operational Commander	Strategic Commander	Tactical Commander	Operational Commander						
SFJ CCA E2 Direct and facilitate exercises to practice or validate emergency or business continuity arrangements									M	M				
SFJ CCA E3 Conduct debriefing after an emergency, exercise or other activity		O	M	M	M	M	M	M	M	M		O	O	
SFJ CCA F1 Raise awareness of the risk, potential impact and arrangements in place for emergencies			O	O		O	O		M	M	M			
SFJ CCA F2 Warn, inform and advise the community in the event of emergencies	O		M	O	O	M	O	O	M		M		O	
SFJ CCA G1 Respond to emergencies at the strategic level	O	O	M			M			M				M	
SFJ CCA G2 Respond to emergencies at the tactical level				M			M		M				M	
SFJ CCA G3 Respond to emergencies at the operational level					M			M	M	O			M	
SFJ CCA G4 Address the needs of individuals during the initial response to emergencies			O	M	O	O	O	O	M			O	M	
SFJ CCA H1 Provide on-going support to meet the needs of individuals affected by emergencies			M	M	O	O	O	O	M				O	
SFJ CCA H2 Manage community recovery from emergencies	M	O	M	O	O	O			M				O	

Appendix 2 – Example NHS roles

The information provided in this Appendix is to provide information as to some of the commonly used roles within the NHS in England and how they may be matched to the roles specified in these standards.

The lists are not intended to be prescriptive or exhaustive and must be adapted to local needs and circumstances.

NHS England

Strategic Commander

Chief Executive
Chief Operating Officer
National Director
Second On-Call
Incident Director
Regional Director

Tactical Commander

First on call
Incident Manager

Operational Commander

Task Manager
SitRep Manager
Briefing Manager

Command Support

Incident Management Team Support Officer

NHS Provider Organisations

Strategic Commander

Chief Executive
Clinical Director
Director
On-Call Director

Tactical Commander

General Manager
Site Manager
Clinical Lead
Matron

Operational Commander

Service Manager
Service Head/Lead

Clinical Lead
Clinical Site Team
Ward Manager

Command Support

Ward staff
Specialist service staff
Pharmacy
Pathology
Security
Supplies
Porters
Administration
Communications, including switchboard
Human Resources

NHS England
Quarry House
Quarry Hill Leeds
LS2 7UE

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NHS Emergency Preparedness Resilience and Response Framework

Version 3, July 2022

Contents

1. Purpose and context

This Framework describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (**EPRR**), to help all **NHS-funded Organisations** in England meet the requirements of the Civil Contingencies Act 2004 (**CCA 2004**), the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

This Framework reflects the changes introduced from the Health and Care Act 2022 and the formation of Integrated Care Boards (ICBs). A summary of the changes are:

- Clinical Commissioning Groups (**CCGs**) as of 1 July 2022 dissolved and Integrated Care Boards (**ICBs**) established
- The CCA 2004 and the NHS Act 2006 will be updated to set out the duties of ICBs in relation to emergency planning
- NHS England and NHS Improvement will formally be merged into one organisation, called NHS England [1].

2. Who is this document for?

This guidance is issued under section 2 and 252A of the NHS Act 2006. It is strategic national guidance for NHS-funded Organisations in England including but not limited to:

- NHS Trusts, Foundation Trusts and Care Trusts
- providers of NHS-funded primary care
- independent and third sector providers of NHS-funded services (whether under a contract with an NHS commissioner or otherwise)
- NHS commissioning organisations, including NHS England and ICBs

All accountable emergency officers (**AEOs**) and EPRR practitioners must be familiar with the principles of EPRR and be competent and confident of their roles and

[1] From 1 April 2019, NHS England and NHS Improvement have worked together to better support the NHS to deliver improved care for patients. They work under a single operating model to deliver all aspects of the existing organisations' functions with shared governance, systems and processes, organisation structures and capabilities, culture and behaviours and financial set up.

responsibilities in planning for and responding to incidents and emergencies.

Whilst this document is intended for ICBs and providers, other Arm's Length Bodies (ALBs) providing NHS services may wish to use this guidance to help inform good resilience planning. This will be a decision for each ALB organisation.

3. Applicable legislation and guidance

This Framework should be read in the context of:

- CCA 2004, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (**2005 Regulations**) and associated Cabinet Office guidance
- NHS Act 2006
- Health and Care Act 2022
- the NHS Constitution
- the requirements for EPRR as set out in the NHS Standard Contract(s)
- NHS England EPRR guidance and supporting materials including:
  - NHS Core Standards for Emergency Preparedness, Resilience and Response
  - other guidance available on the NHS England website
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (**MOS**)
- ISO 22301:2019 Security and resilience – Business continuity management systems
- Integrated Care Systems/ Integrated Care Boards
- National Risk Register
- Equality and health inequalities legal duties

All references to legislation include any amendments made to that legislation.

4. Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the CCA 2004, the NHS Act 2006 and the Health and Care Act 2022.

This work is referred to in the health service as emergency preparedness, resilience and response or EPRR.

4.1 Aim of the framework

To enable the NHS in England to ensure effective arrangements are in place to deliver appropriate care to patients affected by an emergency or incident.

4.2 Objectives of the framework

- To prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario.
- To have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios.
- To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience.
- To ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities.

Governance for EPRR is best achieved through the linkage of EPRR and business continuity to the organisation's risk management framework. The identification and management of risks must be linked to the Community Risk Register (**CRR**) and the National Risk Register (**NRR**) and the National Security Risk Assessment (NSRA), as appropriate.

4.3 Summary of key changes

Below is a summary of the key changes since the last published version of the Framework (version 2, 2015):

- Changed to reflect that the Emergency Preparedness Resilience and Response functions of Public Health England (PHE) now sit with the United Kingdom Health Security Agency (UKHSA) (throughout text)
- Addition of the Health and Care Act 2022 (throughout text)
- Addition of ICBs (throughout text)
- Removal of CCGs (throughout text)
- Addition of context section (1)
- Addition of Cabinet Office (JESIP) definition of Major Incident (6.5)
- Amendment to definition of Level 3 Incident (7)
- Update to definition of Mass Casualty Incident (7.1)
- Update to definition of Cyber Security Incident (7.1)
- Planning structures diagram updated (8.4)
- Amended link to Cabinet Office guidance (8.8)
- Suggested record keeping requirements added (8.9.1)
- Amendment to AEO support requirements from non-executive directors (9.1)
- Incident Coordination Centre (**ICC**) equipment test added to exercise requirements (10.4.5)
- Update to incident response structure for the NHS in England (12)
- Addition of expectation around regard for promoting equality and addressing health inequalities. (18)

5. Service reconfiguration

Commissioners and providers must give due consideration to the potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an incident or emergency. As a minimum, there should be a formal modelling exercise to identify any potential impact and clear evidence of mitigating actions planned or undertaken to ensure effective EPRR is maintained.

6. Definitions

6.1 Emergency preparedness

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

6.2 Resilience

Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

6.3 Response

Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery.

6.4 Incidents

For the NHS, incidents are defined as:

Business Continuity Incident – an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Critical Incident – any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Major Incident – The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder

agency. [2]

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS, this will include any event defined as an emergency under Section 8.1.4.

A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multi-agency support to a lead responder.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally.

The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

Each will impact on service delivery within the NHS, and this may undermine public confidence and require contingency plans to be implemented. When making the decision to declare an incident the person making the decision should be clear on what the declaration of an incident will achieve. NHS organisations and NHS-funded organisations should be confident in judging the severity of an incident and determining if declaration is warranted.

6.5 Classifications of types of Major Incident

The following list provides commonly used classifications for types of Major Incidents. This list is not exhaustive and other classifications may be used as appropriate to describe the nature of the incident.

- **Rapid onset** – develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g. a serious transport accident, explosion or series of smaller incidents.
- **Rising tide** – a developing infectious disease epidemic or a capacity/staffing crisis or industrial action.
- **Cloud on the horizon** – a serious threat such as a significant chemical or

[2] "Emergency responder agency" includes any category 1 and category 2 responder as defined in the CCA 2004 and associated guidance.

nuclear release developing elsewhere and needing preparatory action.

- **Headline news** - public or media alarm about an impending situation, significant reputation management issues, e.g. an unpopular patient treatment plan which gathers significant publicity.

- **Chemical, biological, radiological, nuclear and explosives –** CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.

- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials.

- **Cyber security incident** – a breach of a system's security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.

- **Mass casualty** – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage.

6.6 Organisations

- **NHS-funded Organisation** – organisations who receive direct or indirect funding from NHS England.

- **Provider of NHS-funded services** means NHS trusts, foundation trusts and care trusts and any independent or third-sector providers that are contracted for the delivery of services to support the health service, as defined in the NHS Act 2006

- **Integrated Care Board (ICB)** – each Integrated Care System (ICS) has an ICB bringing together the NHS locally to improve population health and establish shared strategic priorities within the NHS.

- **NHS England**[3] – all parts of the organisation, but specifically NHS England regional teams, and specialist central teams e.g. Estates, Specialised Commissioning etc)

[3] NHS England as a category 1 responder under the Civil Contingencies 2004 has a duty to follow this guidance.

7. NHS incident response levels

An incident is described in terms of the level of response required. This level may change as the incident evolves (see Figure 1).

Incident response levels describe at which level coordination takes place. For clarity, these levels must be used by all organisations across the NHS when referring to incidents. **They are specific to the NHS in England and are not interchangeable with other organisations' incident response levels.** Guidance to assist with escalation and de-escalation is provided in the Appendix.

