Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 29th March 2023

Boardroom, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE
(The meeting is also available via MS Teams)

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** *Apologies: Marion Andrews-Evans, Oleysa Atkinson, Martin Holloway*	Information	**Chair**
2.	2.02 – 2.02pm	**Declarations of Interests** The Register of ICB Board members is publicly available on the ICB website Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	**Chair**
3.	2.02 – 2.04pm	**Minutes of the meeting held on 25th January 2023**	Approval	**Chair**
4.	2.04 – 2.05pm	**Action Log & Matters Arising** • *Sign up to the Smoke Free Pledge* • *Services for vulnerable pregnant women presentation is now available*	Discussion	**Chair**
		Business Items		
5.	2.05 – 2.10pm	**Questions from members of the public**	Discussion	**Chair**
6.	2.10 – 2.25pm	**Patient Story** – The Falls Prevention and Training Programme for Care Homes Film (Youtube Link)	Discussion	**Jane Haros, Leah Bamford**
7.	2.25 – 2.35pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
8.	2.35 – 2.40pm	**Chief Executive Officer Report** (to include a request for the Board *to extend the existing Procurement Strategy from 1 April 2023 to 30 September 2023)*	Discussion	**Mary Hutton**
9.	2.40 – 2.55pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Mark Walkingshaw** **Tracey Cox** **Marion Andrews-Evans** **Cath Leech**
		Items for decision		
10.	2.55 – 3.40pm	**Fit for the Future Phase 2**	Approval	**Ellen Rule**
11.	3.40 – 3.50pm	**Progress Report – Public Sector Equality Duty and the Equality Delivery System**	Approval	**Tracey Cox**
		Information items		
12.	3.50 – 4.05pm	**2023/24 Operational Plan and 2023/24 Budget**	Information	**Mark Walkingshaw & Cath Leech**
13.	4.05 – 4.20pm	**County Deal**	Verbal Update	**Pete Bungard**
14.1	4.20 – 4.25pm	**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 2 February 2023	Information	**Colin Greaves**
14.2		**Chair's verbal report on the Quality Committee** meeting held on 16 February 2023	Information	**Prof Jane Cummings**

14.3		**Chair's verbal report on the Audit Committee** meeting held on 16 March 2023	Information	**Julie Soutter**
15.	4.25 – 4.30pm	**Any Other Business** • *Health & Wellbeing Partnership TOR*	Approval	**Chair** **Siobhan Farmer**

Time and date of the next meeting

2.00pm – 4.30pm, 31st May 2023, 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.

Gloucestershire Integrated Care Board Meeting

Wednesday 25th January 2023, 14:00 – 16:30

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

Members Present:		
Prof Jane Cummings *(Chair)*	**JC**	Non-Executive Director, NHS Gloucestershire
Dr Andy Seymour	**AS**	Chief Medical Officer, NHS Gloucestershire
Cath Leech	**CL**	Chief Finance Officer, NHS Gloucestershire
Clive Lewis	**CLe**	Non-Executive Director, NHS Gloucestershire
Colin Greaves	**CG**	Non-Executive Director, NHS Gloucestershire
Ellen Rule	**ER**	Deputy CEO/Director of Strategy and Transformation, NHS Gloucestershire
Prof Jo Coast	**JCo**	Non-Executive Director, NHS Gloucestershire
Dr Marion Andrews-Evans	**MAE**	Chief Nursing Officer, NHS Gloucestershire
Dr Mark Pietroni	**MP**	Deputy CEO, Director for Safety and Medical Director, Gloucestershire Hospitals NHS Foundation Trust
Mary Hutton	**MH**	Chief Executive, NHS Gloucestershire
Paul Roberts	**PR**	Chief Executive, Gloucestershire Health & Care NHS Foundation Trust
Siobhan Farmer	**SF**	Director of Public Health, Gloucestershire County Council
Prof Sarah Scott	**SS**	Executive Director of Adult Social Care, Wellbeing and Communities, Gloucestershire County Council
Tracey Cox	**TC**	Interim Director of People, Culture and Engagement, NHS Gloucestershire
Participants Present:		
Carole Allaway-Martin	**CAM**	Cabinet Member, Gloucestershire County Council
Christina Gradowski	**CGr**	Associate Director of Corporate Affairs, NHS Gloucestershire
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Kim Forey	**KF**	Director of Integrated Commissioning, NHS Gloucestershire
Mark Cooke	**MC**	Regional Director of Strategy & Transformation, NHS England
Mark Walkingshaw	**MW**	Director of Operational Planning & Performance, NHS Gloucestershire
Martin Holloway	**MHo**	South Western Ambulance Service
Dr Olesya Atkinson	**OA**	GP, Primary Care Network Representative
Ryan Brunsdon	**RB**	Board Secretary, NHS Gloucestershire
In attendance:		
Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire
Lauren Peachey	**LP**	Corporate Governance Manager, NHS Gloucestershire
Rachel Carter	**RC**	Governance Coordinator, NHS Gloucestershire
Alice Brixley *(Agenda Item 6)*	**AB**	Programme Manager, NHS Gloucestershire

Dr Charlie Sharp ***(Agenda Item 6)***	**CS**	Consultant in Respiratory Medicine, Gloucestershire Hospitals NHS Foundation Trust
Micky Griffith ***(Agenda Item 10)***	**MG**	Fit For The Future Programme Director, NHS Gloucestershire
Simon Lancely ***(Agenda Item 10)***	**SL**	Director of Strategy and Transformation, Gloucestershire Hospitals NHS Foundation Trust

1 Apologies for Absence

1.1 Apologies were received from Apologies were noted from Dame Gill Morgan, Rachel Pearce, Pete Bungard, Mark Branton, Graham Russell, Robert Graves, and Julie Soutter.

1.2 The meeting was confirmed to be quorate.

1.3 There were five members of the public present during the meeting.

2 Declarations of Interest

2.1 The Chair advised that all members were required to declare relevant interests at every ICB Board meeting. The Chair also advised that it was in line with best practice to consider any potential conflict of interests at each meeting. No interests were declared. The Register of ICB Board members is publicly available on the ICB website.
Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)

2.2 There were no interests declared during the meeting.

3 Minutes of the Previous Meeting

3.1 The minutes of the meeting held on 30th November 2022 were agreed to be a true and accurate record of the meeting. The minutes were approved.

4 Action Log & Matters Arising

4.1 **Action from 30/11/2022, minute 4.3:** This action related to an update on work being undertaken to support vulnerable pregnant women and service provision, which was expected to be brought to Board in March 2023. Action to remain open.

4.2 **Action from 30/11/2022, minute 5.15:** This action related to a Fit For The Future (FFTF) business case update and was expected to be brought to Board in March 2023. **Action to remain open.**

5 Questions from Members of the Public

5.1 There were no questions received by the members of the public.

6 Patient Story: Smoking Cessation

6.1 JC welcomed both CS and AB to the Board meeting who presented the patient story around smoking cessation.

6.2 SF spoke about rolling out the Tobacco Treatment and Dependency Service in Gloucestershire Hospitals NHS Foundation Trust (GHFT). CS informed the Board that the Tobacco Free Team started work within GHFT at the end of November 2022. Treatment was being delivered on an opt-out basis to inpatients who smoked that presented within Respiratory wards and will shortly be expanded to other medical wards across the GHFT. Smoking was highlighted to be one of the biggest preventable causes of diseases in the County, which prompted the request for the ICB to sign up to the NHS Smokefree Pledge. https://ash.org.uk/uploads/NHS-Smokefree-Pledge-Briefing-FINAL-August-2022.pdf?v=1664967126

6.3 CS provided the Board with statistics around the high numbers of smokers in Gloucestershire and informed the Board that.

- One in five hospitalised GHFT patients (20%) are smokers.
- One in ten women were still smoking at the time of delivering their new-borns and were mostly from the more deprived communities, being twelve times more likely to be a smoker than those who were more affluent.
- 2070 people have died from smoking in Gloucestershire every year; 293 from cancer caused by smoking; 288 from COPD and 109 were cardio-vascular disease related.
- 16,077 people were noted to be out of work as a result of smoking and 10,500 people have received informal care due to disabilities caused by smoking.
- Smokers were likely to die ten years earlier than non-smokers, and sixteen years earlier in the most deprived decile in our county.
- Smokers spend around £2500 a year on cigarettes with 9% more disposable income would have been available had dependency been overcome; and
- 77% of homeless people were dependent on tobacco and twice as many people who are unemployed smoke compared to those who are employed

6.4 CS stated that as a system there was an urgent need to treat tobacco dependency amongst our patients and staff to ensure smokers had access to evidence-based treatments, as well as creating supportive environments, consistent messaging and implementing and enforcing Smoke-Free policies.

6.5 CS informed that following discharge from hospital, patients can be supported by Healthy Lifestyles Gloucestershire who would be able to help patients following hospital discharge, preventing re-admissions and would encourage people to live more fulfilling lives.

6.6 AS said that New Zealand had implemented a strict policy around buying cigarettes from an early age and asked whether CS thought that this was something that could be introduced in this Country.

6.7 ER said that this resonated personally with her and wondered what it would take to create those smoke-free sites that we are seeking, to become a reality. MP recognised that by signing up to the Smoke-Free Pledge, the Integrated Care System (ICS) would be supporting our staff, and they in turn would also then be able to help our patients and their families to help them to stop smoking.

6.8 IB had reflected on the implications for people with Severe and Enduring Mental Health issues. Public Health England (PHE) had stated that prevalence rates for smoking were 34% for those with long term conditions, and for those with serious and enduring conditions, the rate was 40.5%. Those with severe mental health issues tended to die, on average, 15-20 years earlier than the rest of the population if they were smokers. This was a good opportunity to refresh what was being done around smoking in our system.

6.9 SF highlighted that as part of the Tobacco Treatment and Dependency Service, there was funding to enable support for Gloucestershire Health & Care NHS Foundation Trust (GHC). A meeting had been arranged for February with key staff from Wotton Lawn to discuss and explain the long-term mental health commitments around strategies for people with mental health conditions and Learning Disabilities (LD).

6.10 CLe asked whether CS or any of his colleagues had examined any systematic reviews to get an idea of what might work in other parts of the world. CLe also queried learning and support groups/networks for those trying to give up smoking.

6.11 CS said the most effective treatment of tobacco dependency was to use a combination of nicotine replacements and talking treatments for up to twelve weeks from the date of cessation. CS spoke about the Ottawa Model for Smoking Cessation and the Manchester CURE project, which had demonstrated just how cost-efficient these treatments were with an Intensive Cardiac Rehabilitation programme (ICR) of £400 per patient. The cost of admissions around smoking were c£1.5m per year to the NHS; therefore, this programme could positively demonstrate the cost benefits.

6.12 CS had not seen any support groups or networks being formed but recognised the importance of peer support. Support groups were, however, very difficult to study as could be so highly variable, both contextually and culturally.

6.13 CS noted that electronic cigarettes were not harmless; they were just less harmful than tobacco but were an effective tool should other forms of nicotine replacement prove ineffective. SF agreed to share a statement being developed around the use of electronic cigarettes and their use. **SF**

6.14 ER recognised that there was further work to be done with schools around high vaping figures. SF agreed to share data from the People Health and Wellbeing Survey which demonstrated that smoking rates, although having have decreased significantly in young people over the past 10-20 years, had often been replaced with vaping, which was not the desired outcome. **SF**

6.15 Gloucestershire Healthy Living and Learning (GHLL) are working with teachers to ensure that the curriculum addresses some of the findings from the People Health and Wellbeing Survey. SF will update the Board at a future meeting. MAE said the Southwest Clinical Senate had published recommendations around this. Passive smoking was also another area noted too often be overlooked. **SF**

6.16 MP stated that 50% of the excess mortality are derived from smoking, for those with long term health conditions and so there is a huge potential here for a readily identifiable cohort of people. PR agreed that this was an important issue, looking forward to further work. PR felt that it would be helpful to focus on communities of greater deprivation and asked if there was more than could be done.

6.17 SF said that data could be improved enabling better identification of cohorts. CS said if we could target prevention of ill health, this would benefit deprived communities and inclusion groups. CG felt that there needed to be a specific action plan going forward.

6.18 ***Meeting Outcome: The ICB Board agreed to sign up to the NSH Smoke Free Pledge in principle, but requested that the paper be circulated, any concerns flagged and then be brought back to the March meeting to examine a set of actions to take forward.***

7 ICB Chief Executive Officer Report

7.1 MH presented the Chief Executive Officer (CEO) report and highlighted a number of areas:

- December 2022 had been particularly challenging for Urgent & Emergency Care (UEC) services; there had been an increase in the prevalence of Covid, Influenza and Strep A which had contributed to high volumes of patient demand over the Christmas period. Industrial action by staff had also added further pressure.
- The whole system showed a strong response around the Winter Plan and GHC in particular made a great effort working collaboratively with the Southwestern Ambulance Service NHS Foundation Trust (SWASFT).
- Primary Care delivered 20% more activity than that in December 2019/20. It was recognised that the public had also responded well around using NHS 111 resulting in lower Emergency Department (ED) attendances and ambulance handover delays. Category 2 (Cat2) performance response times were much improved since 9th January 2023.
- Locally, derogations had to be agreed around industrial action with a teacher's strike due February 2023. Clinical and management work continued to manage the impact of those strikes on staff availability.
- The Community Diagnostic Centre (CDC) programme continued to deliver additional activity against planned trajectories. From December 2021 to December 2022, 41,000 additional tests had been delivered, which assisted performance on elective care and enabled swifter patient movement through the system.
- Music Works have been tackling health inequalities, helping young people in challenging circumstances.

- The ICB had received a non-recurrent fund of £300k from NHS England (NHSE) to provide a short-term positive impact over the winter for the most disadvantaged in our population. These monies have been distributed to each Integrated Locality Partner (ILP).
- The Primary Care Nursing Workforce Development programme has been encouraging nursing students to gain experience of and consider nursing in Primary Care as an early career choice.
- The Primary Care training hub/workforce team have been developing programmes to support recruitment, retention and development of non-clinical colleagues working in General Practice (GP).
- The One Glos Integrated Care Strategy scheme has been well received by system partners. Themes will consider smoking, blood pressure and employment. Each organisation will be asked to identify their contributions towards a unified Strategy for the next year.

7.2 JCo expressed an interest to see the health inequalities work and asked about people who overlapped within categories, or who did not fall into them and how this information could be used in relation to other services.

7.3 MH explained that overlaps had been noticed within categories and this will be examined further. There was an ambition to create an inequalities plan for the system and noted that the Executive team had received a presentation from the Police and Crime Commissioner, whereby he informed that Gloucestershire had the highest homicide rates in England and Wales in 2022 in relation to knife crime. Music Works are due to commence a programme on 1st March 2023 to work with young people who are involved in knife crime. The inequalities plan needed to be mapped and investments made to take positive action to address these inequality issues.

7.4 CG commended the Primary Care team and the Board for enabling the ILPs to have prompt access and quick distribution to money to help those most in need an evaluation of where the money had been spent and what effect it had had, would be appreciated during the new financial year. JC advised that she and other Non-Executive Directors (NEDs) had attended some of the meetings with the ILPs and had found some of the data and supporting evidence around prioritisation and decision-making, interesting and thought that any evaluation would be valuable to enable further future support around health inequalities.

Meeting Outcome: The ICB Board noted the contents of the ICB Chief Executive report.

8. <u>Integrated Finance, Performance, Quality and Workforce Report</u>

8.1 MW provided the first update to the Board which focussed on Performance:

- The Health and Care system had been under significant pressure, however noted that Cat2 performance had improved with regards to response times of under 30 minutes. This was a locally set system performance improvement target which resulted in a positive morale boost, particularly for front line teams working in UEC who were able to see the benefits of their hard work.

- £6.7m had been awarded to Gloucestershire from the National Discharge fund, significantly contributing to the Winter Plan.
- The new Discharge Waiting area and the new Community Assessment and Treatment Units are now in place at Gloucester Royal Hospital (GRH), which enabled a positive effect on system performance.
- A deep dive is being conducted around the Planned Care waiting lists, and recommendations of will be presented to CEOs at the beginning of February 2023.
- MW confirmed that Cinapsis would be the provider for clinical Advice & Guidance (A&G) services.
- Cancer performance continued to be a major focus. There had been significant challenges in Lower Gastroenterology (GI) and Urology. It was updated that there had been an increase in patients waiting over 62 days for cancer treatment, however this was noted to have been partly driven by patients awaiting final confirmation that cancer had been ruled out. The Board was was advised that there were only a few patients within the County with confirmed cancer who waited over 62 days.
- There were significant demand pressures in Primary Care, but performance continued to be strong.
- The new Community Diagnostic hub in Gloucester city was planned to be fully operational by October 2023, which will enable a reduction in the waiting lists for elective treatments across the county.
- In relation to Adult and Children's Mental Health, Out of Area Placements remained above planned levels. There had been significant progress made within the County to reduce the number of placements and Gloucestershire benchmarked well compared to other parts of the Country.
- A recovery plan has been developed for Maternity and Neonatal services around missed first trimester screenings, which has been closely monitored and noted to be making good progress.
- Nationally, the full implementation of the Continuity of Care (CoC) target has been paused within Maternity Services due to workforce challenges, but local performance remained stable with inroads being made for those in areas of highest deprivation, to ensure continuity of care.
- There will be an increased focus on recovery in the new financial year and with discussions and work taking place with regards to performance recovery.

8.1.1 CG referenced A&G and was pleased to see that Cinapsis had been retained and asked whether there would be a gap in provision with the changeover around possible differences in data. MW advised that assurance had been received from Cinapsis and other partners around the transition and that plans had been provisionally put in place beforehand will not need to be utilised.

8.1.2 MHo recognised the huge amount of work between EDs and SWAST to bring down ambulance waiting times. Demand was noted to have been reduced during strike days and queried whether this had impacted other parts of the system. ER suggested the reduction in demand was driven by changes in public behaviour.

8.1.3 It was advised that more shifts had been filled in NHS 111 and Out of Hours (OOH) with additional Primary Care capacity which has supported services, enabling more resilience within the system. It was suggested that using social and frailty work to support redirection are also areas to explore further. MP stated that there was less flu present in the system which has resulted in fewer staff off sick.

8.1.4 JC said that it was so positive to see what the system had achieved as a whole and she thanked all the teams in every organisation who had stepped up to be able to achieve the current position.

8.2 TC next provided an update on Workforce to the Board:

- There had been a slight uptake increase into nurse vacancy rates which currently stood at 14% across the system. There had also been an increase in the sickness rate across all workforce sectors.
- The percentage of staff who decide to leave the NHS within a year was noted at 18.37%. There had however been a growth in the number of Health and Care support workers across the system with a change in headcount to 57.
- Data was starting to be included on Children's Social Care workforce and there had been a positive increase of eight new social work staff.
- There would be further co-ordinated industrial action on 6th February 2023 between the SWASFT and the Royal Collage of Nursing (RCN) and the system continued to work on preparedness for this and future strike action.
- Funding had been secured for another year for the Wellbeing Line, although there were some areas to be reviewed where recurrent funding was not available, and a sustainable position needed to be reached
- There was an intention this year to grow the People Team and new roles had been recruited too, some of which had been funded non-recurrently by NHSE. This will allow the ICB to embark upon significant pieces of work that can support the system over the coming months.

8.2.1 MP asked whether the gap around those leaving the NHS within a year meant that a downward trend was being experienced. TC clarified that this was a key measure which was being tracked with considerations being taken as to whether this needed to be tracked in a time series fashion.

8.2.2 CG felt that the gap was widening around a workforce strategic approach which was worrying. TC commented that a workshop was held with Health Education England (HEE) which looked at different scenarios in relation to nursing workforce. It was recognised that numbers coming through universities was positive, but it was not a very attractive proposition. MAE suggested that the focus for the future would have to be on retention.

8.2.3 PR commented around trajectories and noted that as ICBs had been established across the Country it would have been good to get to a point where trajectories on performance that matched reality in some of the areas were being received. It was also emphasised that a national workforce strategy for the NHS was about

to be developed and it was felt important that the ICS understood the realistic dynamics of workforce between safe staffing levels, staff satisfaction, retention, numbers coming through basic training and use of agency spend.

8.2.4 TC responded that it had been acknowledged that though progress had been made in recruitment, this would not necessarily translate into a corresponding improvement in agency expenditure. PR said GHC were examining agency and bank staff spending to see what was affordable. This however is not reflected in the way that metrics are reported publicly. TC said a clear system narrative will be needed on what the position was, as the strategy and position will be monitored throughout the year.

8.3 The third update provided at Board was from MAE who provided an update on Quality. The Board were informed of the following.

- The ICB had secured £50,000 to review the Dialysis Milage Reimbursement Scheme and NHSE expressed interest in the ICB to develop a resource pack that could be shared nationally to mirror the approaches taken.
- Patient Surveys revealed that GHC had done really well in their Community Mental Health Trust Survey.
- The Care Quality Commission (CQC) conducted a National Survey of Maternity Service Users and GHFT's Maternity Service came out in the top six of exceeding expectation which MAE said was extremely noteworthy.
- The System Effectiveness Group met on 9th January 2023 and there was good representation from the system and Commissioning for Quality & Innovation (CQUIN) guidance was due to be examined as detailed within the report.
- Work has started on the Patient Safety Incidence Response Framework and will continue to be developed.
- It was noted that understanding of mortality data and how the whole system can support partners to improve outcomes for patients was being better developed. Page 6 of the report demonstrated a diagram which shown that the system had a higher-than-expected standardised hospital mortality rate at GHFT. MP said that following closer examination and discussion with NHS England it would suggest that this was likely to be an issue connected to coding, rather than the quality of care. GHFT are re-examining data and act upon any actions needed.
- Work continues with Patient Participant Groups (PPG's) who provide OOH services, looking for assurance that quality is improving and is delivering what we would expect for our residents
- The ICB had worked with closely with providers to ensure that patient safety was maintained during strike dates and that the quality of care is not compromised.

8.4 CL next provided the Board with an update in relation to finance. The following was reported.

- The forecast for the ICB reported a break-even position for 22/23. There are ongoing pressures noted in a number of areas. Prescribing continued

to show significant cost pressures mainly due to No Cheaper Stock Obtainable (NCSO) and costs have increased again in the last month. It was unclear as to how long this will remain a non-recurrent pressure. NHSE had given some funding to allow for part of that pressure this year.

- Energy and workforce pressures continued with providers, particularly around agency workers to cover vacancies. The forecast agency spend for the year was c£6.8m. The focus remained next year from NHSE to examine spend on agency and there would be a revised cap for next year of £25.6m.
- UEC pressures and placements for children have caused significant cost pressures within the ICB.
- Some savings in programmes have been mitigated in year through non-recurrent measures. Direct Oral Anticoagulants (DOACs) in prescribing have also made savings.
- Elective recover noted to be just under the 104% target which was positive.
- GHC have received funding from the provider collaborative where a small surplus had been made and this had been returned to provider trusts, and plans continued around the extra share of the discharge funding.
- The system have been planning for 23/24 and the recurrent underlying pressures and opportunities available next year.
- Slippage was reported against the new leases which came under IFRS16 and noted there will be a conversation with NHSE to ensure that any which are slipping but will happen in 2023/24, will have capital cover.
- The Better Payment Policy had been achieved as a system.

8.5 KF gave a brief verbal update on the Transforming Care. It was described that there would only be one person left in the Assessment and Treatment Unit at Berkeley House by 31st March 2023 which was recognised as being a really good achievement and one which MH wanted to be brought to the Board's attention.

Meeting Outcome: The Board noted the contents of the Integrated Finance, Performance, Quality and Workforce Report.

9 Joint Forward Plan and Operational Plan updates

9.1 JC invited ER to provide the update regarding Joint Forward Plan and Operational Plan updates. ER informed that the Joint Forward Plan is something that all partners were required to complete and there was a link contained in the pack. A draft is expected by the end of March with final publication being by end of June 2023.

9.2 The Joint Forward Plan will reflect the pillars of the new Integrated Care Strategy. The seventeen legislative requirements of the ICB would be addressed as well as the joint Health and Wellbeing Strategies.

9.3 ER identified that The Joint Forward Plan will represent how the system will deliver the universal NHS commitments as set out in the Long-Term Plan as well as a reflection of NHS priorities.

9.4 Details about the timeline, building blocks of the Plan and the approach to development were included within the pack together with the sign-off timeline which explained how it would be taken through all the various committees at an organisational and system level. This continued to be worked on jointly with planning leads across the system.

9.5 The Operational Plan was described to set out delivery of plans over the next two years and against the five-year timeline within the Joint Forward Plan. A smaller set of national objectives were focussed upon recovering core service delivery and improving productivity, with headline ambitions around ambulance Accident & Emergency (A&E) performance, long cancer waits, diagnostics and access to Primary Care.

9.6 A draft Operational Plan was expected by 23rd February 2023 with a final version by the end of March 2023. ER highlighted that the emphasis this year was on triangulating the Plan in terms of performance, quality, workforce, and finance. There had been strong system engagement noted in working this through and in bringing together a productive set of plans as a system.

9.7 JCo asked whether the Dental Strategy would need to be reflected within the planning documents and asked whether this might be difficult given that we had not been previously responsible. MH replied that the ICB was working with the NHSE team who were producing the Dental Forward Plan and were expecting to jointly produce a Forward Plan for Gloucestershire but not until the end of March 2023. This would have to go through appropriate governance processes before being signed off. It was anticipated the ICB will have delegated responsibility for Dental from 1st April.2023.

Meeting Outcome: The Board noted the verbal updates of the Joint Forward Plan and the Operational Plan.

10 Fit for the Future (FFTF) - Review of Phase One Benefits and Costs

10.1 JC welcomed MG & SL to the Board meeting who provided an update on the review of phase one for FFTF and context for phase two.

10.2 MG reported that the FFTF team had been working closely with the Resources Steering Group and Directors of Finance, to review the benefits and the original aims of the Programme and drivers of change.

10.3 MG highlighted attention to a number of changes listed within page five of the report which had made implementation of the programme more challenging however the team at the Trust worked hard to implement the facilities.

10.4 MG spoke about Emergency General Surgery (EGS) and reported that risks described as untenable with scores of 15-16 at the time of change had been lowered down to 3-4 on the Trust Risk Register. It should be noted that other areas in the country had ceased to run some services like this as they were unable to manage the risk.

10.5 MG reported the following to the Board;

- Planned General Surgery changed were expected in the summer.
- Vascular Surgery had moved in June 2020.
- Image-Guided Interventional Surgery (IGIS) continued to be implemented throughout this year into 2024 as parts of the strategic site development; and
- Acute Medical Take moves were planned in autumn 2023 which will enable more focus on Planned Care and Oncology at Cheltenham General Hospital (CGH) and on Emergency Care at GRH.

10.6 SL thought that the format used could be taken forward to use for other programmes. It was felt that it was good to review what had been achieved within this system programme. Risks had been reduced, improved quality had been delivered and cashable benefits demonstrated.

10.7 MP reflected that the programme had been very successful and gave a clear two site strategy. It was very noticeable on talking to potential new consultants that clarity was attractive and speaks of an Acute Trust that has a plan for the future. Having Centres of Excellence for Planned Care and for Emergency Care will make a difference around staff recruitment and retention. The hard work and effort of all those involved in the programme was noted and very much appreciated.

10.8 CLe acknowledged that one of the challenges around reconfiguration was often with people and their reluctance to change and move and this could affect some of the advantages such as Length of Stay (LoS), from being realised. He asked how colleagues being prepared for some potential moves.MP replied that most of the moves had already taken place; albeit some were temporary during Covid. However, a large number of moves needed to take place to complete the work this coming year and the focus was to accomplish this well, making it clear to teams that they will be moving to permanent locations with support in place

10.9 MG spoke about LoS and said that a number of services will now be able to consolidate their bed numbers.

10.10 There was a query around some non-cash releasing benefits and what the benefits were. MG explained that the business base would be very clear between the separation of real cash out and what would be experienced as efficiencies. Non-cash allowed potential efficiencies to transform things further, or to allow growth in demand or to adapt and have room with which to approach the challenges.

10.11 MP spoke about Trauma and Orthopaedics and highlighted that elective orthopaedics takes place mostly in CGH and Trauma goes to GRH. Prior to the pandemic there was a significant reduction in cancellations and in waiting lists for elective operations. During winter 2022, the elective Orthopaedic beds had been protected in CGH and 97-99% of that ward had been used throughout the winter for elective orthopaedics which made the most use of the time.

Meeting Outcome: The ICB Board noted the updates for the FFTF Phase One.

11 Extension of Section 75 (joint funding arrangements) between Gloucestershire County Council and NHS Gloucestershire

11.1 JC invite KF to present this item. KF had requested approval of the Section 75 joint funding arrangements between GCC and NHS Gloucestershire ICB so that more time could be taken to review what can be put into the version in two years' time.

11.2 The Section 75 Agreement within the Financial Year 2022/23 (subject to year-end variations) totalled £188m as reported to the Joint Commissioning Partnership Executive on the 24th November 2022 i.e., £149m NHS GICB and £39m GCC. This included Continuing Health Care (CHC) and Funded Nursing Care which is solely NHS at a value of £46m.

11.3 MH emphasised that legally there must be an overarching agreement in place and there would be work in the next year review resource. SS said that this document was approved by their cabinet in GCC.

Meeting Outcome: The ICB Board agreed to exercise a two-year extension of Section 75 under the GCC's Framework Partnership Agreement with NHS Gloucestershire Integrated Care Board.

12 Emergency Preparedness Resilience and Response Assurance

12.1 MAE provided the next update to Board with regards to Emergency Preparedness Resilience and Response (EPRR). As part of the EPRR annual assurance process the ICB were bound by NHSE to summit the feedback to the ICB Board, on the level of assurance that had been rated from the evidence that submitted and the Confirm and Challenge meetings that were held for system. National standards for EPRR were noted to had been recently updated.

12.2 It was advised that all partners were compliant. Last year the Clinical Commissioning Group (CCG) was fully compliant, and which was described as a light touch process which focussed on a few of the standards. This year the compliance assessment was due to be conducted over all standards. Key areas of challenge were noted on page 5 of the paper.

12.3 MAE updated that to support training of all staff across the organisations, the ICB had appointed an EPPR Training Manager who would oversee the system-wide training required. A power-outage exercise was scheduled to take place at the end of March 2023 standards would be continually tested together system partners.