All incidents and emergencies resulting in the activation of UK Central Government response arrangements will be managed as Level 4 incidents.

Further explanation about operational, tactical and strategic command can be found at Sections 13.1 to 13.3.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Figure 1: NHS incident response levels

8. Statutory requirements and underpinning principles of EPRR

Under the NHS Constitution the NHS is there to help the public when they need it; this is especially true during an incident or emergency. Extensive evidence shows that good planning and preparation for any incident saves lives and expedites recovery.

All NHS-funded organisations must therefore ensure robust and well-tested arrangements are in place to respond to and recover from these situations.

8.1 Statutory requirements under the CCA 2004 and 2005 Regulations

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 (supporting agencies).

8.1.1 Category 1 responders

Category 1 responders are those organisations at the core of an emergency response and are subject to the full set of civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance coordination
- co-operate with other local responders to enhance coordination and efficiency
- provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only)

Category 1 responders with responsibility for health or public health are:

- The Secretary of State for Health and Social Care (**SofS**) in relation to the SofS duty to protect public health under the NHS Act 2006. In practice, the SofS delegates their role to the United Kingdom Health Security Agency (UKHSA), so that in practice the UKHSA operates as though the UKHSA itself is a category 1 responder.
- NHS England
- ICBs
- NHS trusts and NHS foundation trusts with the function of providing:
  - ambulance services or
  - hospital accommodation and services in relation to accidents or emergencies
- local authorities (including directors of public health (**DsPH**))
- Port health authorities

8.1.2 Category 2 responders

Category 2 responders such as utility providers and transport providers, are critical partners in EPRR that are required to co-operate with and support other Category 1 and Category 2 responders. They are less likely to be involved in the heart of planning work but will be heavily involved in incidents which affect their sector. Category 2 responders have a lesser set of duties, which are to co-operate and share relevant information with other Category 1 and 2 responders.

8.1.3 Others

NHS-funded organisations that are not NHS trusts or foundation trusts (e.g. primary care contractors, out-of-hours providers, independent sector and third sector providers) are not listed in the CCA 2004. However, NHS England and the Department of Health and Social Care (**DHSC**) expect them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and the services they provide. Also, note that NHS-funded organisations not listed as Category 1 or Category 2 responders under the CCA 2004 may still have EPRR obligations under the NHS Act 2006 and/or their contracts with the NHS (see further below).

Under the 2005 Regulations, each local area must have a Local Resilience Forum (LRF). ICBs will represent the NHS at the LRF; NHS England, NHS Trusts and Foundation Trusts providing emergency ambulance services or accident and emergency hospital services are also LRF members.

The NHS in England will also have in place strategic forums for joint planning for health incidents: these are known as local health resilience partnerships (LHRP). These partnerships will support the health sector's contribution to multi-agency planning through the LRF. See section 9.5 for further detail.

It is essential that NHS-funded organisations ensure they have effective, co-ordinated structures in place to adequately plan, prepare and rehearse the strategic, tactical and operational response arrangements with local partners.

8.1.4 Meaning of "emergency"

Under section 1(1) of the CCA 2004 an 'emergency' is defined as:

"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;

(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; or

(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

8.2 Statutory requirements under the NHS Act 2006

The NHS Act 2006 requires NHS England and the ICB to ensure that the NHS is properly prepared to deal with an emergency. ICBs should assure themselves that their commissioned providers are compliant with relevant guidance and standards, and they are ready to assist NHS England in coordinating the NHS response.

The key elements contained in section 252A of the NHS Act 2006 are:

a) NHS England and each ICB must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.

b) NHS England must take steps as it considers appropriate for securing that each ICB and each '**relevant service provider**' (definition set out below) is properly prepared for dealing with a relevant emergency.

c) The steps taken by NHS England must include monitoring compliance by each ICB and service provider.

d) NHS England must take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by ICBs and relevant service providers for which it is a '**relevant emergency**' (definition set out below).

e) NHS England may arrange for any body or person to exercise any functions of NHS England under subsections a) to d) and any functions it has, by virtue of being a Category 1 responder under CCA 2004.

A '**relevant emergency**' is defined as:

- **In relation to NHS England or ICB:** Any emergency which might affect NHS England or the ICB (whether by increasing the need for the services that it may arrange or in any other way).

  In relation to a relevant service provider: Any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way).

This definition of "relevant emergency" should be used when considering the scope of legal obligations under the NHS Act 2006. However, in practice, generally NHS organisations should use the terminology set out at sections 6.5 (incident) and 8.1.4 (emergency) unless otherwise stated.

A '**relevant service provider**' is defined as:

- any body or person providing services in pursuance of service arrangements.

'**Service arrangements**' in relation to a relevant service provider are defined as:

- arrangements made under the 2006 Act for the provision of services.

These elements clearly establish the relationship between NHS England and ICBs. NHS England would seek to work with and through ICBs to ensure the NHS response can be effectively managed at strategic and tactical levels to deliver the service-wide aims and objectives.

In addition, under section 253, the SofS may also give directions to NHS bodies in relation to an emergency.

8.3 Underpinning principles for NHS EPRR

These underpinning principles apply to all commissioners and NHS-funded organisations.

a) **Preparedness and anticipation** – the NHS needs to anticipate and manage the consequences of incidents and emergencies by identifying risks and understanding direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared. This includes having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) **Continuity** – the response to incidents should be grounded within organisations' existing functions and their familiar ways of working. Actions will need to be faster, on a larger scale and in more testing circumstances during a response to an incident.

c) **Subsidiarity** – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building blocks of response for an incident of any scale.

d) **Communication** – good two-way communication is critical to any effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) **Cooperation and integration** – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. This includes active mutual aid across organisations, within the UK and across international boundaries as appropriate (see Section 8.7).

f) **Direction** - clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident.

8.4 Planning structures

Figure 2 below shows the EPRR planning structure for the NHS in England and the interactions with key partner organisations.

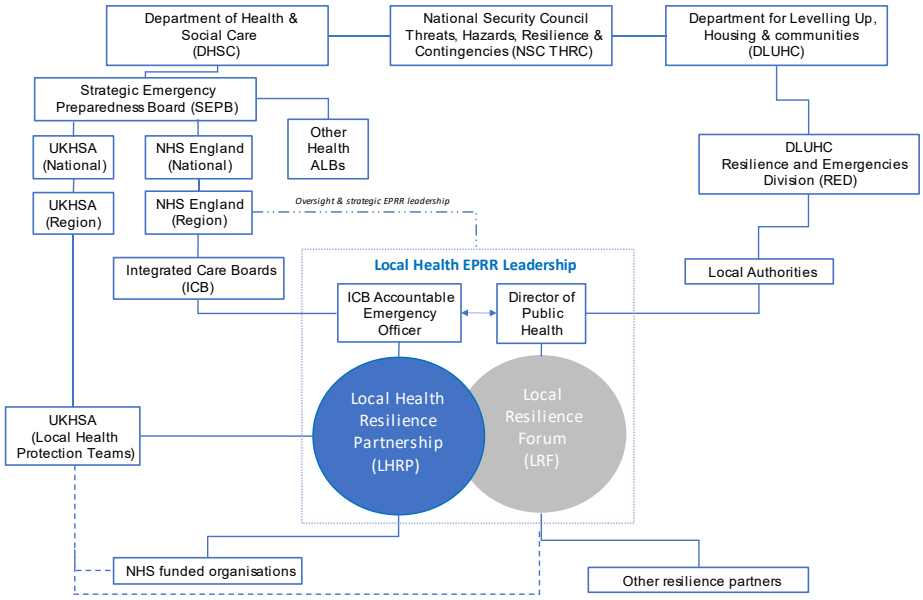

Figure 2: EPRR planning structure for the NHS in England

***** LHRPs will be co-chaired by the ICB AEO and a Director of Public Health. NHS England will be a member of each LHRP[4]

Health resilience sub-groups may exist at LHRP level and at an ICS level to undertake strategic and tactical EPRR work.

8.5 NHS Core Standards for EPRR and the NHS Standard Contract

The minimum requirements that commissioners and NHS-funded organisations must meet are set out in the current NHS Core Standards for Emergency Preparedness, Resilience and Response (**Core Standards**). These Core Standards are in accordance with the CCA 2004, 2005 Regulations and the NHS Act 2006.

The NHS Standard Contract Service Conditions[5] require Providers of NHS-funded services to comply with EPRR guidance. Therefore, commissioners must ensure

[4] see 9.4 for NHS England (London) arrangements

[5] See NHS Standard Contract, Service Conditions SC30

Providers of NHS-funded services are compliant with the requirements of the Core Standards as part of the annual national assurance process (see Section 17).

Details of the annual assurance process are available here.

NHS England will ensure that commissioners are compliant with the requirements of the Core Standards, as part of the annual Core Standards assurance.

8.6 Co-operation between local responders

Under the CCA 2004 and 2005 Regulations, co-operation between local responder bodies is a legal duty. In addition, the NHS Act 2006 sets out a duty on NHS bodies to co-operate with each other in discharging their functions.

It is important that the planning for incidents is co-ordinated within and between individual health organisations and at a multi-agency level with partner organisations. NHS England and ICBs will co-ordinate health services at the LRF level, and ICBs will ensure co-ordination across local ICSs.

The LHRP and local EPRR planning groups facilitate this partnership working.

8.7 Mutual aid

The successful response to incidents has demonstrated that joint working can resolve very difficult problems which fall across organisational boundaries.
Mutual aid arrangements should exist between NHS-funded organisations, and between NHS-funded organisations and partner organisations. These should be regularly reviewed and updated.