12.4 MAE had met and had a Confirm and Challenge meeting with NHSE who agreed that the system was substantially compliant, and they had issued a letter to support that. The Board were asked to agree to the recommendations and

support the output of the EPPR processes across the system. SF thanked MAE for all the work done around leading this work.

Meeting Outcome: The ICB Board approved the Emergency Preparedness Resilience and Response Assurance paper.

13 Committee Meeting Updates

13.1 CG provided the first update with regards to **Primary Care & Direct Commissioning (PC & DC) Committee.** The Committee met on 1st December 2022 and received the standard reports on Performance, Quality and Finance. Approval was given for a major new GP surgery in Brockworth. The practice have appointed a third-party developer and the building will was due for completion in November 2024.

13.2 JC provided an update with regards to **System Quality Committee.** The Committee last met on 14th December 2022 which included.

- A review and approval of the Non-Medical Prescribing Policy which was agreed. There was a request that non-medical prescribing across the whole system were standardised so that every organisation linked to the same policy which would enable any staff who moved across to other organisations, to be already compliant.
- Agreement was given to change the Bariatric pathway for patients subject to a clinical review of Tiers three and four after a year and provide additional patient education.
- GHFT spoke about maternity services and another review was done of the maternity assurance.
- There was an update on UEC around some of the quality issues and a discussion on possible impacts that the strike action would have on quality and safety. In future meetings the Committee would work with Social Care colleagues and the new Director of Quality around collaborative work within the Adult Social Care setting.
- It was advised that CG and JC have had discussions around looking at quality in Primary Care between the two Committees.

13.3 The next update was provided by Cle who gave a verbal update with regards to **People Committee.** The Committee met on 12th January 2023.

- Colleagues took the Committee through some new thinking on the People Strategy, with a programme of work being agreed which looked at the diagnostic phase with review and approval for the April People Committee and the May ICB Board will receive details for approval.
- Workforce and Intelligence updates on key metrics were received. Agency staff were discussed, nursing vacancy rates had increased along with the number of staff who decided to leave within a year. The importance of line management was recognised with their ability to be able to support colleagues to enable retention.
- Sickness absence was noted to have increased 3.8% to 5.1%. More positively, health and care support workers had risen to 57 and there was an update on the joint recruitment campaign in September. 49 people had

joined in December and 38 additional people were due to be starting early 2023.

- Approximately 400 people have gained benefits from the Leadership Development programmes recently.
- during 2023 there are plans to facilitate systemwide Quality and Improvement Development sessions in relation to Allyship and leading transformation change
- The Committee were updated on plans for the People Symposium scheduled for May. The intention was to facilitate a countywide discussion on how to attract and retain people in Gloucestershire.
- A number of risks were identified rated at 15 and above; three were with regards to workforce supply and impacts on objectives
- SF said that majority of the workforce have children and teacher strikes are to be discussed recently. It was felt that it would be helpful to get a summary sent to the leads following that meeting. It was agreed that this would be useful.

13.4 The final update was provided by JCo in relation to **System Resources Committee.** The Committee met on 12th January 2023, and it was reported that the majority of the meeting was taken up with issues around planning, prioritisation, and performance. There were a few risks falling under the System Resources Committee and some thought was given as to how the Committee could report against those going forward.

Meeting Outcome: The ICB Board noted the verbal updates provided from the Committee Chairs.

14 <u>Any Other Business</u>

14.1 CG acknowledged that Pharmacy, Optometry and Dental (POD) was planned to at a responsibility of ICB with effect from 1st April 2023. A presentation was scheduled for the Board in March for agreement to be signed off. Prior to that there is a Safe Delegation Checklist which had been seen in draft form which required signed off by 28th February 2023. An PC&DC had been planned to approve that, subject to approval by this Board if they delegate the responsibility to sign that off on the Board's behalf.

14.2 MH mentioned that this could be circulated to members. PR said it was crucial that we got this right. CG has had a number of concerns around provision and noted he had challenged this to so that when it is presented to PC&DC the Committee will be content.

Meeting Outcome: The ICB Board approved delegation to the PCDC to sign off the POD Safe Delegation Checklist at the next PCDC meeting.

14.3 ER raised an issue relating to the UEC transformation work. Work had been undertaken with Newton Europe to conduct a whole system diagnostic on UEC. The system was now looking to progress the commissioning of a transformation partner to support the implementation of the findings of the diagnostic. This requires a process in order to secure an improvement partner with which to work.

SS and ER are joint SROs of this programme and had looked in depth at the potential options for the most streamlined way to procure the improvement partner.

14.4 ER suggested that on this occasion, in order to procure an improvement partner to be able to work with the ICB and UEC system to bring about change for next winter, the most appropriate option would be for the County Council to procure the improvement partner on behalf of the ICB. This had been worked through with colleagues in Procurement and the suggestion is that Councillor CAM take a paper to the Gloucestershire County Council Cabinet meeting for decision on 29th March 2023. There were still more details to work through and questions will be answered as the procurement process proceeds.

14.5 The Board were asked for approval for ER and SS to continue to work together to procure an improvement partner, with the decision to procure a partner to be taken by the GCC on behalf of the Board.

Meeting Outcome: The ICB Board gave their approval GCC to procure an improvement partner for the diagnostic work on UEC, on the Board's behalf.

There were no further items of any other business.

The meeting closed at. 16:13.

Date and Time of next meeting: Wednesday 29th March 2023, 14:00 – 16:30

Minutes Approved by NHS Gloucestershire Board: Signed (Chair):_____ Date:_____

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log

March 2023

Open actions only

Meeting Date Raised	Reference	Owner	Action	Due	Updates	Status
30/11/2022	**Min 8.14**	**Kim Forey & Matt Holdaway**	To provide an update on work being undertaken to support vulnerable pregnant women, including services available to this group of women to be reported to the Board	**29/03/2023**	25/01/2023: This action related to an update on work being undertaken to support vulnerable pregnant women and service provision, a copy of a presentation is under Matters Arising for information.	**Closed**
30/11/2022	**Min 11.8**	**Ellen Rule & Micky Griffiths**	The Fit for the Future Business Case would be submitted to the March Board	**29/03/2023**	25/01/2023: This action related to a Fit for the Future (FFTF) business case update is on the Board Agenda 29 March 2023.	**Closed**
25/01/2023	**Min 6.13, 6.15 & 6.16 Patient Story**	**Siobhan Farmer**	Smoking Updates following Patient Story: **1)** SF agreed to share a statement being developed around the use of electronic cigarettes and their use **2**) SF agreed to share data from the People Health and Wellbeing Survey which demonstrated that smoking rates, although having have decreased significantly in young people over the past 10-20 years, had often been replaced with vaping, which was not the desired outcome. **3)** Gloucestershire Healthy Living and Learning (GHLL) are working with teachers to ensure that the curriculum addresses some of the findings from the People Health and Wellbeing Survey. SF will update the Board at a future meeting.	**TBC**	Briefing on Vaping in Children and Young People in Gloucestershire February 2023 and its impact on smoking rates was circulated on 7th February to ICB Bard members. The date for sharing with the Board the findings from the People Health and Wellbeing Survey is yet to be agreed.	**Action 1&2 Closed.** **Action 3 Open**
25/01/2023	**7.4 Chairs Briefing**	**Primary Care Team (Helen Goodey)**	CG commended that the Primary Care team and the ILPs had ensured that there was prompt access and a quick distribution of money to help those most in need due to the cost of living crises. An evaluation of where the money had been spent and what effect it had had, would be appreciated during the new financial year.	**31 May 2023**	The Primary Care Team are producing a report for the SW Region on the allocation made by ILPs to assist residents with the cost of living this same report will be made available to the Board at the Mary meeting.	**Open**

25/01/2023	**Min 13.3 Committee Update**	**Clive Lewis**	CL updated the Board through around some new thinking on the People Strategy, with a programme of work being agreed which looked at the diagnostic phase with review and approval for the April People Committee and the May ICB Board which will receive details for approval.	Agenda Item 0 - Agenda ICB board m **May-23**		**Open**
25/01/2023	**Min 13.3 Committee Update**	**Colin Greaves**	The Pharmacy, Dental and Optometry Delegation Agreement was sent to the Board for their approval outside the ICB Board meeting.	**29/03/2023**	An update is provided as part of the Chief Executive's Report on the POD Delegation Agreement.	**Closed**

Gloucestershire LMNS

Supporting vulnerable pregnant women/birthing people and mothers/families in Gloucestershire

Gloucestershire
Local Maternity and Neonatal System

Equity and Equality in Maternity

- Gloucestershire LMNS undertook a **Population Health Needs Analysis** of pregnant women and babies in Gloucestershire to identify areas of the county where outcomes are poorest (June 2022).
- The following risk factors and maternal and neonatal outcomes were analysed

Deprivation	**Smoking at Time of Delivery (SATOD)**	**Stillbirths**
Ethnicity	**BMI**	**Breastfeeding**
Maternal Age	**Late Bookings**	**Perinatal Mental Health**

Gloucestershire Local Maternity and Neonatal System

Key Findings

- Outcomes are poorer for those from more deprived areas, ethnic minorities, younger mums, and traveller communities
- Key risk factors of smoking in pregnancy and maternal obesity, plus booking late, are associated with some poorer outcomes, such as stillbirth, low birth weight, and low Apgar scores.
- High smoking and BMI rates, and lower rates of breastfeeding, are generally in the most deprived areas of the county.

Gloucestershire
Local Maternity and Neonatal System

Key Findings

- Women from ethnic minority communities breastfeeding rates are generally higher but women from ethnic minority backgrounds appear more likely to book late.

- Young mums and those from travelling communities are also likely to have higher risk factors and poorer outcomes.

- Gloucester and the Forest of Dean were identified as being the most deprived areas in the county with smaller numbers in areas of Cheltenham, Tewkesbury and Stroud. The next slides show wards with poorest outcomes and highest risk factors in Gloucester and the Forest of Dean.

Gloucestershire
Local Maternity and Neonatal System

Poorest outcomes and highest risk factors in Gloucester Wards

1. Gloucester	Smoking	Obesity	Late booking	Breast-feeding	Perinatal mental health
Barton & Tredworth	✓	✓	✓		
Coney Hill	✓	✓	✓	✓	
Matson & Robinswood	✓	✓	✓	✓	✓
Moreland	✓		✓		
Podsmead	✓	✓		✓	
Westgate	✓		✓	✓	✓
Tuffley	✓		✓	✓	

Gloucestershire Local Maternity and Neonatal System

Poorest outcomes and highest risk factors in Forest of Dean Wards

Forest of Dean	Smoking	Obesity	Late booking	Breast-feeding	Perinatal mental health
Cinderford West	✓	✓		✓	
Coleford	✓	✓		✓	✓
Lydney East	✓	✓		✓	
Cinderford East	✓	✓		✓	
Bream	✓	✓	✓	✓	✓
Newent & Taynton	✓	✓		✓	
Pillowell	✓	✓			✓

Gloucestershire Local Maternity and Neonatal System

Projects/services in place or ongoing

- **LMNS EDI workstream** well established – systemwide membership including engagement leads
- **Midwifery Continuity of Carer** – initially 3 teams focused on areas of high deprivation and ethnic minority communities currently reduced to 2 teams due to staffing challenges – monitoring metrics in place. Plan to re-establish Team 3 and review roll out in March/April 2023
- **Enhanced Midwifery Continuity of Carer Support -** MSW's in areas of greatest need to support the midwifery team with additional safeguarding support, increased antenatal education and booking interpreters and ensuring access to translated resources.
- Sheffield Community Collaborative **Cultural competency and awareness training** rolled out to all staff across the system in 21/22
- **Black Maternity Matters Project** commencing April 2023 – supported by WEAHSN
- Relaunched **Interpreting & Translation services** amongst staff Sept 2022 - funded staff pocket I & T booklets for staff in GHFT to increase awareness and uptake of I & T. Currently evaluating impact on use of Interpreters compared to 2021.

Gloucestershire
Local Maternity and Neonatal System

Projects/services in place or ongoing

- **Staff Engagement Roadshow** underway to share the data and ask staff from GHT/GHC/Childrens Centres for feedback and soft intelligence – Romanian Community in FoD identified
- Task and finish group to focus on needs of **Romanian women in the FoD** – non-English speaking, deprivation and social isolation
- Development of an **Asset map** of community support groups & resources
- **Maternity Voices Partnership** linking with engagement leads to gain feedback on maternity & neonatal care from seldom heard ethnic and deprived communities
- **Treating Tobacco Dependency**: Systemwide **QSIR project** to provide MSW targeted support to pregnant women who smoke in Gloucester & FoD where smoking rates are highest.

Gloucestershire
Local Maternity and Neonatal System

Projects / services in place or ongoing

Perinatal Mental Health

- **PIMH workshop** held October 2022 to encourage systemwide approach by joining up the whole pathway including VCSO provision (will run VCSOs workshop in May 2023) - eg. Nelson Trust service to support those communities and people who do not access PIMH services

- Development of **Birth Debrief Review & Reflect** service for women who have had experience of birth trauma (currently reviewing costs and options) - commence April 2023

- Yoga/art **Social Prescribing Pilot** (to start May 2023) for vulnerable women with MH issues

- **Single point of access scoping project to improve** referral to appropriate Perinatal Mental Health Services – commencing April 2023

Gloucestershire Local Maternity and Neonatal System

Projects / services in place

- **Latchaid Breastfeeding Proof of Value Project** – Project to implement a breastfeeding support app (pilot) to areas of the county where breastfeeding rates are lowest - project supported by WEAHSN – Steering group established evaluation will be supported by WEAHSN

- Development of **training films** for mandatory training 2023/24 to raise awareness of vulnerable pregnant women and services available to support women and professionals - Maternity Voices Partnership involvement in developing films for mandatory training for professionals systemwide, looking at different scenarios for vulnerable women

Gloucestershire
Local Maternity and Neonatal System

Specialist Roles

- A number of specialist midwives and teams work with vulnerable pregnant / postnatal women:
- **Vulnerable women's team, GHT**: works with women where any of the following are involved - **substance misuse and teenagers (both GCC funded), safeguarding and complex mental health**
- **PUP (Preventing Unplanned Pregnancy)** GCC funded – MW offering contraception to vulnerable women while on postnatal ward at GHT
- **Perinatal mental health team - GHC**: works with women who have a moderate-severe/complex mental health need. Also includes the Birth Anxiety and Trauma Service
- **Parent Infant Relationship team - GHC**: works with women and babies to support parent/infant attachment

Gloucestershire
Local Maternity and Neonatal System

Challenges

- Refugees and asylum seekers living in hotels
- Maternity Continuity of Carer paused due to midwifery staffing challenges
- Capacity to engage widely to enable co-production of actions
- Systemwide information sharing and data
- Improving communication across the system - organisational and professional boundaries

Gloucestershire
Local Maternity and Neonatal System

Agenda Item 7

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**Board Assurance Framework**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	The Board Assurance Framework was presented to Audit Committee and Operational Executive on several occasions during March.					
	ICB, ICS & Partners			**Date**		
	NHS Gloucestershire Audit Committee			16th March 2023		
Executive Summary	This paper provides an overview of the current strategic risks facing the ICB and have been aligned to the ICS Strategic Objectives / Priorities for 2022-23 as agreed by ICS partners.					
Key Issues to note	The BAF has been reviewed by directorate risk leads and Directors. Feedback from the Audit Committee held on 16 March was sent to Executive Directors and risk leads. The Audit Committee reviewed the risks and requested that they were updated with the latest actions undertaken, reviewed in terms of their current risk rating, update the controls and assurance and include a Director's summary. The BAF contains: • 10 strategic risks under 9 categories • 3 Red Rated risks (urgent care – 20; workforce 16; finance 16) • 7 Amber Rated risks					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without a BAF and the identification of strategic risks the Board would not know about emerging and potentially damaging risks to the ICB. 5x4 if there was no BAF reporting within the ICB 5x1 residual risk after risk mitigation					
Management of Conflicts of Interest	There are no conflicts of interests involved in producing this report.					
Resource Impact (X)	**Financial**	X	**Information Management & Technology**			
	Human Resource	X	**Buildings**			
Financial Impact	See the Finance risk ref 3.					
Regulatory and Legal Issues (including NHS Constitution)	The ICB has a host of legal duties and responsibilities around financial management and provision of services which relate to the risks (NHS Act 2006 as amended)					

Impact on Health Inequalities	See strategic risks that are aligned to the following strategic objectives. 1. Across all priorities tackle health inequalities across our populations drawing on data and population health approaches. 2. Improve population health through locality based working, placing a greater focus on personal responsibility, wellbeing and prevention.		
Impact on Equality and Diversity	See health inequalities risk		
Impact on Sustainable Development	The BAF includes a strategic risk on Sustainability		
Patient and Public Involvement	There is no public and patient involvement in creating the BAF		
Recommendation	The Board is requested to: • **Note** the Board Assurance Framework		
Author	**Christina Gradowski / Ryan Brunsdon**	**Role Title**	**Governance Team**
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**		

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
FFTF1	Fit for the Future – Phase 1
FFTF2	Fit for the Future – Phase 2
DMBC	Decision-making Business Case
RSG	ICS Resources Steering Group
NHSE	NHS England

Document Last Updated: 22/03/2023

Strategic Risks - Board Assurance Framework March 2023

Strategic Objective					
Support improvements in urgent and emergency care–ensuring a range of options are available to those who need it					
Risk Ref: 1 Strategic Risk	Insufficient capacity and capability to deliver transformational change across Urgent and Emergency Care **Due to**: Prioritisation of available resource on operational flow pressures **Impact**: Reflective of overall system risks regarding operational pressures (including Industrial Action) and recognised challenges in system patient flow	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Seek**	**5x4=20**	**4x4=16**	**5x2=10**	↓
Strategic Risk Owner (Director)	**Ellen Rule, Deputy CEO/Director of Strategy and Transformation**				
Aligned to other system partners risks (include ref no.)	GHC GHFT GCC				
Aligned to current ICB Risks	Please note: The risks below are under review as the UEC risk register is currently being updated. UC 1, & 4 - Risk of failure to meet a range of core performance metrics (National Ambulance Response times, hospital length of stay (LOS), Emergency Department (ED) and Ambulance Handovers UC 3 - Risk of insufficient access to alternative pathways to ED UC – Risk providers of UEC services do not comply with required standards as set out by CQC				
Committee	**Strategic Executive**	**Review Date:**	**21st March 2023**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Strong system wide governance for system operational issues (daily and weekly rhythm), supported by SCC and TOCB. • Leadership identified for system flow and Transformation, alongside programme leadership for identified areas of UEC. • Agreed reporting on priority improvements in place as part of winter planning 22/23. • System approach to operational planning for 23/24 producing one plan for UEC transformation and operational optimisation.	• UEC Transformation Programme Board to be established from May 2023	• Reporting into the ICB Quality Committee • Reporting to the Board of the ICB • Ongoing monitoring of agreed system wide Sloman metrics • NHSEI Reporting	• Awaiting confirmation of the additional capacity funds as part of the 23/24 operating plan process.

Document Last Updated: 22/03/2023

• Strong governance through system meetings (UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG). • Use of demand and capacity, discharge and BCF funds to deliver improvements within UEC system flow ○			

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
1. Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. Transformation programme Board to be in place May 2023, with delivery resource mobilised from early summer. 2. System wide operating plan submission to align with Transformation priorities for 2023/24 3. Learning from winter 22/23 to be factored into Transformation programme 4. Priority Transformation programmes to be articulated April 2023, built from existing schemes where work is underway and impact already starting to be seen. 5. Agree funding for improvements as part of the 23/24 operating and financial planning process.	1. Cabinet paper regarding delivery resource due to be tabled end March. Diagnostic output being discussed with partners and governance structure being developed in advance of delivery partner being in place. 2. Draft operating plan submission agreed by system partners (via T&F group), Final submission due 30th March 3. HOSC report shared in March regarding winter so far. Initial winter de-brief held with TEG members, full de-brief planned for 24th April 4. Outline Transformation programme in draft following Newton diagnostic. To be refreshed with CPG in April post winter de-brief exercise. Programme delivery approach to be confirmed, building on existing arrangements. 5. Schemes within priority committee process, additional capacity template submitted to NHSE.

	Relevant Key Performance Indicators: (taken from the Integrated Performance report) ○ IPR Reporting for Acute, Winter monitoring and Ambulance metrics

Document Last Updated: 22/03/2023

Strategic Objectives					
Support **improvements in urgent and emergency care**–ensuring a range of options are available to those who need it Expand and improve **mental health support for people of all ages** as well as for **people with learning disabilities and autism** so they have the support needed Bring together specialist resource across the county to deliver new models of care through **Fit for the Future**					
Risk Ref: 1 **Strategic Risk**	Insufficient capacity and capability to deliver transformational change across a wide variety of strategic priorities: • Mental health services **Due to:** Number of vacancies across CAMHS and difficulties in recruiting to vacant posts. **Impact:** Waiting list for treatment has stabilised but remains long with average waits for routine referrals of approx.one year.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**2x3=6**	⟷
Strategic Risk Owner (Director)	**Kim Forey, Director of Integration**				
Aligned to other system partners risks (include ref no.)	GHC 8. Resources targeted at acutes: There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities.				
Aligned to current ICB Risks	ID 25 -Increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals PC & E 1Lack of workforce in key services across the ICS				
Committee	Quality Committee	**Review Date:**	16th February 2023		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Eating Disorder Action Plan	• No significant gaps identified as a monthly system-wide multi-agency meeting is well established and any and all matters of programme management around and performance against the trajectories within the action plan for eating disorders are progressed. If the programme is of trajectory, then the matter is escalated.	• Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput.	• No significant gaps identified.

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
	28/02/2023: Work continues in this area and we are beginning to see some positive, albeit limited, outputs from this work stream

Document Last Updated: 22/03/2023

	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Improving Access to Psychological Therapies Eating Disorder Access Perinatal mental health -% seen within 2 weeks

Document Last Updated: 22/03/2023

<table>
<tr><td colspan="6">Strategic Objective</td></tr>
<tr><td colspan="6">Deliver our workforce programme to attract new people into Gloucestershire to work across health and social care
Bring together specialist resource across the county to deliver new models of care through Fit for the Future</td></tr>
<tr><td>Risk Ref: 2
Strategic Risk</td><td>People & Culture: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans.
Due to: High levels of vacancies across many staffing groups
Impact: Increased pressure on existing staff, impacting staff morale and wellbeing and leading to higher bank and agency usage.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
↓ ↔ ↑</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Cautious</td><td rowspan="3">4x4=16</td><td rowspan="3">4x4=16</td><td rowspan="3">3x2=6</td><td rowspan="3">↔</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Tracey Cox, Director of People, Culture and Engagement</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHC – BAF Risks 5, 6 and 7 (Recruitment & Retention, Workforce Wellbeing and Culture)
GHFT – BAF Risk SR2: Failure to attract, recruit and retain candidates from diverse communities resultingin the Trust and workforce not being representative if the communities we serve.</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">PC&E 1 - Lack of workforce in key services across the ICS
PC&E 2 - Cost of living crisis and its potential impact on staff
<s>PC&E 3 - Impact of pay and pension changes on staff</s>
PC&E 4 - Industrial action being carried out by multiple staff groups.</td></tr>
<tr><td>Committee</td><td colspan="2">People Committee</td><td>Review Date:</td><td colspan="2">Reviewed on 12th January 2023 with next review scheduled for 27th April 2023.</td></tr>
<tr><td colspan="2">Current Controls (what do we have in place to mitigate the risk?)</td><td>Gaps in Controls</td><td colspan="2">Current Assurances
(how do we know the controls are working?)</td><td>Gaps in Assurance</td></tr>
<tr><td colspan="2">• Utilisation of HEE monies on Continuing Professional Development to support staff training & development
• Leadership learning and development programmes in place
• Creation of additional bank and substantives roles to manage gaps</td><td>• Lack of an adequately defined and resourced system-wide and medium-term plan for staff and leadership development</td><td colspan="2">• Reporting to the People Board, People Committee and the Board of the ICB
• On-going monitoring progress on key workforce metrics through Integrated Performance Report (see below)</td><td>• National issues include uncertainty on continued funding for Continuing Professional Development funding.

• Awaiting publication of NHS Workforce Plan.</td></tr>
</table>

Document Last Updated: 22/03/2023

• Staff working flexibly to support delivery (e.g. community-based staff providing additional support in ED). • Targeted recruitment initiatives including international recruitment • Further promotion of resources and support available to staff including The Wellbeing Line • Retention initiatives and additional system-wide retention project to commence in Q4.			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
The system continues to develop and embed targeted initiatives: 1. New roles and new ways of working e.g. upskilling of Optometrists, mentoring support (on-going) 2. On-going system focus on international recruitment inc options for a shared approach. 3. Retention programme pilot (NHSE Funded) (begins 1st April 2023) 4. Implementation of five high-impact actions for recruitment 5. ICS People Framework to enable cross-organisational working (in place). 6. Mitigation planning for ongoing industrial action. 7. Initiation of system-wide project on agency spend - Mobilise: March 2023 8. On-going recruitment activities at organisational level and at system level development of a system wide recruitment campaign 9. On-going focus on health and Wellbeing initiatives for staff		**Updated 06/03/2023** 1.Bids and new initiatives and proposals being developed with Clinical Programme Groups for 2023/24 HEE funding round) 2. Work commenced on mapping provision and risk and issues relating to staff accommodation and international recruitment 3. New retention role to support a system approach starts on 1st April to support identification of potential actions. 4. No change 5. No change 6. Industrial action management is on-going and tailored to clinical and staff groups taking action 7. Focus on e-rostering and early booking of rotas to support use of bank rather than agency staff System-wide mapping of current approaches commenced. 8) Funding source being identified and aim to commission support in Q1 of 2023/24 9. A further year of non-recurrent funding for The Wellbeing Line pending a wider system review.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Staff Engagement Score (Annual) • Sickness Absence rates • Staff Turnover % • Vacancy Rates • Bank and Agency Usage • Apprenticeship levy spend and placement numbers		

Document Last Updated: 22/03/2023

Strategic Objective					
Work together to **address the financial challenge** we have across the system to narrow the financial gap and deliver efficiencies					
Risk Ref: 3 **Strategic Risk**	**Financial Sustainability** Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity. – **Due to**: increasing demand for services, increased inflation, ongoing impact of the covid pandemic on a wide range of services and staff and new service requirements Lack of delivery of recurrent savings and productivity schemes Recruitment & retention challenges leading to high-cost temporary staffing Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost – **Impact**: underlying deficit position within the system as a whole revenue and the system is unable to achieve breakeven recurrent position Increased requirement to make savings leading to inability to make progress against ICS strategic objectives Capital costs growth meaning that the system is unable to remain within its capital resource limit	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**4x4=16**	**4x4=16**	**4x2=8**	↔
Strategic Risk Owner (Director)	**Cath Leech, Chief Finance Officer**				
Aligned to other system partners risks (include ref no.)	GHC: 8 There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care GHC 9 Funding - National Economic Issues There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs GHFT: SR7 - Failure to deliver financial balance.				

Document Last Updated: 22/03/2023

Aligned to current ICB Risks	F&BI 18 - The ICB does not meet its breakeven control total in 2022-23 F&BI 21 - The ICS does not meet its breakeven financial duty in 2022/23 F&BI 22 - ICB Headquarter Lease Capital Funding Access F&BI 23 - The ICS does not achieve a breakeven position against its Capital Resource Limit		
Committee	**System Resources Committee Audit Committee**	**Last Review & Update Date:**	**19th March 2023**

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Governance in place in each organisation and System-wide Financial Framework in place • Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC • Financial plan aligned to commissioning strategy • ICS single savings plan in place managed by PMOs & BI teams across the system forming part of the monthly finance review process • Contract monitoring in place • Robust cash monitoring with early warnings • System Financial Improvement Plan in place and further development in progress • Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme	• Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. • Methodology on realisation of productivity not in place • Capacity of teams through the system to deliver programmes of work required to transform system is limited particularly in times of ongoing urgent care escalation	• Reporting into Board of the ICB and relevant Committee for each organisation • Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position. • Capital monitoring is produced monthly and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system. • Annual internal audit reviews on key financial controls	• Gaps in knowledge of continuation of some funding sources into 23/24 and beyond leading to uncertainty in planning

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• GHFT internal financial improvement plan being updated further and implemented in order to mitigate financial pressure. reporting through to the GHFT Finance Committee. • System Financial Improvement Plan in place, ongoing updating for additional actions to improve the system financial position. • 2023/24 budget setting including efficiencies well progressed, this includes the joint implementation of the recent urgent care diagnostic findings	• GHFT internal financial improvement plan being updated further and implemented in order to mitigate financial pressure. Reporting through to the GHFT Finance Committee. • System Financial Improvement Plan in place, ongoing updating for additional actions to improve the system financial position. • System operational and longer-term plan in development which will be underpinned by financial plans, operational plan due end of March, longer-term plan timescale: summer

Document Last Updated: 22/03/2023

	• Urgent care diagnostic implementation being planned, Directors of Finance will sit on the benefits realisation programme
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Delivery of Full year efficiency target Achievement of Elective Services Recovery Fund Target Delivery of in-year breakeven financial position

Document Last Updated: 22/03/2023

<table>
<tr><th colspan="6">Strategic Objective</th></tr>
<tr><td colspan="6">Improve access to care, recovering from the last two years. This includes work to recover elective care, reducing long waits whilst ensuring that those waiting are given advice and support to manage their conditions.</td></tr>
<tr><td>Risk Ref: 4
Strategic Risk</td><td>System Recovery: Failure to deliver the recovery of services due to the impact both short term and long term of the Covid pandemic such that waiting times for cancer, diagnostics, mental health, outpatient appointments and elective treatment result in poorer access and outcomes for our patients.

Due to: Waiting list backlogs generated through Covid as elective services were stood down for long periods of time. On-going impact of staff sickness/absence and general workforce shortages in both medical and nursing posts affecting smaller specialties such as haematology, rheumatology and Cardiology. UEC pressures on elective bed availability continue to be an issue although some elective ring fencing has been possible with new ward reconfigurations.
There has also been a growth in 2ww referrals across a number of big cancer specialties such as Lower GI which has diverted all elective capacity towards seeing and treating them at the expense of routine patients.