Clinical networks will retain a key role in coordinating their specialist capacity.

8.8 Information sharing

Under the CCA 2004 and 2005 Regulations responders have a duty to share information with partner organisations. This is a crucial element of civil protection work; it underpins all forms of co-operation.

NHS-funded organisations should formally consider the information required to plan for and respond to an emergency. They should determine what information can be made available in the context of the CCA 2004. An organisation's information governance policies and procedures should cover the requirements of EPRR.

Cabinet Office Data Sharing Guidance 2019 is available on the Civil Contingencies Secretariat page of Resilience Direct.

8.9 Record keeping

The day-to-day management of people and patients in the NHS is subject to legal obligations such as duties of care, candour and confidentiality as well as professional obligations. This does not change when responding to an incident. However, these events can lead to greater public and legal scrutiny. This may include coroners' inquests, public inquiries, criminal investigations and civil action. When planning for and responding to an incident, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence.

8.9.1 Logging and record keeping

NHS-funded organisations must have appropriately trained and competent Loggists to support recording of decisions made in the management of an incident. Loggists are an integral part of any incident management team. All those tasked with logging must do so to best practice standards and understand the importance of logs in the decision-making process, evaluation and identifying lessons, and as evidence for any subsequent inquiries.

Following an incident, internal investigations, external scrutiny and/or legal challenges may be made. These may include coroners' inquests, public inquiries, criminal investigations and civil action.

When planning for and responding to an incident, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence. It may be necessary to provide all documentation; therefore, robust and auditable systems for documentation and decision-making must be maintained. The organisation's document retention policies and procedures should cover the requirements of EPRR. For example, NHS England uses the categories and retention periods shown in Table 1 for EPRR-related records.

Category	Examples	Minimum retention period	Final action
Incidents (declared)	Decision logbook, on-call logbook, incident-related documents including plans and organisational structures Paper and electronic records	30 years	Review, archive or destroy under confidential conditions
Exercise	Paper and electronic records	10 years	Review, archive or destroy under confidential conditions

Category	Examples	Minimum retention period	Final action
On-call (routine – non-Major Incident)	Decision log, on-call log, handover records Paper and electronic records	10 years	Review, archive or destroy under confidential conditions
EPRR	Incident response plans, guidance, standard operating procedures, core standards for assurance Electronic records	30 years	Review, archive or destroy under confidential conditions
EPRR	Information sharing protocols, memorandum of understanding, service-level agreements Paper and electronic records	10 years	Review, archive or destroy under confidential conditions
EPRR	LHRP and sub-group minutes, papers, action logs Risk registers Electronic records	30 years	Review, archive or destroy under confidential conditions

Table 1: Records to be retained and retention periods

9. Roles and responsibilities

This section outlines the EPRR roles and responsibilities of:

- accountable emergency officers (**AEOs**)
- Providers of NHS-funded services
- specific roles and responsibilities for:
  - NHS ambulance services
  - NHS mental health and learning disability secure services
  - ICBs
  - LHRPs
  - NHS England
  - DHSC
  - UKHSA
  - Department for Levelling Up, Housing & Communities (DLUHC)

9.1 Accountable emergency officers

The NHS Act 2006 places a duty on relevant service providers (defined at Section 8.2) to appoint an individual to be responsible for discharging the duties under section 252A(9), outlined below. This individual is known as the AEO.

NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. Chief executives will be able to delegate this responsibility to a named director.

The AEO will be a board-level director (or equivalent in organisations without a board) responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the board that strategies, systems, training, policies and procedures are in place to ensure their organisation responds appropriately in the event of an incident.

AEOs will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

Specifically, the AEO will be responsible for ensuring that their organisation:

- itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards
- is properly prepared and resourced to deal with an incident
- itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this
- has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served
- complies with any requirements of NHS England, in respect of monitoring compliance
- provides NHS England with such information as it may require for the purpose of discharging its EPRR functions
- is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

The independence that Non-executive Directors (NEDs) bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. Therefore, EPRR should be included on appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually. Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Whilst it is recognised that EPRR is a collective board level responsibility, a number of NEDs bring skills and experience in crisis and incident management. Where this is the case, additional support to the AEO from a suitably experienced NED is recommended. This will be a decision for local Chairs and Chief Executive Officers (CEOs).

9.2 Providers of NHS-funded services

To meet their obligations under the Civil Contingencies Act 2004, NHS Act 2006 and the NHS Standard Contract providers of NHS-funded services are required to:

- support ICBs within their ICS and NHS England in discharging their EPRR functions and duties, locally and regionally
- have robust and effective structures in place to adequately plan, prepare and exercise the tactical and operational response arrangements, both internally and with their local healthcare partners
- ensure business continuity plans mitigate the impact of any emergency, so far as is reasonably practicable
- ensure robust 24/7 communication ‘cascade and escalation’ policies and procedures are in place, to inform the ICB, NHS England, healthcare and multi-agency partners, as appropriate, of any incident impacting on service delivery
- ensure that recovery planning is an integral part of its EPRR function
- provide assurance that any sub-contractors are delivering their contractual obligations with respect to EPRR
- ensure organisational planning and preparedness is based on current risk registers
- provide appropriate director-level representation at LHRP(s) and appropriate tactical and/or operational representation at local ICS planning groups in support of EPRR requirements.

In addition to these general requirements under this Framework the following specific requirements apply.

9.2.1 NHS ambulance services

Ambulance tactical adviser

The NHS emergency ambulance service will ensure the provision of on-call ambulance Tactical Advisers who are subject matter experts. They will be appropriately equipped and competent to give appropriate advice to the ambulance Tactical Commander and, if necessary, the ambulance Strategic Commander. Tactical Advisers can also be called on to give advice to ambulance staff and managers in support of risk assessing and responding to unusual incidents.

The ambulance Tactical Adviser may be required to attend the scene of the incident or emergency, a tactical coordinating group (**TCG**) and/ or a strategic coordinating group (**SCG**).

Medical support

The NHS ambulance service must have in place arrangements for the provision of medical support in the event of a mass casualty incident.

9.2.2 Mental health and learning disability secure services

Providers of these NHS services must have in place evacuation plans which provide for re-location of service users to alternative secure premises in the event of any incident and how that re-location is to be effected in such a way as to maintain public safety and confidence.

9.3 Integrated Care Boards

The ICB's role and responsibilities are to:

- fulfil the relevant duties under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 and the Health and Care Act 2022
- AEO to co-chair the LHRP and maintain the involvement and support of LHRP partners at strategic and tactical level
- ensure appropriate director level representation at the LRF
- establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies, 24/7. This will include representing the NHS at Strategic Coordinating Groups and Tactical Coordinating Groups

- support NHS England in discharging their EPRR functions and duties locally, including supporting ICS tactical coordination during incidents (level 2–4 incidents)
- ensure robust escalation procedures are in place to respond to disruption to delivery of patient services
- provide a route of escalation for resilience planning issues to the LHRP in respect of commissioned provider EPRR preparedness
- develop and maintain incident response arrangements in collaboration with all NHS-funded organisations and partner organisations
- ensure that there is an effective process for the identification, recording, implementation and sharing of lessons identified through response to incidents and emergencies and participation in exercises and debrief events
- provide annual assurance against the NHS EPRR Core Standards, including by monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable Core Standards
- ensure contracts with all commissioned providers (including independent and third sector) contain relevant EPRR elements, including business continuity

Where the ICB or LRF covers more than one geographical location then agreement will be made locally in respect of representation for planning and response.

9.4 NHS England (London)

Due to the unique structure of resilience across the capital, NHS England (London) leads on NHS resilience matters across the region including the response. NHS England (London) as the lead organisation coordinates resilience planning, assurance and response with their ICBs, for example, via the London Local Health Resilience Partnership, and continues to represent the NHS at the London Resilience Forum.

9.5 Local Health Resilience Partnerships

LHRPs provide strategic forums for joint EPRR planning across a geographical area and support the health sector's contribution to multi-agency planning through the LRF.

The roles and responsibilities around LHRPs are as follows:

- LHRPs coordinate NHS EPRR across the LRF area and provide health input into LRFs and multi-agency planning for incidents

- LHRPs ensure coordinated strategic planning for incidents impacting on health or continuity of patient services and effective engagement across the LHRP and local ICSs
- the DPH co-chair has a specific responsibility to provide public health expertise and coordinate public health input
- the ICB co-chair provides local leadership on EPRR matters to all NHS-funded organisations and maintains engagement across the local health and social care system to ensure resilience is commissioned effectively, reflecting local risks
- the LHRP should consider, and contribute to, the Community Risk Register (CRR) developed by the LRF. These assessments should inform the planning and strategy set by the LHRP.

The LHRP will co-ordinate health input to NHS England, UKHSA and local government in ensuring that member organisations develop and maintain effective health planning arrangements for incidents. Specifically, they must ensure that:

- the arrangements reflect strategic leadership roles, ensuring robust service and local ICS response at the tactical level to incidents
- coordination and leadership across health organisations within local ICSs are in place
- there is opportunity for co-ordinated training and exercising and the sharing of lessons identified
- the health sector is integrated into appropriate wider EPRR plans and structures of civil resilience partner organisations within the LRF area(s) covered by the LHRP
- there is a mechanism for the peer review of EPRR assurance against the Core Standards.

9.5.1 Accountability

- LHRPs are not statutory organisations and accountability for EPRR remains with individual organisations.
- Each constituent organisation remains responsible and accountable for its effective response to incidents in line with its statutory duties and obligations. The LHRP provides a strategic forum for joint planning and preparedness for incidents, supporting the health sector’s contribution to multi-agency planning and preparation through LRFs.