Impact: Most elective specialties have a level of long waiters >52 weeks and the total waiting list size is growing at nearly 1000 a month. Clearance of non-admitted patients generates additional admitted patients, and the shape of the waiting list curve is such that waves of long waits come through at different times making PTL management difficult.
The increase in cancer work for specialties such as Lower GI and Urology has made it difficult to maintain routine elective activity and so these patients continue to wait longer than we would want. Prioritisation of waiting lists for cancer and urgent P1-2 categories often pushes the P4 routine waits further and further back.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
↓ ⟷ ↑</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Zero</td><td rowspan="3">3x4=12</td><td rowspan="3">3x4=12</td><td rowspan="3">3x2=6</td><td rowspan="3">⟷</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Mark Walkingshaw, Director of Operational Planning and Performance</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHC 3 There is a risk of demand for services beyond planned and commissioned capacity</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">OP&P 5: Risk of failure to comply fully with NHS Constitution standards for planned care waiting times
OP&P 7: Risk of services not delivering to commissioned standards or provider failure</td></tr>
</table>

Document Last Updated: 22/03/2023

Committee	Quality Committee	Last Review & Update Date:	20th March 2023
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Clinical validation and prioritisation of system waiting lists plus regular contact with patients to notify them of delays and what to do if clinical condition changes. Elective waiting list prioritised with P codes. • Elective care hub undertaking patient level contact, validation and link to social prescribers as well as escalation of any patients with a worsening condition to the relevant specialty. • Additional elective activity commissioned with Independent Sector providers both for new referrals and transfer of long waiters from GHFT where required. • Work continues with primary care to manage referral demand into secondary care. Increase in A&G services and access to Cinapsis as well as progress with "Advice First" approach and RAS role out. Expanded GP education programme and G-Care pathway content. • Regular analysis of waiting lists in place to ensure equity of access, waiting times and outcomes for our most deprived populations and ethnic minority groups. • Clinical harm reviews undertaken for all long waits. • Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility in CGH.	• Stratification of waiting list based on other health and socioeconomic factors not in place. • Specific plans for improving CYP access to elective services in development • Uncertainty of elective recovery plans for out of county NHS providers	• Performance Reporting to the Planned Care Delivery Board, System Resources Committee and the ICB. • Elective recovery planning and oversight provided by the Planned Care Delivery Board (PCDB) with escalation via Programme Delivery Group and ICS Execs as required. • Reporting to NHSE/I on waiting times. Any elective cancellations reported to NHSE/I. System waiting times monitored through the WLMDS tableau report. Regular Elective Recovery COO and Performance Directors meetings with NHSE for the region. • Regular contract and performance management governance structures in place to review performance and associated recovery plans with all providers including independent sector.	• Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.

Document Last Updated: 22/03/2023

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
1) Review of 23/24 operational plan by systemwide planning group to confirm plans are robust and affordable 2) Review of 23/24 operational plan by ICB board for sign off 3) Additional capital investment (new theatres) with associated revenue funding 4) Additional elective activity planned for 2023/24 (e.g. endoscopy, WLI GLANSO lists as well as insourcing and outsourcing) 5) Roll out of CDC activity (new building to come online in December 2023) 6) Additional activity to be commissioned from ISPs as part of 23/24 planning 7) ICB elective delivery plan to be finalised following planning submission 8) 19/20 baseline adjustment to be made with NHSE	1) Plans have been created jointly with system partners and are detailed, robust and achievable. 2) Plans meet all elective operational plan targets with the exception of a 25% reduction in follow ups. Meetings in place to sign off plans in stakeholder organisations ahead of ICB board 3) Two additional theatres at CH to be completed at the end of 2023. Funding to be agreed from ERF allocation. Further TIF bid approved for an additional orthopaedic theatre in 2 years. 4) Specialty plans currently being reviewed by Execs within GHFT to assess affordability and deliverability. 5) CDC on track for delivery as planned 6) IAPs with ISPs currently in negotiation, ready for sign off alongside planning deadline. 7) Draft delivery plans complete and will be updated as soon as detailed specialty plans are agreed within GHFT 8) Baseline adjustment accepted by NHSE
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Elective recovery as a % of 2019/20 • ERF achievement • Long waiters' performance • % of diagnostic tests completed within 6 weeks • Early diagnosis rates for cancer • Waiting Time Performance in 2 week waits • % of patients with cancer receiving first definitive treatment within 31 and 62 days

Document Last Updated: 22/03/2023

<table>
<tr><th colspan="6">Strategic Objective</th></tr>
<tr><td colspan="6">Continue changes in services that enable care to be delivered closer to home. Our Clinical Programme Approach and the work within Primary Care Networks are key to making this happen.
Improve integrated care across the life course–increasing our focus on the needs of Children and Families and supporting people to age well
Improve access to care, recovering from the last two years. This includes work to recover elective care, reducing long waits whilst ensuring that those waiting are given advice and support to manage their conditions</td></tr>
<tr><td>Risk Ref: 5
Strategic Risk</td><td>Quality: - Failure to deliver safe, effective, responsive, caring and well-led services and reduce harm.
Due to: Lack of robust oversight arrangements to ensure high quality care is delivered by organisations with NHS contracts.
Impact: Patients and citizens will be put at risk and have a poor experience if those with NHS contracts are unable to deliver high quality care.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
↓ ⟷ ↑</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Zero</td><td rowspan="3">5x2 = 10</td><td rowspan="3">5x2=10</td><td rowspan="3">5x1=5</td><td rowspan="3">⟷</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Dr Marion Andrews-Evans, Chief Nursing Officer
Dr Andy Seymour, Chief Medical Officer</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHFT: SR1 Breach of CQC regulations or other quality related regulatory standards.
SR3 Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework
GHC: There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support…</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">C 2 - There are some clinical areas where aspects of NICE guidance have not been fully implemented. Therefore there is a potential risk to patient care and outcomes.
ID 10 - CHC unable to meet the NHSE target for the assessment of people with a learning disability
ID 11 - Waiting List for Wheelchair Service provision in the recovery phase.
ID 25 - Increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals
ID 27 - Child/young adults not receiving the specialised care they would receive in a Tier 4 Eating Disorder Bed
ID 44 - Medically complex and vulnerable children in non-health care settings (eg school nursery) are not supported with their medical needs</td></tr>
<tr><td>Committee</td><td colspan="2">System Quality Committee</td><td>Last Review & Update Date:</td><td colspan="2">17th March 2023</td></tr>
<tr><td colspan="2">Current Controls (what do we have in place to mitigate the risk?)</td><td>Gaps in Controls</td><td colspan="2">Current Assurances
(how do we know the controls are working?)</td><td>Gaps in Assurance</td></tr>
</table>

Document Last Updated: 22/03/2023

• ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput. • Reporting from and attendance at Provider Quality Committee. • Learning from Case Reviews • System Quality Group • System Effectiveness Group • System IPC Group	• We are currently working on developing an ICS Mortality Group to support system development and discussion. • We will also work to develop a System Safety Group linked to the development of the new Patient Safety Incident Response Framework.	• Reporting to Quality Committee • Quality Assurance discussions • Contract Management Boards • Regulatory reviews	• We are assured that the governance process in place mean that we have full oversight.

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
ID 27: Work with National and Local VCS providers to develop range of community options to be used to facilitate discharge. ID 44: Expansion of a nurse training service to meet the growing needs of training within non-heath care settings (eg schools)	Governance arrangements are in place and remain our primary control to mitigate risk. However, we are mindful that we can tighten control the development of a system wide mortality group. We also aim to set up a new Safety Group in conjunction with the role of the new Patient Safety Incident Response Framework. As this risk is rated 10, we would like to propose that it is considered to be removed from the BAF. Should the risk increase, would we immediately reinstate it.

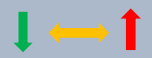
Relevant Key Performance Indicators: (taken from the Integrated Performance report)

Ref No	Metric
S034a	Summary Hospital-Level Mortality Indicator (SHMI)
S035a	Overall CQC rating (provision of high-quality care)
S036a	NHS staff survey safety culture theme score
S037a	Percentage of patients describing their overall experience of making a GP appointment as good
S038a	National Patient Safety Alerts not declared complete by deadline
S039a	Consistency of reporting patient safety incidents
S040a	Methicillin-resistant Staphylococcus aureus (MRSA infections)
S041a	Clostridium difficile infections

Document Last Updated: 22/03/2023

		S042a	E. coli blood stream infections	
		S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	
		S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	
		S046a	Population vaccination coverage – MMR for two doses (5 years old to reach the optimal 95%)	
		S047a	Proportion of people aged 65 and over who received a flu vaccination	
		S059a	CQC well-led rating	

Document Last Updated: 22/03/2023

Strategic Objective					
Across all priorities tackle health inequalities across our populations drawing on data and population health based approaches.					
Risk Ref: 6 Strategic Risk	**Health Inequalities & Outcomes:** Failure to address health inequalities and improve health outcomes for the population of Gloucestershire. With a particular focus upon delivery against the agreed Core20Plus5 priorities. Due to: long-term, entrenched and multi-faceted social, economic and racial inequalities in Gloucestershire, which have been further exacerbated by the adverse effects of Covid-19 and the economy moving into recession. This has profoundly impacted racially minoritized and socially marginalised communities and will continue to do so. Multiple disadvantage manifests in our system as health inequalities. Health inequalities are avoidable. They arise when people experience barriers to access and uptake of services, and difficulties achieving best practice management of their conditions (e.g. due to cultural barriers or delayed diagnosis). Impact: This can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions, and ultimately higher mortality. All of this is associated with greater cost – to the individual, to society and to the health and social care system.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** 
Risk Appetite (include colour)	**Seek**	**3x3=9**	**3x3=9**	**2x2=4**	
Strategic Risk Owner (Director)	**Mark Walkingshaw/ Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	GH&C, GHFT, GCC (including Public Health Team).				
Aligned to current ICB Risks	ID 11 - Waiting List for Wheelchair Service provision in the recovery phase. F&BI 9 - Primary Care Data Quality				
Committee	**People Committee**	**Review Date:**	**20th March 2023**		
Current Controls (*what do we have in place to mitigate the risk?*)	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

Document Last Updated: 22/03/2023

		(how do we know the controls are working?)	
• Work on health inequalities embedded into the work of transformation programmes. This includes activity in Gloucester City ("Core20"), activity on race relations ("PLUS") and activity across the 5 nationally identified clinical areas. • Baseline work underway for children and young people (Children's Core20Plus5). • Support taking place with BI and Prevention Teams. • Analysis taking place across ICS with BI supporting programmes with information and interpretation to define key health inequalities and support addition of actions addressing health inequalities into programmes and projects across transformation, people and prevention.	• Coordination controls in place to be able to understand the breadth of work underway on inequalities and • ensure system-wide actions are co-ordinated. • Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. • Social value policy to guide proportionate universalism in funding allocations.	• Some health inequalities measures built into strategic outcomes framework with Board-level assurance. • Programme of health inequalities analysis commenced to report into board and inform specific actions to reduce health inequalities across all delivery areas.	• Co-ordinated reporting on both longitudinal health inequalities and medium term control impact (e.g. Core20Plus5). • Public reporting of health inequalities not fully established.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Regular analysis of key priorities for health inequalities (e.g. elective recovery) – commenced but not yet fully established (see Assurance gaps) • Commissioning Support Unit activity underway with NHS Gloucestershire ICB to baseline work on health inequalities and identify gaps (by end of June 2023) • New Health Inequalities Improvement Manager post (appointed to March 2023). • System mapping for HI analysis planned for 27th April 2023 to allow inter-organisation collaboration and support system projects. • Incorporation of regular health inequalities measures into Integrated Performance Report to be undertaken (to commence June 2023).		• Successful appointment to Health Inequalities Improvement Manager post. • Provided additional detail on approach to identifying and responding to Health Inequalities within final Operational Plan submission for 23/24. • Update on Health Inequalities in elective recovery being presented at ICB public board in March 2023. • Work ongoing around ICB board level leadership for Health Inequalities.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Under development.		

Document Last Updated: 22/03/2023

Strategic Objective					
No exact correlation with the strategic objectives but is a key priority for the ICB					
Risk Ref: 7 Strategic Risk	**Sustainability**: Failure to take effective measures to reduce our carbon footprint by tackling the key drivers such as energy consumption, waste management, travel and logistics as well as creating new sustainable ways of working (i.e. digital technologies)	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ → ↑
Risk Appetite (include colour)	**Cautious**	**5x3=15**	**5x2=10**	**5x1= 5**	↓
Strategic Risk Owner (Director)	**Cath Leech, Chief Finance Officer**				
Aligned to other system partners risks (include ref no.)	GHC 10 Sustainability Environment: There is a risk that responding to the climate emergency is not prioritised resulting in the failure to transform and embed green practice. GHFT: SR8 Failure to develop our estate which will affect access to services and our environmental impact..				
Aligned to current ICB Risks	There are no current operational risks around sustainability included in the risk system				
Committee	**TBC**	**Last Review & Update Date:**	**19th March 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		
• Board level lead in place • Green Plan in place • ICB Sustainability Group in place, including • ICS Wide Green Plan Steering Group established • Full active member of Climate Leadership Gloucestershire with other public sector partners	• Available, timely and accurate data • Financial resource • Lack of staff resource • Tracking delivery of detailed plans and projects	• Plan document • Minutes of meetings • Project plans	• Co-ordinated reporting across the system on implementation and progress against plans		
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**			
• Agree shared priorities • Developing and sharing resources, including programme and project management • Improving data and ongoing tracking • Shared commissioning of specialist resource		• ICS contribution to Climate Leadership' Gloucestershire finalised including contribution to Gloucestershire Adaptation Plan			
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)				

Document Last Updated: 22/03/2023

Strategic Objective					
Successfully **transition to an Integrated Care System,** develop our five year strategy and embed new ways of working across the Gloucestershire (ICS) enabling further collaborative working across all partners and with local people and communities					
Risk Ref: 8 Strategic Risk	**System Development**: Failure to develop robust governance structures and accountabilities based on strong system wide collaborative partnerships, which impact on the effectiveness of the ICB	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**3x3=9**	**3x3=9**	**2x2=4**	↔
Strategic Risk Owner (Director)	**Tracey Cox, Interim Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	GHC; BAF Risk Nos & 12: Partnership Culture & NHS re-organisation GHFT; BAF risk SR5 Poor engagement and involvement with/from patients, colleagues, stakeholders and the public				
Aligned to current ICB Risks	GHFT: SR4 Risk that individual organisational priorities and decisions are not aligned. SR5 Poor engagement and involvement with/from patients, colleagues, stakeholders and the public				
Committee	**ICB Board People Committee**	**Review Date:**	**Board 30th March 2023 People Committee 27th April 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		
• ICB Constitution • ICB Governance Handbook • Scheme of Reservation and Delegation • ICB BAF, Corporate Risk Register and new Risk Management Framework • Audit Committee has a role in scrutinising the ICB's risk management, & conflicts of interests' arrangements; as well ensuring	• Finalisation of arrangements for a commissioning hub for pharmacy, optometry and dentistry	• Pharmacy, Dental and Optometry Assurance Checklist Steps to Working with people & communities training	• Training of all relevant staff to be completed		