9.5.2 Membership

- Members of LHRPs will be executive representatives who are able to authorise plans and commit resources on behalf of their organisations. They must be able to provide strategic direction for health EPRR in their area.
- Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

9.5.3 Working groups

Due to the strategic nature of the LHRP, the co-chairs will determine the need for any specific working groups and/or ICS sub-groups to reflect locally identified risks and to ensure effective tactical and operational planning/response arrangements.

It is for the co-chairs of the LHRP and the chair of the corresponding LRF to agree the coordinated approach to health planning between any LRF sub-groups and LHRPs to avoid any duplication.

Further information on the work of the LRF can be found here.

9.6 NHS England

NHS England's general EPRR role and responsibilities are to:

- set a risk based EPRR strategy for the NHS
- ensure there is a comprehensive NHS EPRR system and assure themselves and DHSC that the system is fit for purpose
- lead the mobilisation of the NHS in the event of an emergency, in line with the NHS incident response levels (section 7)
- work with UKHSA and DHSC, where appropriate, to develop joint response arrangements
- undertake its responsibilities as a Category 1 responder under the CCA 2004.

9.6.1 NHS England (Region)

At a regional level NHS England will:

- provide director level representation at the LHRP
- ensure that each LHRP is suitably co-chaired by the ICB

- as a category 1 responder, ensure suitable representation at the LRF(s)
- ensure integration of plans across the region to deliver a unified NHS response to incidents, including the provision of surge capacity
- maintain capacity and capability to coordinate the regional NHS response to an incident 24/7 through effective surge and escalation planning at ICB level
- work with relevant partners through the LHRP and LRF structures
- seek assurance through the local LHRP and commissioners that the Core Standards are met and that each ICS can effectively respond to and recover from incidents
- coordinate and locally endorse any requests from NHS organisations for military assistance
- provide support to the ICB, as required, to ensure any response to a Major Incident is effective
- discharge the local NHS England statutory EPRR duties as a Category 1 responder under the CCA 2004 (delegated function).

9.6.2 NHS England national team

At a national level NHS England will:

- support the NHS England AEO to discharge their EPRR duties
- participate in national multi-agency planning processes including risk assessment, exercising and assurance
- provide leadership and coordination to the NHS and national information on behalf of the NHS during national incidents
- have available specialist clinical advice to the NHS on planning for and responding to an incident. This may also include the provision of a clinical support cell during the response to an incident
- provide assurance to DHSC of the NHS's ability to respond to incidents, including assurance of capacity and capability to meet wider UK resilience strategy requirements as they affect the health service
- support DHSC in its role in the UK central government response to emergencies
- action any requests from NHS organisations for military assistance

- support organisations during the response and recovery phases of an incident or emergency.

9.7 DHSC

DHSC's EPRR role is to:

- identify EPRR policy requirements for the health sector and communicate these, as appropriate, to NHS England, UKHSA and other relevant organisations
- provide assurance to Ministers, the Cabinet Office and other government departments of the health system's preparedness for and contribution to the UK central government's response to domestic and international emergencies, in line with the NSRA
- as the lead government department for health, ensure that plans are in place for identified risks to health in the NSRA
- ensure the coordination of the whole system response to high-end risks impacting on public health, the NHS and the wider healthcare system
- support the UK central government response to emergencies, including ministerial support and briefing, informed by data and reports provided by NHS England and UKHSA
- take other action as required on behalf of the SofS ensure a national emergency is appropriately managed
- work with devolved administrations and internationally to plan and respond to relevant emergencies.

9.8 United Kingdom Health Security Agency (UKHSA)

At local, regional and national levels the UKHSA will deliver SofS responsibilities as a Category 1 responder.

9.8.1 UKHSA (locally delivered services)

At a local level UKHSA will:

- ensure that UKHSA has plans for incidents and emergencies in place across the local area
- support the LHRPs, coordinating with local government partners
- provide assurance of the ability of UKHSA to respond to incidents and emergencies

- provide a representative to the LHRP as required
- represent the SofS on the LRF.

9.8.2 UKHSA regional

At a regional level UKHSA will:

- ensure the delivery of the national EPRR strategy across its region
- provide strategic EPRR advice and support to UKHSA at a local level
- ensure integration of UKHSA emergency plans to deliver a unified public health response across more than one LHRP
- maintain UKHSA's capacity and capability to coordinate regional public health responses to emergencies 24/7.

9.8.3 UKHSA national

At national level UKHSA will:

- ensure there is a comprehensive EPRR system that operates for public health at all levels and provides assurance that the system is fit for purpose.
- work together with the NHS at all levels and NHS England at the national level and where appropriate develop joint response plans
- provide specialist expert public health services and input to national and local planning for emergencies.

9.9 Department for Levelling Up, Housing and Communities (DLUHC)

DLUHC provides the platform for multi-LRF co-operation and planning in emergency preparedness. The function of this sub-national tier is to improve coordination and communication between UK central government and local responders, and other organisations. DLUHC should ensure that areas are prepared to respond to events that would affect most or all of the area or could overwhelm any locality.

DLUHC Resilience and Emergencies Division (RED) works directly with LRFs, supporting collaboration and co-operation in planning for wide-area, high-impact events affecting more than one locality. RED provides the government liaison officer in a response where appropriate to facilitate this communication function.

DLUHC may, on its own initiative or at the request of local responders or the lead government department in consultation with the Cabinet Office, convene a multi-SCG

Response Coordinating Group (ResCG) to bring together appropriate representatives from local multi-agency Strategic Co-ordinating Groups.

9.10 Cabinet Office

Responsibilities of the Cabinet Office include co-ordinating the government's response to crises and managing the UK's cyber security. As part of its ongoing work, the Cabinet Office engages with central, local and regional partners to prepare for emergencies and to coordinate the UK central government response to major disruptive challenges, including:

- maintaining a state of readiness in all central crisis management facilities
- deciding whether, when and where the central response mechanism should be activated.

The UK central government response to an emergency is underpinned by the Cabinet Office Briefing Rooms (**COBR**), which is the physical location from which the central response is activated, monitored and co-ordinated. Ministers and senior officials, as appropriate, from relevant UK government departments and agencies along with representatives from other organisations, as necessary, are brought together in COBR to ensure a shared situational awareness and to facilitate effective and timely decision-making.

All incidents and emergencies where the UK central government response is activated will be managed as Level 4 incidents.

10. Cycle of preparedness

10.1 Risk management

Risk management is covered within the CCA 2004 and the 2005 Regulations and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

Within each LRF, NHS-funded organisations have responsibility in the context of multi-agency planning to contribute to the CRR. NHS-funded organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services.

Risk assessment undertaken at a regional or national level should be informed by local risk assessments.

An agreed methodology for risk assessment is available on the Cabinet Office website.

10.2 Planning

Incident response plans (**IRPs**) should contain a framework for response. There should be sufficient background information so that responders can make informed decisions. They should include a command and control framework to manage the response and sufficient operational procedures to enable responders to manage an incident.

10.3 Training

The training of staff who have a response role for incidents is of fundamental importance. NHS organisations are familiar with responding to routine everyday challenges by following usual business practices. Notwithstanding COVID-19, very few staff members will respond to incidents on a frequent basis. If staff are to respond to an incident in a safe and effective manner, they require the tools and skills to do so in line with their assigned role.

Training needs to be an ongoing process to ensure skills are maintained; it is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

Training should focus on the specific roles and requirements assigned to the individual, aligned to a training needs analysis (**TNA**), and ensure training objectives and outcomes are met and recorded. In addition to covering all aspects of the response role, training should also highlight wider organisational and multi-agency response structures, as appropriate to the role.

Standards for NHS incident training are contained within **MOS**, which should be referred to when identifying staff training needs, as well as the Skills for Justice NOS framework.

10.4 Exercising

Plans developed to allow organisations to respond efficiently and effectively must be tested regularly using a variety of processes, such as table-top and live play exercises. Roles within the plan, not individuals, are exercised to ensure they are fit for purpose and encapsulate all necessary functions and actions to be carried out in an incident. The outcome (log) of testing and exercising must identify and record whether functions and actions worked and what needs changing. The log must also identify what has changed as a result. This information provides an audit tool highlighting that lessons have been identified and action taken. It is key evidence for any inquiry.

Through the exercising process individuals can practise their skills and increase their confidence, knowledge and skill base in preparation for responding to a live incident.

Organisations should consider carrying out joint exercises with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate.

Learning from exercises is central to developing a method that supports personal and organisational goals and must be part of an annual plan validation and maintenance programme.

Each NHS-funded organisation is required to undertake the following:

10.4.1 Communications systems exercise

Minimum frequency – every six months.

These exercises test the organisation's ability to contact key staff and other NHS and partner organisations 24/7. They should include testing telephone, email, paging and other communications methods in use. The communications systems exercise should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

Participation in a communications systems exercise initiated by another organisation does not remove the requirement for each organisation to undertake its own communications system exercise.

10.4.2 Table-top exercise

Minimum frequency – every 12 months.

The table-top exercise brings together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a scenario and can help validate a new or revised plan. Participants can interact and gain knowledge of their own and partner organisations' roles and responsibilities.

10.4.3 Live play exercise

Minimum frequency – every three years.

The live play exercise is a live test of arrangements and includes the operational and practical elements of an incident response: for example, simulated casualties being brought to an emergency department or the setting up of a mass counter-measure distribution centre, hostage situation or mass evacuation.

If an organisation activates its plan for response to a live incident, this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.