Document Last Updated: 22/03/2023

financial governance is effective and robust within the ICB. • Integrated Care Strategy development • ICB Working with People & Communities Strategy & Advisory Group • ICB Board development programme • VSCE Memorandum of Understanding • Delegated commissioning arrangements with NHS England • Annual staff survey results			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
1. Mobilisation of Working with People & Communities Advisory Group (WPACG) 2. Goverance Review of ICBs to be undertaken. NHS England are producing a self-assessment toolkit which will be available in Q1 of 2023/24 3. Individual review of the effectiveness of Committees to be carried out at an appropriate point 4. On-going ICB Board development programme		1.This group has now been mobilised and has supported work on an independent assessment of the ICB's performance against the Equality Delivery System 2. As part of the Internal Audit programme of audits, an ICB Committee Effectiveness audit has been and will shortly be shared with ICB Board. The outcome of that audit will be reflected in the assurances. 3. To be confirmed subject to the review of the above. 4. Development dates scheduled for April and June 2023	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) TBC – Annual 360 survey as part of review of effectiveness of ICB		

Document Last Updated: 22/03/2023

Strategic Objective					
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB					
Emergency Preparedness, Resilience and Response (EPRR)	**EPRR:** - Failure to meet the minimum occupational standards for EPRR and Business Continuity. **Due to:** Lack of effective EPRR systems and On-Call EPRR training **Impact:** Unable to fulfil our responsibilities as a Category One responder.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Zero**	**4x3=12**	**4x3=12**	**4x1=4**	↔
Strategic Risk Owner (Director)	**Dr Marion Andrews-Evans, Chief Nursing Officer**				
Aligned to other system partners risks (include ref no.)	System EPPR				
Aligned to current ICB Risks	N/A				
Committee	**System Quality Committee**	**Last Review & Update Date:**	**17th March 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		
• EPRR On-call manager training • EPRR exercises • Oversight of EPRR through the Local Health Resilience Partnership. • EPRR ICS Business Group work programme.	• Our On-Call manager and senior system can be enhanced to provider better control of the risk.	• Reporting to Quality Committee • NHS England system assurance review and provider assurance process against national standards.	• None - The NHSE review offers a full assurance process. This was last presented to the Quality Committee in 2022.		
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**			
• Review On-Call system – supported at Operational Executives on 10 January. Review due to complete by end of February with proposals for change (if needed) delivered early March.		• The On-Call review concluded with five potential options for change to strengthen systems and controls. • These options have been considered with a formal decision not yet made. • We have a full rota in place until June 2023, which mitigates risk until that time.			
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)				

Document Last Updated: 22/03/2023

	N/A

5x5 Risk Matrix

Green: Low; Yellow: Moderate; Amber: Significant; Red: High

Likelihood \ Consequence	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Document Last Updated: 22/03/2023

ICB Risk Appetite levels

1. ZERO - Minimal	• Avoidance of risk is a key organisational objective • Our tolerance for uncertainty is very low • We will always select the lowest risk option • We would not seek to trade off against achievement of other objectives
2. Cautious	• We have limited tolerance of risk with a focus on safe delivery • Our tolerance for uncertainty is limited • We will accept limited risk if it is heavily outweighed by benefits • We would prefer to avoid trade off against achievement of other objectives
3. Open	• We are willing to take reasonable risks, balanced against reward potential • We are tolerant of some uncertainty • We may choose some risk, but will manage the impact • We are prepared to take limited risks where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.
4. Seek	• We will invest time and resources for the best possible return and accept the possibility of increased risk • In the right circumstances, we will trade off against achievement of other objectives • We will pursue innovation wherever appropriate. We are willing to take decisions on quality / workforce and reputation where there may be higher inherent risks but the potential for significant longer-term gains • We outwardly promote new ideas and innovations where potential benefits outweigh the risks
5. Bold	• We will take justified risks. • We expect uncertainty • We will choose the option with highest return and accept the possibility of failure • We are willing to trade off against achievement of other objectives

Agenda Item 8

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**Chief Executive Report**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.					
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer.					
Key Issues to note	This report covers the following topics ○ The Winter Plan 2022-23 ○ Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms ○ Transforming Care (Learning Disability and Autism Program) ○ Joint Commissioning of Specialised Services: New Arrangements For 2023/24 ○ Research for Gloucestershire (R4G) ○ Pharmacy, Optometry and Dental Services Delegation ○ Procurement Strategy – request for an extension ○ Chair and CEO action report – s.256					
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 through established groups and committees.
Regulatory and Legal Issues (including NHS Constitution)	POD Delegation Agreement; Joint Commissioning of Specialised Services
Impact on Health Inequalities	Not overtly covered in the reports but the Transforming Care programme seeks to transform care and support for people with a learning disability and/or autism.
Impact on Equality and Diversity	See the Transforming Care programme which focuses on people with a learning disability / autism.
Impact on Sustainable Development	Not covered
Patient and Public Involvement	See Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms; a project that works collaboratively with patients and service users.
Recommendation	The Board is requested to: • Note the Chief Executive Officer report including the Chair and Chief Executive action reported, the update on arrangements for specialist commissioning and the Board decision on accepting delegation of Pharmacy, Optometry and Dental services from NHSE(a verbal update will be provided) • Approve the extension of the ICBs existing procurement strategy document from 1 April 2023 to 30 September 2023.
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
29th March 2023

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 is provided on a bi-monthly basis to Board meetings held in public.

2. Winter plan 2022-23

2.1 An overview of the Urgent and Emergency Care (UEC) and System flow's response to winter pressures including, all aspects of winter plan delivery and performance across the Gloucestershire system, was sent to ICB Board members and participants prior to the board meeting. A presentation given to the Health Overview and Scrutiny Committee (HOSC) about the Winter Pressures was also included.

2.2 The Winter Plan 2022-23 provided an update on:

- improved performance across all six winter key performance indicators reported nationally; noting that there is further improvement work required across all areas, particularly with regard to over 21-day length of stay and reduction of system wide no criteria to reside. It was noted that overall performance has improved.
- the winter assurance framework has been largely delivered against trajectory with successful schemes being put forward for this year's priorities funding.
- HOSC feedback was positive about the ICB's progress, and the approach taken during winter, with incremental improvement in performance through sustained delivery of the winter assurance framework and system wide winter pledges. It was noted that Plan Do Study Act (PDSA) based ReSET programmes are taking place to support the operational recovery during times of peak pressure.

2.3 Winter de brief work is still ongoing with initial feedback received from operational teams and a system-wide workshop with executive attendance planned for 24th April 2023. The outputs will inform this year's Urgent and Emergency Care (UEC) operational plan and development of the wider UEC and System Flow transformation programme.

3. Optimising personalised care for adults prescribed medicines associated with dependence or withdrawal symptoms

3.1 *Framework for action for ICBs and primary care'* was launched on 30 February 2023. The publication highlights some of the work of the Living Well with Pain Programme (LWwPP) here in Gloucestershire. Professor Tony Avery, National Clinical Director for Prescribing visited Gloucestershire a few days before the launch to find out more about our work.

3.2 The morning of Professor Avery's visit was spent in Gloucestershire Hospitals NHS Foundation Trust (GHFT) where the secondary care pain, high intensity user and critical care teams demonstrated how social prescribing can be incorporated into hospital management plans. They described the development of social prescribing initiatives to support their services. The hospital pain team described work with Artlift to co-produce a variety of art-based therapy sessions for adults with persistent pain and with the creative health consortium to produce a music, circus and art programme for children with long term health conditions.

3.3 The high intensity user service and post COVID critical care teams demonstrated the incorporation of social prescribers as part of the multi-disciplinary team, to provide individualised support and advice. Patients have benefitted from these services by facilitation of the transition from hospital to the community and improvement in social connections, mental health, confidence and activity levels. As result, patients are able to manage their long-term conditions better and to reduce contact with hospital and primary care medical services.

3.4 Professor Avery reflected that the strong relationships and collaboration between the ICB, hospital teams and voluntary sector have resulted in social prescribing offers, which demonstrated a reduced pressure on medical services and improve outcomes for patients. He noted the positive culture of collaboration and innovation within the OneGloucestershire system, enabling the development of exemplary services.

3.5 During the afternoon Professor Avery was invited along with members of the programme group to the GL11 Community Hub who hosted the afternoon session. He was able to see first-hand some of the work of the GL11 as an organisation and also gained an insight into the project which the ICB has commissioned. The project work that GL11 has led is to explore what types of support there is available to live well with pain and are required by our local population.

3.6 The 'formal' afternoon session began with an overview of the purpose and activities of GL11 and the background to their involvement in the LWwPP. We emphasised the importance of a whole system approach and the excellent executive sponsorship and support that have enabled our programme to evolve.

3.7 We discussed how, from a starting point of a brief to optimise prescribing for pain, we have shown that initiatives to change prescribing are about much more than medicines and include: understanding the complexity of the chronic pain experience, confidence in using best medical evidence and acquiring the skills to help clinicians move from '*fixer' to 'facilitator'* in supporting people with pain to live well with their symptoms. The LWwPP is a rich collaboration of colleagues from physical and mental health disciplines, social prescribers and their extensive network of community offers, VCSE partners, adult social care, pain charities and with people with lived experience at the heart of what we do. We

highlighted the success of our 'It's Your Move' programme that we developed in partnership with Active Gloucestershire.

3.8 Professor Avery was inspired by the creative ways in which people with lived experience, colleagues in healthcare and the voluntary sector have come together across the health and care system to bring about transformative change in the lives of people living with pain.

3.9 He commented 'What's so impressive is that NHSGloucestershire ICB has transformed its whole system, working collaboratively with many providers and clinicians, enabling people with lived experience to co-design services, and mapping the services that are already in place to enable better access and address health inequalities. This shows what health and care communities can do when working together as teams in a holistic way and is a great example to other ICBs throughout the country.

4 Transforming Care (Learning Disability and Autism Program)

4.1 Since the investigation into the abuse at Winterbourne View, there has been a cross-government commitment to transform care and support for people with a learning disability and/or autism who display behaviour that challenges through the national Transforming Care Programme (TCP). A key focus of the programme is to facilitate discharges for those people who are living in specialist Learning Disability and Autism inpatient services back to appropriate community settings.

4.2 Working together as a local system, we have:

- Reduced the number of Gloucestershire NHS funded placements from to 7 and the number of secure placements to 15.
- Gloucestershire ICS has the 2nd lowest number of placements in the southwest region.
- By June 2023, there will be no NHS Gloucestershire funded placements out of area. This is a significant achievement and Gloucestershire is bucking the regional and national trends, which has seen significant increases placements in specialist private mental health hospitals out of area.
- A Dynamic Risk Register has been developed across adults and childrens, with clear pathways for blue light meetings and Care and Treatment Reviews (CTRs).
- There has only been 1 new admission since November 2019.
- There are no children or young people in a Tier 4 bed.

5. Joint Commissioning of Specialised Services: New Arrangements For 2023/24

5.1 From April 2023 ICBs are entering into new joint working arrangements and will become *jointly responsible* with NHS England for commissioning specialised services. This is a steppingstone to delegating full commissioning responsibility from April 2024 and recognises the increased role ICBs should be playing in decisions relating to specialised commissioning in the future. Under the proposed arrangement for 2023/24. ICBs will have a stake in decision making regarding the Jointly Commissioned services, but do not assume any responsibilities or liabilities.

5.2 To administer this NHS England and the ICBs will form a Joint Committee. NHS England will still hold the risk for specialised commissioning but the decision making will be devolved by them to this new statutory committee. The responsibility of each ICB is to have a senior decision maker on that committee.

5.3 In terms of the differences this will make for the ICB:

- It will give us more say in specialised commissioning decisions which impact our patients and providers.
- It will allow us to prepare for full delegation (in particular understanding specialised commissioning activity and financial flows for our population).
- It will allow us to begin to align specialised commissioning with Gloucestershire's planning and transformation programmes.

5.4 In terms of our internal governance, it is proposed that the lead ICB Director on the Joint Committee (Mark Walkingshaw, Director of Operational Planning & Performance) provides regular updates and reports into the ICS Strategic Executive. Further engagement with the Board on the implications of this change will take place as the new arrangements are introduced.

6. Research 4 Gloucestershire (R4G)

6.1 Research 4 Gloucestershire (R4G) is a group established to promote research across the ICS. It has membership from local Trusts, primary care, social care, University of Gloucestershire, the NHS Applied Research Collaborative (ARC) for the southwest and the ICB. The group meets monthly to develop and oversee the delivery of the research strategy for the ICS, with the common aim being to develop and support research for the benefit of patients, carers and staff. This work supports the newly publication by NHSE, '*Maximising the benefits of research: Guidance for integrated care systems'*. The R4G priorities for research are currently being developed and will be based on the agreed priorities for the ICS.

6.2 To raise the awareness of the work of R4G and to promote research across the ICS, the county's research leads and R4G members have been running the 'Gloucestershire Festival of Health and Social Care Research' throughout March. The festival took place both virtually and on occasions in person at the Oxtalls campus, with more than 15 different events and over 40 speakers contributing. The festival comprised several presentations on a wide range of research and service topics; this included: Arts, Health & Well-being; Reflective research methods in practice; Research in Ophthalmology; Social Prescribing; Elevating public involvement in research; Social Work & Care; Dementia; Inclusion; Workforce Health; and Supporting Mental Health and Medical Imaging
Research.

7. POD Delegation

7.1 Further to national mandate, from 01 April 2023 NHS Gloucestershire ICB will be expected to take on delegated responsibility for Pharmacy, Optometry and Dental services across the county. The Primary Care team has been currently working with NHSE Southwest, along with the other ICBs in the South West (SW) to ensure the smooth transition of services to ICBs.

7.2 Work has been undertaken to produce an effective Southwest Operating Model to ensure stability and continuity of services during transition. As part of the transition, a Collaborative Commissioning Hub (CCH) is being established to work alongside ICBs during the preparation for delegation up to 31 March 2023 and thereafter as an operational CCH taking commissioning responsibilities and working in close collaboration with the ICBs.

7.3 The Primary Care and Direct Commissioning Committee has been fully involved in the POD delegation developments, with bi-monthly briefings and discussions on the work of the POD project team which was set up in July 2022. A dedicated workshop delivered by Primary Care Consulting (PCC) on the POD services to be delegated to the ICB was held in January this year and attended by committee members. The Committee has reviewed and sign off the POD Safe Delegation Checklist for submission to NHSE in February 2023 and has received updates on the progress towards agreeing the POD Memorandum of Understanding and Delegation Agreement.

7.4 NHSE meetings have been ongoing on a fortnightly basis with ICB finance teams to discuss financial arrangements for delegation. This has included the completion of a Memorandum of Understanding (collaboratively across all ICBs in the SW) and finalisation of the Delegation Agreement. Due to the imminent completion of the MoU and Delegation Agreement both documents will be sent to Board members to consider and approve outside of the Board meeting and an update will be provided at the ICB Board on 29th March 2023. The Scheme of Reservation and Delegation and Terms of Reference for the Primary Care and Direct Commissioning Committee will need to be updated to reflect POD delegation. These documents will be reported to the next ICB Board in May.

8. Extension to GICBs Procurement Strategy document

8.1 The Procurement Bill will reform and replace the existing Procurement Rules known as the Public Contracts Regulations 2015 and are being introduced as a consequence of the UKs decision to leave the European Union. The new procurement Bill is now due to go to the Report Stage following its second reading and Committee stage in the House of Commons (as of 17 March 2023).

8.1.1 The Procurement Bill will introduce the most significant changes to the way public sector organisations buy goods and services for a generation. And although these changes will not come into force until late 2023 at the earliest, and with a six-month advance preparation period, contracting authorities are being encouraged to start planning now to ensure they are ready to take advantage of the new regime.