Under interoperability there is an expectation that NHS-funded organisations will actively participate in exercises run by multi-agency partners, including the LRF, where relevant to health.

10.4.4 Command post exercise

Minimum frequency – every three years.

The command post exercise (**CPX**) tests the operational element of command and control and requires the setting up of the incident coordination centre (**ICC**). It provides a practical test of equipment, facilities and processes, and familiarity for those undertaking roles within the ICC. It can be incorporated into other types of exercise, such as the communications systems exercise or live play exercises.

In conjunction with local CPXs, NHS-funded organisations should also test links, communication arrangements and information flows with their multi-agency partners.

If an organisation activates its ICC in response to a live incident, this replaces the need

to run an exercise, providing lessons are identified and logged and an action plan developed.

10.4.4 ICC equipment test

Minimum frequency – every three months.

The functionality of equipment used in an ICC must be tested.

10.5 Lessons identified

NHS-funded organisations are required to share lessons identified through exercising or incident response across the wider NHS, using a common process coordinated by the LHRP. Relevant information must also be shared with partner organisations. Working collaboratively will improve organisational cohesion and ensure patients and the public are safeguarded during an incident.

The national business continuity guidance offers a useful model (Figure 3) for a learning cycle that can be adopted for EPRR purposes.

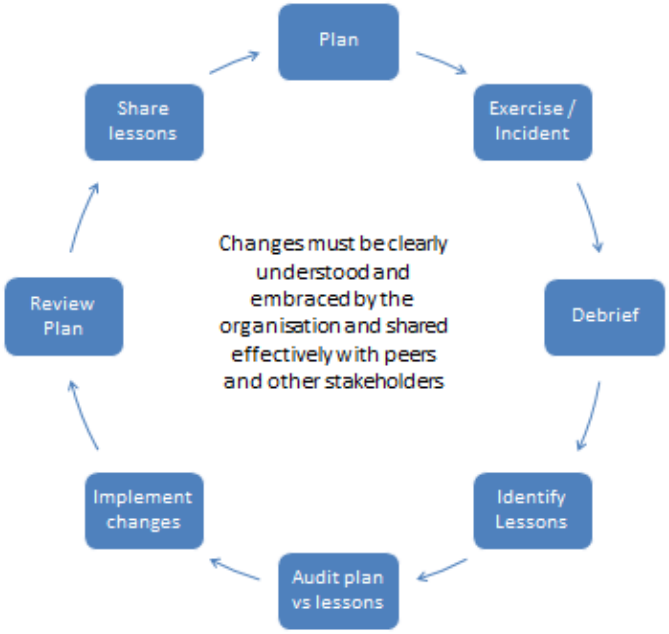

Figure 3: (Adapted from Chapter 6 Business Continuity Management of the Emergency Preparedness guidance issued by the Cabinet Office, revised March 2012)

11. Organisational resilience

Business continuity management (**BCM**) is an essential tool in establishing an organisation's resilience to maintain its business prioritised activities. BCM gives organisations a framework for identifying and managing risks that could disrupt normal services.

While business continuity and emergency planning are usually separate processes within an organisation, an incident may occur that requires business continuity arrangements and the IRP to be triggered. It is critical that both plans are integrated and complementary and there is early recognition of the resource implications.

Detailed information on business continuity management is available in the NHS England Business Continuity Management Framework.

12. Incident response

For the NHS to respond to a wide range of incidents that could affect health or patient care, the appropriate alerting and escalation processes need to be in place to inform those responsible for co-ordinating the applicable response.

Provider organisations must inform their respective Integrated Care Boards who are required to maintain 24/7 on-call arrangements.

As the accountable organisation for maintaining resilience across the NHS, NHS England EPRR On-Call should be made aware of any incidents that have affected or are likely to affect an organisations ability to continue to delivery safe patient services. The usual route for notification is from ICBs to NHS England via regional on-call teams, so they can ensure appropriate support and coordination is put in place for the response but also consider the impact on service delivery from other multiple/concurrent incidents. Specific examples include when:

- a Business Continuity Incident or Critical Incident is declared by your organisation
- a Major Incident is declared by your organisation or a partner agency your organisation is supporting in the response
- your organisation's resources have become overwhelmed due to an incident and mutual aid is required
- an ambulance re-direction is required due to disruption at your hospital site
- due to overwhelming system pressure your organisation is unable to support the response to any potential Major Incident declarations in your area
- your organisation is the target of a threat involving chemical, biological, radiological, nuclear or explosive materials (**CBRNe**); or your organisation has activated its CBRNe response plans
- an emergency evacuation of some or all of your organisation's sites/premises is required or underway
- your organisation is supporting a large-scale community evacuation
- your organisation anticipates or is experiencing media interest relating to an incident or emergency to which your organisation is responding.

In addition to alerting your ICB and/or NHS England EPRR On-Call, it is your organisation's duty to ensure that its partners and supporting organisations (e.g. community services, primary care services etc) are alerted to the declaration of any incidents.

Figure 4 shows response structures for the NHS in England and its interaction with key partner organisations. Local NHS Strategic Command will lead the mobilisation of NHS-funded organisations to respond to a major incident in line with the priorities set by the Strategic Coordinating Group that has NHS membership, and at the Tactical Coordinating Group.

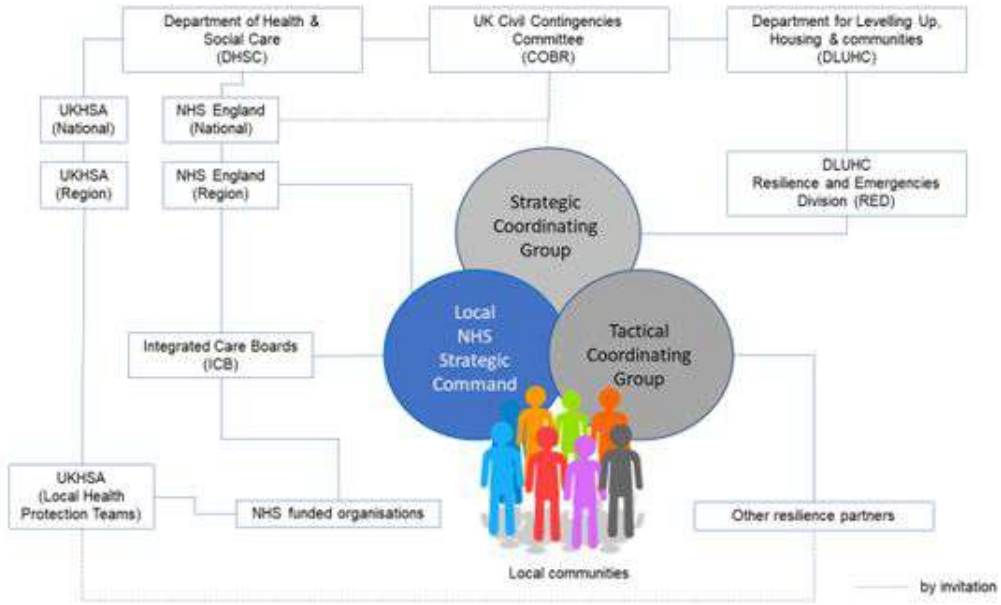

*Figure 4: Incident response structure for the NHS in England (*In London, this is the responsibility of NHS England (London) see 9.4).* ***n.b.*** *LRFs and LHRPs are not part of the response structure*

12.1 Alerting mechanism to be used in the event of an incident

While incidents and emergencies are often triggered by 'rapid onset' events and alerts are cascaded by NHS ambulance services, there are other potential circumstances where an incident affecting the NHS occurs, e.g. infectious disease outbreaks. In such cases the NHS ambulance service may or may not be involved and may not be the alerting mechanism for the health sector.

In the event of such an incident the communication cascade mechanism should be via ICBs who should ensure they also alert the NHS England regional team. In some instances, such alerts may also come directly from NHS England.

NHS England will assist ICBs in implementing command and control mechanisms and the deployment of appropriate NHS resources.

Although the alert could come from an external partner, health services should always use standard alerting messages.

12.2 Standard alerting messages

To avoid confusion about when to implement plans it is essential that standard messages are used, as shown in Figure 5.