8.2 **Recommended Preparatory Work**

8.2.1 The UK Government has identified four areas where early consideration and action will assist contracting authorities to forward plan and be able to comply with the legislation once it comes into force:

1. **Processes and Policies**:

Making sure that current processes and procedures are robust on areas such as pre-market engagement and supplier evaluation / assessment with governance documents that record key decisions.

2. **Systems**:

ICB procurement staff to familiarise themselves with the document 'Transforming Public Procurement – Our Transparency Ambition' which outlines the Government's proposals to improve transparency of UK public contracts and spending. Consider the readiness of the ICB to meet new data requirements, including where data currently resides in existing e-procurement systems.

3. People:

Consider the procurement and contract management capability across your organisatio and consider benchmarking the organisation against relevant commercial and procurement operating standards and other comparable organisations, in line with the National Procurement Policy Statement.

4. Transition:

Ensure contract registers and details are up to date. Conduct a review of pipelines to identify planned procurement activity over the next 18 months. Engage with our key supply chain about the new regime and directing them to the Transforming Public Procurement landing page at Gov.UK for further information.

8.3 **NHS Gloucestershire ICB Progress to Date**

8.3.1 Contracts and Procurement staff have been fully briefed on the planned regulatory changes. The ICB is confident that we have taken all necessary steps to comply with the recommended preparatory work as shown above.

The ICBs approach was tested in the recent Contract and Procurement Pipeline Management, Internal Audit Report conducted by BDO Limited. In the final report, dated 19 December 2022, BDO concluded:

"The ICB has begun to consider the impact of the new procurement legislation – the Provider Selection Regime, which is set to be released in the new year. This includes evaluating which areas of the legislation will impact them and to what extent. Additional columns within the contract register and procurement work plan have been added to document actions / information needed for the change".

8.4 **Potential impact of new legislation**

8.4.1 In June 2022, The Cabinet Office published a paper entitled: *Transforming Public Procurement – our transparency ambition*.*

*Transforming Public Procurement -Our transparency ambition (publishing.service.gov.uk)

The paper outlined additional information acquired from both contacting and procurement process stages that 'may' need to be published via a public facing website to comply with the revised transparency requirement of the new procurement legislation. This is likely to include publication of the following:

- Information on (potential) future procurements where the total aggregated contract value exceeds £5M. A 'forward view' of contract opportunities in excess of this value should be shown for a minimum of 18 months but preferably for a period of 3 to 5 years where commissioning intentions are known.
- Details of the Key Performance Indicators applied within individual contracts.
- Details of contract management including performance against KPIs.
- Actual spend data through awarded contracts.
- Contract expiry / termination date information.
- Contract changes (variations) with redactions where permitted.
- Copies of resulting signed contracts with redactions where permitted.

8.4.2 The updated regulations are now at the Committee stage and will subsequently move to the Report stage at the House of Commons and are not expected to become law until the summer of 2023. In view of the delay to the introduction of the above legislation, permission is sought for a further extension to the ICBs Procurement Strategy of 6 months from 1 April 2023 to 30 September 2023.

8.4.3 **The ICB Board is asked to:**
Approve the extension of the ICBs existing procurement strategy document from 1 April 2023 to 30 September 2023.

9 **Chair's and Chief Executive Officer Action – s.256**

9.1 The Board is notified that Chair's and CEO's action was required with regard to agreeing s.256 monies. Section 256 agreements are between NHS Gloucestershire ICB and Gloucestershire County Council and are put in place where better value will be achieved through joint working. Approval was urgently required ahead of the Board due to a number of reasons:

- Late allocations from NHSE for specific funding purposes.
- Finalisation of financial agreements relating to the urgent care diagnostic.
- Unexpected allocations from NHSE which have allowed the ICB to progress several strategic ICP joint programmes with partners.

9.2 The paper was submitted to the Chair and Chief Executive (see attached).

The Chair and Chief Executive authorised expenditure on a number of s256 agreements with GCC. It should be noted that some of the numbers contained in the paper are still being finalised or confirmed but they will not exceed the amounts for the programmes that are outlined in the paper.

9.3 The Board is asked to note that Chair's and Chief Executive action was taken in line the ICB's Standing Orders s.4.4.1 – 4.4.3 (the SOs are contained within the ICB's Constitution). The action taken by the Chair and Chief Executive will be reported to the Audit Committee (s.4.4.3).

10. Recommendation

10.1 The Board is asked to

- Approve a 6th month extension to the Procurement Strategy 1 April 2023 to 30 September 2023
- Note that the POD Delegation Agreement and MoU was sent to the Board members for their approval and an update will be provided at the Board meeting.
- Note the update on the Joint Commissioning arrangements between NHSE and the ICB for specialised commissioning
- Note that the Chair's and CEO's action taken with regard to s.256
- Note the CEO report.

Appendix 1

ICB Chairs & Chief Executive Officer action

1 Introduction

This formalises a request for ICB Chair's action relating to a number of payments to Gloucestershire County Council. The ICB Standing Orders which are incorporated into the ICB Constitution allow for Chair's action to be taken if urgent decisions are required to be taken.

4.4.1 Urgent decisions - In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.4.2 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.4.3 The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

2 Chair's Action

A request for Chair's action was made to the Chair and Chief Executive to authorise expenditure on a number of s256 agreements with GCC, some of the numbers are still being finalised or confirmed but they will not exceed the amounts below for the programmes outlined on the list These s256 agreements represent areas of joint work between the ICB and GCC and are focussed where better value will be achieved through joint working. The request was made on the 21st March 2023 following a discussion between the Chair, Chief Executive and Chief Finance Officer where the proposal was verbally agreed, with a confirmatory e-mail.

The requests below have arisen for a number of reasons:

- Late allocations from NHSE for specific funding purposes
- Finalisation of financial agreements relating to the urgent care diagnostic
- Unexpected allocations from NHSE which have allowed the ICB to progress several strategic ICP joint programmes with partners

	£'m

Digital hubs and digital inequalities programme of work £100k, £150k - digital inclusion \TEC strategy \digital workforce	0.250
D&C - Social Workers in ED & hospital *	0.000
Pilot Social Workers in ED/ Weekends & Evenings	0.200
Fit out costs in Shire Hall **	0.375
ICP Programme of work via GCC	0.300
ICP blood pressure prevention work	0.200
Children in care/care leavers	0.200
Section 256 UEC Diagnostic Contribution	2.000
Section 256 UEC Diagnostic Contribution	2.000
ICES	0.690
Funding for transformation of brokerage systems including reporting	0.200
Autism/neurodiversity service redesign including assessments & waiting list reduction	0.675
Information sharing arrangements between ICB and GCC, PHM and other	0.100
Bed based reviews D2A beds, LOS reduction	0.350
Green travel plans: EV collaboration focus	0.150
Section 256 UEC Diagnostic Contribution: GHFT – to be confirmed	1.000
Digitising social care	0.630
CYP weight management	0.190
	9.510

* removed as covered through another agreement already in place
**** reduced from original value of £0.45m to £0.375m
*** increased from original value of £0.6m to £0.675m.

Agenda Item 9

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**Integrated Performance Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	N/A						
	ICB Internal	**Date**	**System Partner**	**Date**			
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for March 2023. The report brings information together from the following four areas: • Performance (supporting metrics report can be found here) • Workforce • Finance • Quality The report includes assurance pages from each of the relevant ICB Committees relating to their part of the IPR, a headline summary from each of the areas above and a more detailed breakdown of progress within the remainder of the document. We are continuing to evolve the Integrated Performance Report. Taking on board feedback received we will be looking to develop the report in the following areas: 1. Structure sections of the report (particularly performance) around the strategic themes described in the (forthcoming) Joint Forward Plan so that we can assess progress in delivering our priorities. 2. Incorporate information on our key strategic schemes that describe the work we are undertaking to deliver improved outcomes and performance (aligned to the strategic themes in the forthcoming Joint Forward Plan) 3. Ensure that the measures and trajectories for 2023/24 as confirmed in operational planning are incorporated into the plan so that we are assessing progress in delivery. 4. Ensure there is visibility in the report of the relevant health inequalities measures (from Core20PLUS5) – most of which are already included in the supporting metrics report.						
Key Issues to note	Areas of key exceptions have been included at the front of the Integrated performance Report.						

<table>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The Integrated Performance Report (IPR) provides an overall summary of the current position of health and social care in Gloucestershire. Issues in delivery will have an impact on our ability to deliver against the priorities for the health and care system that we have committed to.

It will also have an impact on our ability to deliver against the NHS Oversight Framework and influence segmentation decisions made by NHS England.

There is a close link between the risks within the BAF and delivery of our objectives through the Integrated Performance Report.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">None</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">See financial section of the report.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The ICB has a statutory duty not to exceed the revenue resource limit set by NHS England.

The Integrated Performance Report will be used to inform regional discussions as part of the NHS Oversight Framework.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">This report includes specific analysis that has been carried out on the elective waiting list (based on a snapshot at January 2023).

Initial analysis suggests higher use of elective care from the Core20 population group compared to the wider Gloucestershire population in line with expectations due to the population health of this group. There are no obvious differences between waiting times for any ethnic or deprivation group compared to the wider population.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">See above section on health inequalities.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">None</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">The Integrated Performance Report (Quality section) currently provides information on patient and public feedback.</td></tr>
<tr><td>Recommendation</td><td colspan="4">The Integrated Care Board are asked to:

Discuss the key highlights from the Integrated Performance Report
identifying any further actions that may be required</td></tr>
</table>

Author	**Kat Doherty (Performance)** **Clare Hines (Workforce)** **Stephen Edmonds (Finance)** **Rob Mauler (Quality)** **Mark Golledge (PMO)**	**Role Title**	**Senior Performance Management Lead** **Workforce and OD Project Lead** **Finance Programme Manager** **Senior Manager, Quality & Commissioning** **Programme Director – PMO & ICS Development**
Sponsoring Director (if not author)	**Mark Walkingshaw, Director of Operational Planning & Performance – NHS Gloucestershire ICB** **Tracey Cox, Interim Director – People, Culture & Engagement – NHS Gloucestershire ICB** **Cath Leech – Chief Finance Officer – NHS Gloucestershire ICB** **Marion Andrews-Evans – Chief Nursing Officer – NHS Gloucestershire ICB**		

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

NHS

Integrated Performance Report

March 2023

Please note – this report will be a public report

@One_Glos
www.onegloucestershire.net

System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	12 January 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
System Performance – Planned Care and Productivity	**Limited**	Reviewed position of waiting list for elective treatment, acknowledging that specialties with largest waiting lists and longest waits tend to be areas with workforce challenges.		March 2023
System Performance – Urgent & Emergency Care	**Limited**	There has been significant increase in pressure across the majority of UEC services over Christmas impacting on performance. This has also been impacted by COVID, flu and STREP A as well as nursing/residential home closures.	Newton Diagnostic completed and key workstreams identified and being moved forward. Programme of work to be further defined. Funding has been awarded to support hospital discharge and system flow to Gloucestershire.	March 2023
System Financial Position 22/23	**Limited**	The system is currently forecasting a break even position for the end of year. There is currently a system financial deficit at Month 8 of £2.0m.	Discussions were held about mitigations that are underway and plans to bring the system back into financial balance by the end of the financial year.	March 2023
Operational Planning & 5 Year Planning – including prioritisation framework	**Significant**	Planning guidance was published in December covering Operational Planning and Financial Planning as well as the Joint Forward Plan. Work is underway to triangulate performance, workforce and finance ahead of submissions February and March.	Discussions were held about work underway to ensure planning timelines are delivered. Operational plan submissions will be due at the end of March. The Joint Forward Plan will be produced in draft by end of March / end of June for final.	March 2023 – June 2023
System Resources Committee Risks	**Limited**	The Committee reviewed the Strategic Risks confirmed at ICB relevant to System Resources Committee. Discussion was held on the risk appetite and arrangements for reporting against the Strategic Risks. The Committee also asked that there was close alignment with partner Board Assurance Frameworks.	Actions to be put in place to report the relevant Strategic Risks to System Resources Committee.	March 2023

Assurance Level	Colour to use in risks/actions below
Not assured	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	We are assured appropriate action plans are in place to address any gaps
Significant	We have a high level of confidence in delivery of existing mechanisms / objectives
Full	Delivered and fully embedded

Issues referred to another committee

Topic	Committee
None	

People Committee

Accountable Non-Executive Director	Tracey Cox
Meeting Date	12 January 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
On-going threat of industrial action	**Limited**	Risk of further industrial action by nursing and ambulance staff (strike action since suspended pending talks). Potential Junior Doctors strike action (now confirmed for Mon 13-16 March)	Continue to work with EPRR and Operational teams to ensure local Business continuity management plans are in place.	On-going strike action is from Dec 2022 to May 2023 (or June 2023 for BMA)
Inadequate workforce supply & recruitment of health and social care staff across a variety of roles and settings	**Limited**	All organisations continue to focus on a range of recruitment initiatives including recruitment events and international recruitment.	Continue to scope development of system wide campaign highlighting the benefits of working and living in Gloucestershire	April/ May 2023
Band 2/ band 3 HCSW potential pay re-banding	**Limited**	Response to national Employers guidance and profile review of Band 2 and band 2 HCSW roles and implications for local staff currently undertaking these roles.	Continued assessment of roles impacted across the system and financial impact.	Quarter 1 of 2023/24 for work to be completed.
Cost of living impact on staff	**Limited**	Continued negative impact on staff morale and wellbeing due to negative impacts of rising costs	Range of initiatives in place to support staff. Scoping work on other options delayed due to other work pressures.	March 2023

Assurance Level	Colour to use in risks/actions below
Not assured	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	We are assured appropriate action plans are in place to address any gaps
Significant	We have a high level of confidence in delivery of existing mechanisms / objectives
Full	Delivered and fully embedded

Issues referred to another committee

Topic	Committee
None	

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	16 February 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Safeguarding Training	**Limited**	There is an issue with the recording of training compliance of staff undertaking safeguarding training greater than level 2 on the ESR system. There is also the need for all staff including board members to undertake safeguarding training.	A training needs analysis has been undertaken for the ICB. Staff required to take training above level 2 will be informed how they can capture/record multi-disciplinary safeguarding training on consult OD as a part of their appraisal process The Safeguarding staff in the Trusts and ICB are developing training specifically for board members in all 3 organisations that they can do together virtually.	May
Gloucestershire Out of Hours service	**Limited**	The Committee was updated on the progress and response from PPG to their latest CQC inspection. The ICB was able to demonstrate the work underway to provide limited assurance on progress.	The ICB continues to meet with the provider to seek interim assurance. The Deputy CNO has visited the PPG base and examined their processes and progress with the improvement plan. Further visits are planned.	April
Delay related harm in a community setting	**Limited**	The committee received a full update on delays in community settings and how it impacts patients safety and well-being.	A small working group is to be set up to bring an update back to the next Quality Committee.	April

Issues referred to another committee

Topic	Committee
None	

Assurance Level	Colour to use in risks/actions below
Not assured	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	We are assured appropriate action plans are in place to address any gaps
Significant	We have a high level of confidence in delivery of existing mechanisms / objectives
Full	Delivered and fully embedded

Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- Significant reductions in the number of patients waiting over 6 weeks for echocardiography have been achieved through increasing capacity within the service. This will continue to have a positive impact on the overall waiting time performance for diagnostics as the backlog is cleared.
- Good progress continues to be made in reducing the number of long elective waits – Gloucestershire providers continue to have no 104 week waits for elective care.
- Ambulance category 2 response times and ambulance handover delays at GHFT have reduced substantially since mid-January – the trajectory for handover times to be reduced was met in February and Category 2 response times were just over the 30 minute target at 32.6 minutes.
- A digital provider for virtual wards has been contracted, with implementation of increased capacity due to begin in the coming months.
- The non-specific symptoms pathway for suspected cancer has now been rolled out to 75% of Gloucestershire PCNs with full countywide roll out projected to be completed from the beginning of the 23/24 financial year.