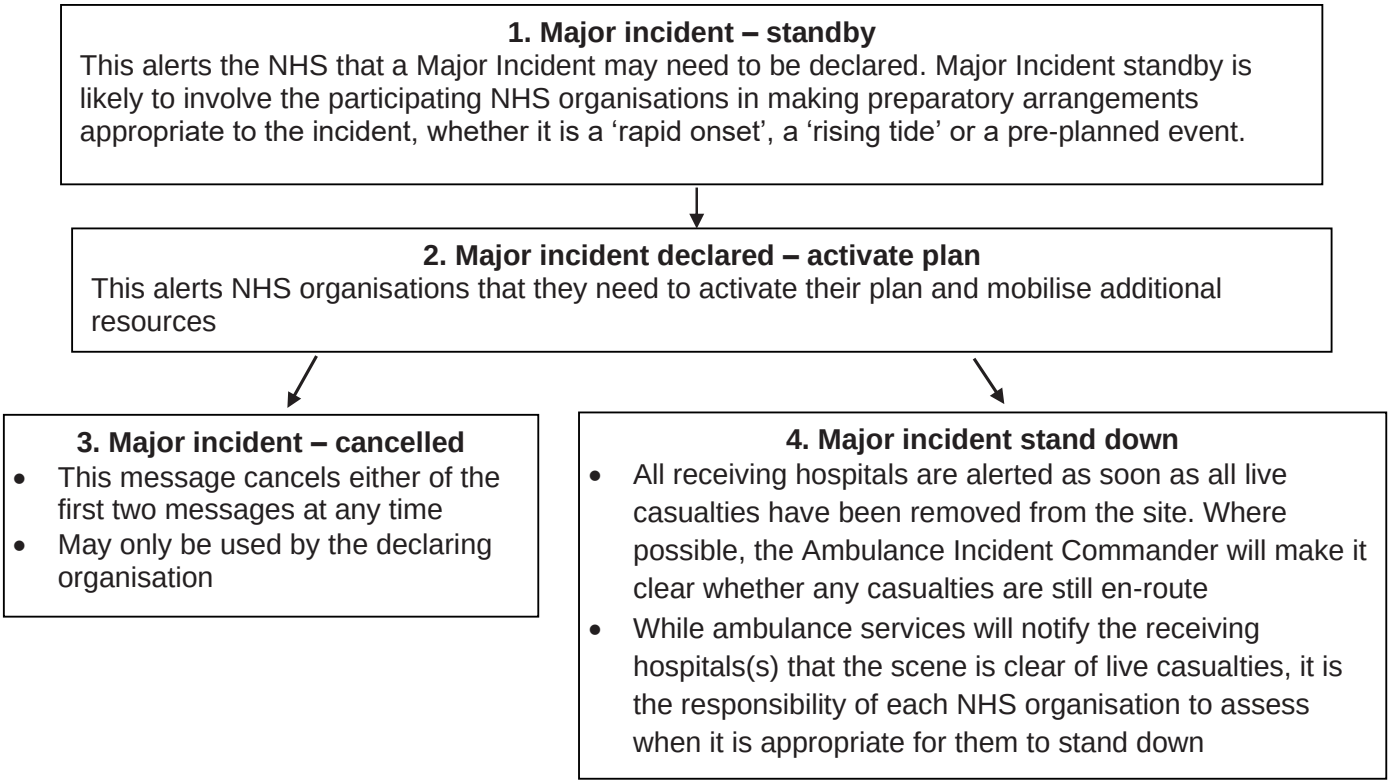

Figure 5: Standard alerting messages

12.3 METHANE

The JESIP identify METHANE as the preferred model for sharing information to promote a shared situational awareness.

Major incident – standby or declared?

Exact location

Type of incident

Hazards present or suspected

Access – routes that are safe to use

Number, type, severity of casualties

Emergency services present and those required

This format should be used when sharing information across partner organisations. It can be adapted to be used in a variety of incident types. Figure 6 provides an example of how it could be applied to a cyber incident.

M	**Does the attack affect two or more agencies and require full command and control** **Are critical services impacted**
E	What network area is affected including potential spread and/or containment of the attack
T	Nature of the cyber attack (worm, zombie, Trojan etc.)
H	Data breach including financial loss Business continuity and your ability to continue to deliver critical services Threat and Risk to other partners
A	Single agency response plan along with their capabilities to resource the response/recovery, including skill sets Request for mutual aid for additional resources and/or subject matter experts
N	Potential disruption to services delivered to vulnerable people
E	Incident has been reported to: NHS Digital Information Commissioners Office National Cyber Security Centre Shared services providers or partners joined through the network

Figure 6: METHANE for cyber incident

12.4 Critical Incident

A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services that are or will have a detrimental impact on the NHS-funded organisation's ability to deliver safe patient care.

Any organisation declaring a Critical Incident should adopt this format: 'Critical Incident declared by (*organisation*)'. This format could also be used for example when reporting a business continuity incident.

SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety (NHS Institute for Innovation and Improvement):

SBAR report	
Situation	Describe situation/incident that has occurred
Background	Explain history and impact of incident on services/patient safety
Assessment	Confirm your understanding of the issues involved
Recommendation	Explain what you need, clarify expectations and what you would like to happen
If the message is passed by voice message, ask the receiver to repeat information to ensure understanding	

12.5 Internal and external communications

Effective communications form an essential part of any incident response. They ensure that patients and the wider public are well informed about NHS services in their local area and what is expected of them. Retaining public confidence depends on the organisation's ability to manage the situation and ensure NHS staff are aware and informed.

Effective communication with staff and the public about an incident will minimise its wider impacts and increase confidence in the NHS response. This involves identifying specific audiences and the appropriate communication methods and messages to achieve this. NHS England needs to work closely with NHS-funded organisations and other partners to ensure that patients, staff and the wider public receive accurate, timely, reliable and easily understood information.

Any incident is likely to generate significant media interest at local, regional and potentially national levels. It is important to ensure that communications are co-ordinated to ensure that messaging is consistent across all organisations.

A large and diverse 24/7 media, alongside the growth in social media, has meant that information about incidents and events is now readily available and coverage is likely to evolve faster than ever before. This coverage needs to be managed as effectively as possible. Speculation can quickly become presented as fact, misleading key audiences. This can reduce effective management of the wider incident. It is therefore essential the NHS works with its partners to respond to media interest quickly and effectively.

NHS-funded organisations should make the NHS England (Region) communications teams aware of any communications activity related to an incident. NHS England (Region) communications teams will ensure effective engagement with national organisations, via the NHS England national communications team, and LRF communication structures and processes.

Communications specialists in NHS organisations will need to ensure they can deliver:

- **Joined-up communication.** A managed and co-ordinated communication and media response across responding NHS bodies and aligned to the multi-agency response, DHSC and UKHSA, via NHS England regional and national communications teams.

- **Accurate and timely statements to staff and media.** NHS England and NHS-funded organisations should provide regular statements, where appropriate, to both the public and staff. These should include situational updates and reliable, useable information about accessing services, facilities and other aspects of the incident response.

- **Sharing key information to warn and inform the public.** The NHS has a duty to provide timely information, warning and informing the public, in coordination with partner organisations, if an emergency has occurred or is likely to occur.

- **Ensure websites and other digital channels are kept up to date.** The public, media and staff will use digital media to find out about an incident and the response to it. Websites and other NHS digital media must be regularly updated to give clear, accurate, consistent and reliable information about the situation. This should include ensuring that any press statements are put on the relevant organisations' websites and disseminated more widely using social media sites such as Twitter and Facebook.

- **Support designated spokespeople.** The modern media landscape means there is around-the-clock demand for information during an incident. Responder organisations will need a cadre of trained and informed spokespeople to take part as required.

- **Support for any nationally led communications strategy** in response to a Level 4 incident, or similar declaration will be advised via national NHS England communications.

12.6 Escalation and de-escalation

The level of the response may need to be escalated or de-escalated. The process for this needs to be agreed in conjunction with health strategic commanders so it can be coordinated across all organisations.

The Appendix shows the criteria for triggering an escalation and or a de-escalation.

12.7 Staff welfare

NHS-funded organisations must ensure staff welfare, including wellbeing and comfort. Incident commanders (managers and directors) must ensure they are mindful of their own and their teams' levels of stress and fatigue and be aware of their potential to impact on individual performance and decision-making. Effective arrangements need to be in place to minimise the potential impact, e.g. rest breaks and shift systems for protracted incidents.

Further guidance and resources are available at ResilienceDirect.

12.8 On-call staff

Each NHS-funded organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so each organisation must have an

appropriate out-of-hours on-call system. A director with delegated authority to allocate resources should always be available to make strategic decisions for the organisation; other staff should also be on-call to provide support. Staff must be appropriately trained, noting the **MOS** relevant to their role within the organisational response.

13. Concepts of command and control

The following is based on and adapted from the Emergency response and recovery guidance (Cabinet Office, 2013).

The management of emergency response and recovery is undertaken at one or more of three ascending levels: operational, tactical and strategic. This is based on the concepts of command, control and co-ordination, which are defined as follows:

- **Command** is the exercise of authority that is associated with a role or rank within an organisation, to give direction to achieve defined objectives.
- **Control** is the application of authority, combined with the capability to manage resources, to achieve defined objectives.
- **Co-ordination** is the integration of multi-agency efforts and available capabilities, which may be interdependent, to achieve defined objectives. The co-ordination function will be exercised through control arrangements and requires that command of individual organisations' personnel and assets is appropriately exercised in pursuit of the defined objectives.

The levels are defined by their differing functions rather than specific rank, grade or status.

13.1 Operational command

Operational command is the level at which the immediate 'hands on' work is managed. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility. Operational commanders will be identified in the organisational response plans.

Individual organisations retain command authority over their own resources and personnel, but each organisation must liaise and coordinate with all other organisations involved, ensuring a coherent and integrated effort. This may require the temporary transfer of personnel or assets under the control of another organisation.

These arrangements will usually be able to deal with most events or situations but if greater planning, co-ordination or resources are required, an additional tier of management may be necessary. The operational commander will consider whether a tactical level is required and advise accordingly.

13.2 Tactical command

The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated to achieve maximum effectiveness, efficiency and desired outcomes.

Where formal co-ordination is required at tactical level, then an LRF tactical co-ordinating group (TCG) may be convened SCG with multi-agency partners within the area of operations. The NHS tactical commander at the TCG will be identified by the ICB. They will ensure that all NHS-funded organisations are coordinated through local health tactical coordination groups. In addition, the NHS ambulance service(s) will be present on the TCG in their role as an emergency service.

The NHS tactical commander will:

- determine priorities for allocating available resources
- plan and coordinate how and when tasks will be undertaken
- obtain additional resources if required
- assess significant risks to inform tasking of operational commanders
- ensure the health and safety of the public, patients and NHS personnel.

The NHS tactical commander must ensure that the operational commanders have the means, direction and coordination to deliver successful outcomes.

Where it becomes clear that resources, expertise or coordination are required beyond the capacity of the tactical level, it may be necessary to invoke the strategic level of management to take overall command and set the strategic direction.

13.3 Strategic command

The purpose of the strategic level is to consider the incident in its wider context; determine longer-term and wider impacts and risks with strategic implications; define and communicate the overarching strategy and objectives for the response; establish the framework, policy and parameters for operational and tactical; and monitor the context, risks, impacts and progress towards defined objectives.

Where an event or situation has a particularly significant impact, substantial resource implications or lasts for an extended duration, it may be necessary to convene a multi-agency coordinating group at the strategic level, bringing together the strategic commanders from relevant organisations. This group is known as the strategic coordinating group (SCG[6]). This group is usually convened by the chair of the LRF following a request from one of the LRF members.

The SCG does not have the collective authority to issue commands to individual responder agencies; each will retain its own command authority and defined responsibilities and will exercise control of its own operations in the normal way.

The local NHS strategic commander at the SCG will be identified and agreed between NHS England and the ICB.

The SofS and/or NHS England may require some organisations to act in a particular way in an emergency, under section 253 of the NHS Act 2006). The organisations that are subject to such orders include:

- NHS England, ICB, NHS trusts and NHS foundation trusts, and
- other organisations that provide services commissioned by the SofS, NHS England, ICB or a local authority under particular sections of the 2006 Act

In addition, the providers of NHS ambulance service(s) will be present in their role as an emergency service.

The purpose of the SCG is to take overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which operational and tactical command and coordinating groups will work. The SCG will:

- determine and promulgate a clear strategic aim and objectives, and review them regularly
- establish a policy framework for the overall management of the event or situation
- prioritise the requirements of the tactical level and allocate personnel and resources accordingly
- formulate and implement media handling and public communication plans

[6] The SCG is the formal response structure based on the same geography and membership of the LRF. The LRF does not have a role in the response to an incident. Whilst the chair of the LRF is set by the group, the SCG chair will be decided at the time based on the type and scale of the incident.

- direct planning and operations beyond the immediate response to facilitate the recovery process.

For incidents across multiple SCG areas, NHS England regional and national teams, as appropriate, will undertake command, control and coordination of the NHS and will be responsible for appropriate representation to regional and central coordination structures and groups. The decision on the impact of the incident on the NHS from across more than one SCG area will be taken by the relevant NHS England (Regional) Director(s) and the NHS England National Director for EPRR.

14. NHS command and control

Response arrangements need to be flexible to match individual situations, many of which can be dealt with by individual organisations at the operational or tactical level.

14.1 The NHS in England

Responses at incident Level 1 or 2 (see Figure 1 in Section 7) may be managed by an individual organisation through the ICB in liaison with NHS England (Region). For a response at incident Level 1 managed by an individual organisation, the ICB and NHS England (Region) must be informed through their on-call arrangements.

All actions that are or would be undertaken at lower incident levels will need to be maintained, in addition to any actions arising from a higher incident level. For example, an incident identified as Level 3 will require all actions identified at Level 1, 2 and 3 to be maintained.

14.2 NHS England (Regions)

NHS England (Regions) provide leadership across a geographical area. If a response requires a wider strategic NHS response, then the respective regional team will provide command, control and coordination for the NHS.

Responses at incident Level 3 will require the regional team to take command, control and coordination of the NHS across their region. Tactical command will remain with local responding organisations, as appropriate.

Responses at incident Level 4 will require NHS England (National) command, control and coordination of the NHS across England. Tactical command will remain with local responding organisations, as appropriate.

14.3 NHS England (National)

For responses at incident Level 4 and in certain situations such as pandemics, national fuel shortage or extensive extreme weather events, NHS England national may require some organisations to respond in a particular way to the emergency. NHS England is able to do this under section 253 of the NHS Act 2006, provided the SofS delegates the appropriate authority to NHS England. The organisations that are subject to such orders include:

- ICBs, NHS trusts and NHS foundation trusts; and
- other organisations that provide services commissioned by the SofS, NHS England, ICBs or a local authority under particular sections of the 2006 Act

In this situation direction from the national team will be actioned through the regional teams.

14.4 Incident coordination

Incident coordination is the function that brings together organisations and resources to ensure effective response to and recovery from incidents. The coordination function can be conducted by a person or a team.

Any command, control and coordination system must be sustainable to operate 24 hours a day, seven days a week to deliver the strategic objectives, over a protracted period where necessary.

14.5 Incident coordination centres

The incident coordination centre (**ICC**) supports the incident management team (**IMT**) to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved by having a formal structure. Benefits of this include:

- **unity of effort** – all team members operate under a common list of objectives
- **accountability** – everyone has a specific role for which they are responsible
- **eliminates redundancy** – clearly established division of labour eliminates duplication of effort.

All organisations need to have in place suitable and sufficient arrangements to effectively manage the response to an incident. Arrangements for the ICC need to be flexible and scalable to cope with the range of incidents and hours of operation required.

14.5.1 ICC functions

While the specific activities undertaken by the ICC will be dictated by the unique demands of the situation, there are five broad and typical ICC tasks:

- **coordination** – matching capabilities to demands
- **policy-making** – decisions pertaining to the response
- **operations** – managing as required to directly meet the demands of the incident
- **information gathering** – determining the nature and extent of the incident to ensure shared situational awareness
- **dispersing public information** – informing the community, news media and partner organisations.

The ICC will provide a focal point for coordination of the response and the gathering, processing, archiving and dissemination of information across the NHS and externally, as required. ICC plans should also include arrangements for the management of visitors to the organisation.

14.5.2 Organisational ICC requirements

Each NHS-funded organisation needs to establish an ICC and maintain a state of organisational readiness. Large organisations with multiple sites may need a facility at each location where tactical and operational functions can be coordinated and supported by a separate strategic facility for overall command and control.

There should be sufficient resilience within the organisation to ensure an alternative ICC can be used in the event the primary ICC is unavailable.

An ICC must be resilient to loss of utilities, including telecommunications, and to external hazards such as flooding.

The ICC should have an activation plan with action cards for key staff working within it. Sufficient resources should be made available to coordinate an incident over an extended period.

ICC equipment should be tested every three months as a minimum to ensure functionality.

14.6 Decision-making

Decision-making, especially during an incident, is often complex and decisions are open to challenge. Decision-makers will be supported where they can demonstrate that their decisions have been informed by all known information or situational awareness, assessed risks, and managed these risks reasonably in the circumstances existing at the time. The use of decision support models and processes assist in providing this evidence, particularly in conjunction with decision logs.

The joint decision model (JDM) is suitable for all decisions and has been adopted by JESIP in the Joint Doctrine to practically support decision-makers working under difficult circumstances (see Figure 7). It is organised around the three primary considerations: situation, direction, action.

Decision-makers are expected to use their judgement and experience when deciding what additional questions to ask and what to consider in order to reach a decision. The JDM supports the decision-making process in achieving the desired outcomes.

Figure 7: Joint decision model

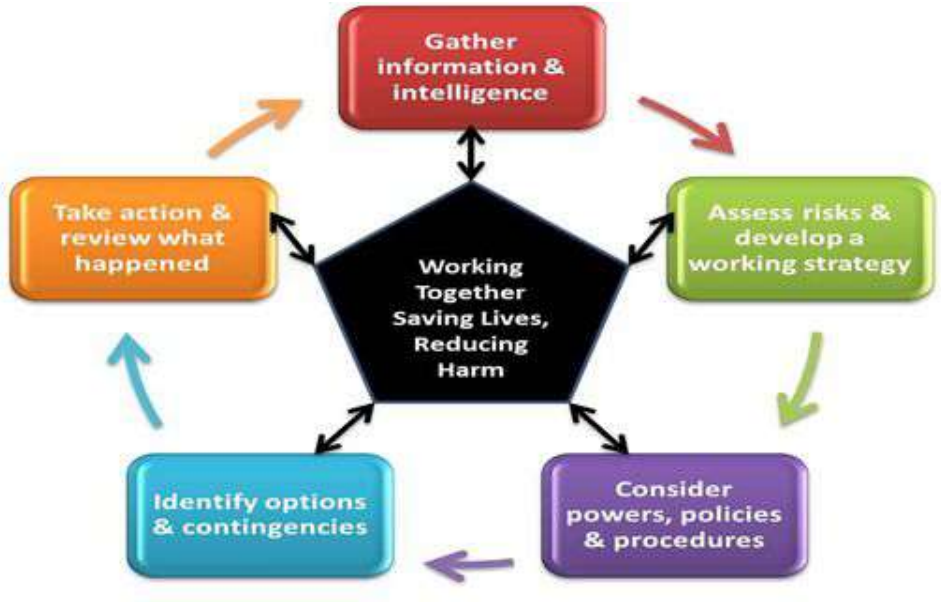

Figure 7: Joint decision model

15. Recovery

Recovery from any incident is imperative and requires a coordinated approach from the affected organisation(s) and multi-agency partners, depending on the type and scale of the incident.

The national Emergency response and recovery guidance provides detailed advice for organisations. This advice may also help identify opportunities for service redesign and changes to operational practice.

The recovery phase should begin at the earliest opportunity and should be run in parallel with the response. It does not end until all disruption has been rectified, demands on services have returned to normal and the physical and psychosocial needs of those involved have been met.

16. Debriefing

To identify lessons from any incident or exercise, it is important to capture as much detail about the incident and the experiences of those involved as soon as is reasonably practicable. A series of debriefs post incident is good practice.

The purpose of a debrief is to identify issues that need to be addressed. They must be attended by all staff who had a part in the response to review what went well, what did not go well and what needs to change. The process of debrief should provide a support mechanism and identify staff welfare needs.

Organisations should ensure they use appropriately trained staff to facilitate debriefs.

Debriefs should be held as follows:

- **hot debrief** – immediately after the incident or period of duty, but within 48 hours of stand down
- **cold/structured/organisational debrief** – within 28 days post incident
- **multi-agency debrief** – within eight weeks of the close of the incident (actual timing will be set by the lead organisation for the response)
- **post-incident reports** – within four weeks of the debrief.

The post-incident reports should be supported by action plans, with timescales and accountable owners, and recommendations to update any relevant plans or procedures and identify any required training or exercises.

There should be a mechanism for sharing lessons identified across the local ICS, through the LHRP, the wider NHS and with partner organisations. Following the response to COVID-19, numerous plans have been tested/implemented and this learning should be considered and feedback back into other resilience plans as required.

17. Assurance

The minimum requirements that NHS-funded organisations must meet are set out in the Core Standards. These standards are in accordance with the CCA 2004, the 2005 Regulations the NHS Act 2006, the Health and Care Act 2022 and the Cabinet Office national resilience standards.

All NHS-funded organisations are required to provide evidence of their compliance to their board, at a public board meeting, and for their board to issue a Statement of EPRR Conformity to their commissioners. NHS England will ensure that ICB compliance forms part of the annual assurance process.

NHS England will, in collaboration with LHRPs, ensure an annual assurance programme is undertaken to inform the national report to the SofS.

18. Equality and health inequality analysis

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this Framework, we have, by undertaking a detailed equality impact assessment:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

All guidance developed under this Framework will have due regard to the need to reflect the impact on and from health inequalities in local populations during times of preparing for and responding to major incidents.

Guidance on the NHS equality and health inequalities legal duties can be found here.

18.1 Health Inequalities during a major incident

Reducing the actual or unintentional impact from health inequalities during a major incident is vital. During the planning phase, AEOs must ensure the diverse range of local health needs is considered when preparing for a range of incidents.

Additionally, Incident Commanders, as part of their role leading the response to an incident, should consider the impact of their decisions on health inequalities either within the existing population or on the community as a result of an incident. This, along with other decisions, should be appropriately recorded in incident logs along with the rationale underpinning the decision being made.

The NHS England National EPRR team routinely reviews health lessons from a range of incidents as part of a learning cycle to improve and make changes to national EPRR guidance as necessary. As part of learning from COVID-19 and similar incidents, specific guidance on managing health inequalities during a major incident is being developed and will be published in due course.

19. Acronyms

Without a common understanding of what specific terms and phrases mean, multi-agency working will carry the risk of potentially serious misunderstandings. Since 2007 the Cabinet Office has worked with a wide range of partners to build and maintain a single point of reference for civil protection terminology as one of the underpinning elements of interoperable communications and coherent multi-agency working.

The latest version of this lexicon can be found here. Key acronyms set out in the Cabinet Office resource are highlighted in the text in bold for ease of reference.

Appendix: Escalation

The below criteria set out the point at which an issue could be escalated to the next level of incident response. In turn, if the measures are no longer required, the incident response level can be de-escalated.

Level 1 – Organisation level response **Coordinating organisation: NHS-funded organisation**
If the following applies the incident may need to be escalated to Level 2: • Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the provider • A Business Continuity Incident that threatens the delivery of patient services (in line with ISO 22301) • Responding to a declared Major Incident or Major Incident standby • A media or public confidence issue that may result in local, regional or national interest • A significant operational issue that may have implications wider than the organisation e.g. public health outbreak, suspected high consequence infectious disease (HCID), security incident, Hazmat incident

Level 2 – Local level response **Coordinating organisation: ICB with NHS England (Region)**
If the following applies the incident may need to be escalated to Level 3: • Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the ICB • A Critical Incident that threatens the delivery of **critical** services or presents a risk of harm to patients and/or staff • Responding to a declared Major Incident or Major Incident standby • A media or public confidence issue that may result in local, regional or national interest • A significant operational issue that may have implications wider than the local ICS e.g. public health outbreak, suspected HCID, security incident, Hazmat/CBRN incident

Level 3 – Regional level response
Coordinating organisation: NHS England (Region)

If the following applies the incident may need to be escalated to Level 4:

- Capacity and demand reaches, or threatens to surpass, a level that requires national coordination or NHS mutual aid e.g. need for ECMO, HCID, burns treatment or other specialist functions
- A Business Continuity Incident that threatens the delivery of an **essential** NHS England function or a protracted incident effecting one or more NHS England site
- A Critical Incident with the potential to impact on more than one ICB
- A declared Major Incident which may have a significant NHS impact and/or the establishment of an NHS England Incident Coordination Centre
- A media or public confidence issue that may result in regional, national or international interest
- A significant operational issue that may have implications wider than the remit of one NHS England region e.g. flooding, security incident, Hazmat/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region
- An incident that may require the request and activation of Military Aid to the Civil Authorities (**MACA**)

Level 4 – National level response
Coordinating organisation: NHS England National Team (with DHSC where appropriate)

If any of the following apply or are required, DHSC should be informed:

- Capacity and demand reaches, or threatens to surpass, a level that requires international coordination e.g. need for ECMO, HCID, burns treatment or other specialist function
- Invocation of central government emergency response arrangements
- Issues that may require **invocation of** 'Emergency Powers' to be invoked under the CCA 2004 or measures under sections 252A or 253 of the NHS Act 2006
- A Business Continuity Incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant
- A declared Major Incident which may have national and/or international implications e.g. CBRN, MTA
- A media or public confidence issue that may result in national or international interest
- A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure
- An incident that may require the request and activation of MACA

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This publication can be made available in a number of other formats on request.

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To: Marion Andrews-Evans, Executive Nurse, Gloucestershire Clinical Commissioning Group

Copy: Andy Ewens, EPRR Manager

Sent by email

18 October 2021

Dear Marion,

Gloucestershire Clinical Commissioning Group Emergency Preparedness, Resilience and Response core standard assurance confirm and challenge outcome.

A big thank you for preparing your EPRR Core Standards self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on the 11 October 2021. This letter summarises the outcome of the meeting, including a confirmed compliance level, agreed actions and points from our discussions.

Outcome from the 2021 EPRR Core Standards review
The 2021 Core Standards assessment had been modified to reflect activity undertaken by organisations during the response to COVID-19 and other concurrent incidents in which assurance was not deemed necessary. The table below summarises the outcomes of the assurance review and provides the overall compliance rating.

Organisation	2019	2020	2021
Gloucestershire CCG	**Substantial**	**Substantial**	**Full**

Confirm and challenge outcome (see annex 1 for descriptors)**: Full Assurance**
Through the submission of your self-assessment, supporting evidence and additional commentary provided during your confirm and challenge session, you were able to address the queries raised by NHSEI. We support your self-assessed level of compliance.

NHSEI observations and reflections:
The first part of the confirm and challenge session focused on your organisational governance and assurance systems and processes to ensure a supportive environment for the management of EPRR risks and controls. Marion, you provided a summary of the assurance structures currently operating within the organisation that supports the visibility of EPRR. In addition, you described the steps being taken to move from a paper based to electronic risk system for managing your organisational risks that will support greater oversight and interconnectedness between risks and teams. Andy described the process of engaging with your internal stakeholders to collect evidence and narrative to support your submission.

NHSEI identified several areas in which further clarity was requested including:

1. Core Standards 7/8 – Duty to assess risk. You provided further clarity on the issues identified, which stemmed from some unclear statements submitted as narrative.

2. Core Standards 11/12 – Duty to maintain plans (Critical/Major incident). You provided further clarity on the issues identified, which stemmed from some unclear statements submitted as narrative.
3. Core Standard 55 – Assurance of Commissioned Providers/Suppliers BCPs. You provided further clarity on the issues identified, which stemmed from some unclear statements submitted as narrative.

Without any prompts you provided further detail on training and exercising undertaken by your organisation and emphasised your belief that these continued to be important facets in ensuring an effective and resilient workforce to support the response to incidents.

The second part of the session was focused on your provider organisations. You reported significant progress especially within Gloucestershire Hospitals NHS Foundation Trust and Practice Plus Group (formerly Care UK). You advised that you were monitoring the EPRR leadership of Gloucestershire Health and Care Trust due to a number of recent changes in personnel. You confirmed no major concerns had arisen with regards to your providers and further detail would be provided in your system assurance summary letter.

Actions:

1. Submit to NHSEI a CCG to NHSEI System Assurance Summary letter (templates available on FuturesNHS)*.
2. Prepare a short presentation for the Gloucestershire LHRP Executive Group on the 28 October 2021 (example template available on FuturesNHS - Templates - South West EPRR - FutureNHS Collaboration Platform)
3. Send NHSEI confirmation that your assurance submission is reviewed and approved by your Trust Board (e.g. minutes of the meeting).

*Please could this be completed by the 22 October 2021.

Next Steps

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England and Improvement South West and is subject to further scrutiny and challenge by the Local Health Resilience Partnership (LHRP).

The CCG will be required to present a system summary of the assurance process and findings to the LHRP with assistance from Provider colleagues.

NHS England and Improvement will produce and present a regional report to the LHRP Executive Group prior to submitting a Regional return to the NHSEI National Team.

Finally, our thanks must go to your EPRR team for their hard work over the last eighteen months, while managing and supporting the response to a range of issues and incidents.

Yours Sincerely,

Leigh Clarke
Head of EPRR
NHS England and Improvement

Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

This is verbal.