Areas of Focus

- Elective recovery – the system is currently ensuring that all objectives for 22/23 will be met by March 2023. This includes revising counting and coding changes with NHSE to reflect an accurate baseline position.
- The Newton Europe Urgent Care diagnostic is now informing the UEC operational planning for 23/24. Key workstreams are now underway.
- Primary care appointments remain at high levels – with very high levels of demand from the public. The system is exploring how to support colleagues and patients to ensure staff are supported and that patients are able to access the care they need.
- IAPT referrals continue to be below the levels required to meet the ambition for IAPT access in the system however have increased slightly in January. The service is exploring workforce diversification and marketing initiatives to improve the resilience of the service and experience for patients.

Please note the full set of measures and progress against the agreed trajectories is available here.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

- Completion and submission of DRAFT 23/24 operational planning workforce submission (data template & narrative)
- Completion of year end financial forecast for HEE & NHSE&I funded projects
- Submission of Stay & Thrive Innovation Funding PID for a system wide induction event for international recruits. Collaboration and co-ordination with GHFT's and GHC's related bids. All 3 were successful - £3k each.
- One Gloucestershire People Strategy and Health & Wellbeing strategy workshops held.
- Co-ordination & facilitation of system wide collaborative meetings held for My E Coaching platform, Legacy Mentoring, jobs fairs/recruitment events, International Recruitment, staff Health & Wellbeing and temporary staffing.

Areas of Focus

- Continued preparation for industrial action following confirmation of strike action by Junior Doctors.
- On-going engagement to support the development of a One Gloucestershire People Strategy.
- On-going co-ordination and facilitation of system wide priorities and HEE/NHSE&I funded projects (12 currently active)
- System wide review of Staff Survey results at next People Board in April

Please note: The Quality report is updated bimonthly.

Quality

Quality – Safety, Experience and Effectiveness

Key Achievements

- Regional discussions have commenced on how ICBs might be able to link quality frameworks so that we are able to better share intelligence and information between the ICB, Trusts, Primary care and social care.
- System Quality Committee have approved new policies in relation to Section 117 of the Mental Health Act and Safeguarding Adults.
- We have seen improvements in the CQC maternity user survey, with service users reporting that access to midwives and services were good. This feedback has helped raise staff morale amidst the current challenges in Maternity.
- The ICB has agreed to be a pilot site with the AHSN as they roll out the Black Maternity Matters programme to improve outcomes and experience for BAME mothers and their babies.
- The ICB has been selected as a demonstrator site for vaccine inequality initiative.

Areas of Focus

- To support rollout of the Patient Safety Incident Response Framework we have designed an event planned for 28th March in conjunction with the AHSN.
- Work is underway to better understand mortality data to address concerns that GHFT is a national outlier in relation to Standardised Hospital Mortality Indicator (SHMI). This will be linked with new population level data coming from NHSE.
- Pharmacy, Ophthalmology and Dental (POD) are due to transfer from NHSE to the ICB this year. The ICB remains concerned about the lack of information in relation to quality, safety and safeguarding.
- There is an increase in focus by CQC on adult social care assessments. From April to September there will be a data review and intelligence gathering review of local authorities. GCC have been gathering evidence and undertaking a detailed self-assessment in preparation.

Finance and Use of Resources

Finance

Headline Summary

- All NHS organisations within the Gloucestershire System are forecasting delivery of a break-even financial position at year-end which is in line with the plan. There remain some uncertainties and risks within each organisation, these are believed to be manageable within the position. A number of pressures have arisen in the ICS, with the most significant being in GHFT. The recurrent impact of each organisation's position is being included in planning for 2023/24.
- Within the ICS year-to-date (YTD positive position of £1.6m, GHFT has a favourable variance to plan of £1.5m which is due to a number of factors including a reduction in anticipated COVID costs.
- GHFT has had a Financial Recovery Programme running for a number of months, led by the Director of Finance, and this forms part of the Recovery Programme which forms part of the 2023/24 planning process across the ICS.
- The ICS Financial Improvement Plan has been updated for additional in-year mitigating actions by the System including the further actions agreed by Board in September to help mitigate the financial pressures within the system.
- Key risks in the ICS's financial position are:
  - Under-delivery of savings and efficiency plans
  - Workforce pressures leading to increased expenditure on agency and locum staff
  - Elective activity and recovery performance
  - Inflation – pay and price; one significant element of this is No Cheaper Stock Obtainable (NCSO) within the ICB's Prescribing budget, which is continuing to show a forecast pressure of £3.0m.
  - Demand and growth pressures; specifically for CHC (work ongoing still to understand true extent of this) and children's placements
- Within the ICS's capital envelope, capital expenditure is due to break-even against the budget for the year, which was set based on the original capital plan. Additional allocations have now been received for a number of schemes for both GHC and GHFT, and which now show as forecast variances.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Our Themes

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)

@One_Glos
www.onegloucestershire.net

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- Emergency Department (ED) type 1 performance in February 2023 was 59.7% against the 4 hour target. Whole system performance including Type 3 (MIIU) attendances was 74.1% in February. Gloucestershire system ranked 14/41 ICSs with Type 1 ED activity nationally.

- Ambulance handover delay performance has significantly improved since the New Year with an average of 67 hours/ day lost in February 2023. This met the target for planned improvement (which was to achieve an average of 75 hours lost daily) and has supported the continued improvement in Category 2 ambulance response times which averaged 32.6 minutes in February (down on 37.4 minutes in January).

- Additional funding from the national discharge fund has been successfully used to block purchase home based care via collaborative working with GHC and brokerage. This has helped to improve capacity and assisted flow through the acute with a reduction in long stays and patients with No Criteria to Reside (now an average of 190 patients with NCTR, down from previous levels of ~250). The improved flow in the acute hospital is also supporting the continued strong performance improvements in ambulance response times and handover delays.

- Winter investment schemes have had a clear impact mitigating the impact of increased demand over the winter period. These have included: The Community Assessment and Treatment Unit (CATU) to aid admission avoidance, Virtual ward expansion to offer a home alternative to hospital admission, Discharge to Assess ward at Kingham Unit to aid rehabilitation, A new discharge waiting area at GHFT, Additional escalation capacity (Prescott Ward) at CGH), Increased Social Work capacity in the acute hospitals (with further recruitment planned to support evening and weekends additionally). A winter review is planned for later April to inform transformational work as well as supporting the process for 23/24.

- The Newton Europe Urgent Care diagnostic key workstreams are now underway, with impact being modelled into the operational plan for 2023/24.

- Virtual wards are continuing to provide alternatives to hospital based care with the respiratory and COVID wards successfully helping avoid admissions and facilitate discharge throughout winter. Further test and learn cycles are being carried out across a number of medical and surgical specialties, beginning with heart failure, as alternatives to admission. A new digital provider contract has been awarded which will start to be implemented in Q1/Q2 of 2023/24 – significantly increasing virtual ward provision in the county.

Improving Services & Delivering Outcomes

Elective Care

- The waiting list for elective care in Gloucestershire is currently running at 69,448 with the majority waiting at GHFT. 72.1% of the RTT waiting list had been waiting less than 18 weeks in January (against a target of 92%), with 1674 patients waiting over 52 weeks, 87 waiting over 78 weeks and 3 (all out of county) waiting over 104 weeks. GHFT is on target to meet the national expectation that 78 week waits will be eliminated by the end of March 2023 (some over 78 week waits for Gloucestershire patients may occur at out of county providers).

- The operational plan for 23/24 has prioritised elective recovery, in particular the reduction of long waits for elective care with the ambition to eliminate 65 week waits by March 2024. The system plans to deliver additional activity/productivity to achieve this, with an expected increase in 52 week waits temporarily seen while longest waits are reduced.

- 2 new theatres and day surgery unit at CGH will open in September 2023 which further increases ringfenced elective capacity ahead of winter. Further capital bids to support elective activity have been awarded (7.5 million for an additional orthopaedic theatre at CGH in the next 2 years).

- Recovery of weighted cost activity for the Elective Recovery Fund target is currently expected to achieve the 104% target by March 2023. For 2023/24, an ambitious target of 109% recovery against 2019/20 activity has been set nationally. As a system we are expecting to meet these requirements in our elective recovery plan. *N.B. There are discussions ongoing with NHSE to resolve the baseline position for 2019/20 which is currently showing an inflated position due to counting and coding changes – this results in underreporting of system recovery rates.*

- Theatre utilisation rates are improving – future lists are booked above 85% at GHFT. National expectations around day case ratios are targeting 85:15 (Day case: Inpatient activity). A system visit (GHFT/ICB) has been planned to Devon Nightingale Orthopaedic centre to learn and replicate the hip and knee day surgery process in order to support increased day case rates at GHFT.

- A project is underway to improve the pre-assessment process ahead of surgery, learning from best practice in the South West to support efficiency and patient experience.

- We have commenced a programme of work to understand the impact of health inequalities upon access to services and ensuring that elective recovery is equitable across our system. Initial findings are appended to the performance report and further work will be published as available.

Improving Services & Delivering Outcomes

Cancer

- Performance against the majority of Cancer Wait Times targets failed to meet performance thresholds in January 2023. 2 week wait performance decreased slightly to 84.1% in January 2023 (down from 86.7% in December). There were a total of 509 breaches with the majority being found in lower GI, suspected skin cancers and suspected breast cancers. 31 day treatment failed to meet the 96% target with performance at 92% in January. 62 day treatment performance was 58.9% - driven primarily by Urology (where only 25% of patients were treated before 62 days). This is due to bottlenecks in the Urology pathway meaning that both 62 and 104 day waits have been rising in these specialties – additional clinics were carried out in January (hence the rise in reported breaches).

- A new trajectory to reduce the number of over 62 waits on the cancer PTL is being agreed as part of the 23/24 planning process – this will have a target of no more than 175 patients over 62 days on the cancer by March 2024. Currently (as of 5th March) the position is 224 patients waiting over 62 days. N.B. not all patients on the cancer PTL will be diagnosed with cancer – some patients waiting past 62 days are waiting for a final confirmation that cancer has been ruled out.

- The non-specific symptoms pathway has now been rolled out to 75% of Gloucestershire PCNs with referrals rising in line with modelled expectations. Full roll out of the pathway countywide is expected to be completed in early 23/24, with projections of around 2% of cancer referrals using the pathway by the end of 23/24.

- In line with national ambitions, focus on increasing use of faecal immunoprecipitation testing (FIT) prior to Lower GI 2 week wait referral is underway – with planned increase in Lower GI referrals accompanied by a FIT test to 80% (from 64% currently). This will ensure patients are not subject to invasive tests unnecessarily and assist with improving the wait times for the Lower GI specialty (currently a key driver of lower performance against cancer wait times targets).

- Work exploring early diagnosis and opportunities to narrow gaps associated with deprivation (in particular the Core20 population) is underway with work initially focussing on access to cancer services. Initial findings focussing on the make up of the cancer patient list have been presented to the ICB board and will be refined for further analysis and updates in the coming months.

Improving Services & Delivering Outcomes

Primary Care

- Patient demand for GP surgery services in the county continues to be extremely high, with practices seeing a significant increase in contacts since 2019. Appointment volume was the highest on record in October 2022 with 406,275 appointments recorded in Gloucestershire GP practices (this includes GP and other clinical staff, face to face, virtual and telephone appointments) and remained high at 370,840 appointments delivered in January 2023. Gloucestershire continues to see a higher proportion of patients face to face compared to the national average.

- The Autumn Booster (2022) phase of the Covid-19 Mass Vaccination programme has now closed having delivered 248,823 doses to eligible cohorts. Overall vaccination uptake in Gloucestershire (primary course) is 81.7%, and uptake of booster (for those eligible) reached 73.8%, higher than the national average of 70.2%. Guidance is awaited from the JCVI around a Spring 2023 booster campaign.

- Work is ongoing for delegation of pharmacy, optometry and dental services to Gloucestershire ICB for 23/24 – a draft plan has been submitted to NHSE.

NHS111

- High demand for NHS111 call centres and online services that was seen in the run up to Christmas 2022 (driven by Strep A concern, and increased COVID and Influenza infections) did not continue into 2023 with January activity levels falling to seasonal average.

- Call answering performance has stabilised however both average time taken to answer calls and call abandonment rates have been higher than target levels throughout 2023 to date.

- Regional call management centre project is underway to have a single centralised South West call centre for NHS111 to improve resilience. This will continue to have access to directly bookable alternatives to referral to ED/ ambulance where appropriate via the Directory of Services (DoS).

Improving Services & Delivering Outcomes

Diagnostics

- Additional echo insourcing capacity has been established which has now started to have a significant impact on the waiting list – a reduction of over 1000 patients has been seen on the echocardiography waiting list since October, and now only 394 patients are waiting over 6 weeks for echocardiography (at the end of January 2023). Activity planned for this test will ensure that the backlog is cleared by the end of March 2023

- Funding for the Community Diagnostic Centre (CDC) at Quayside House has now been confirmed – with the new hub in Gloucester city due to be fully operational by October 2023. CDC delivery structure agreed and established with working groups set up and meeting. Additional capacity across Non-obstetric ultrasound, CT, plain film x-ray and MRI is already operational, with additional Echocardiography due to come on line throughout 2023.

- Diagnostic test activity has increased in January compared with December – (20,629 vs 18,054 tests carried out across the 15 key modalities). The waiting list has continued to decrease with 9,244 patients on the waiting list at the end of January 2023.

- Waiting times for tests continue to improve (predominantly due to the clearance of the echocardiography backlog), with 13.5% of the waiting list was waiting more than 6 weeks at the end of January 2023. Performance targets for 23/24 are to reach a position of no more than 15% of patients waiting more than 6 weeks for each diagnostic test. Both the ICB and GHFT are already meeting this target overall, however Endoscopy has a higher percentage of patients waiting more than 6 weeks currently. The endoscopy recovery programme at GHFT will support continued improvements in waiting times for these tests throughout 2023/24 in order to meet the target.

- Reporting times for imaging tests at GHFT are currently 4-6 weeks, which is not routinely monitored as a performance target, but may be into 2023/24. GHFT are in discussions to outsource some imaging reporting to support reductions in these waiting times.

Improving Services & Delivering Outcomes

Adult and Children's Mental Health

- Out of Area Placements remain above planned levels with 950 days declared in 22/23 YTD (April-January) – and 125 new days declared in January. The total for the full 2022/23 year plan is 800 and although the national ambition for this target is 0, this is extremely challenging to balance the needs of a patient for urgent treatment, with system flow and bed availability. Plans for 23/24 reflect this, with 800 days projected for the 23/24 financial year (with the rate reducing each quarter). This will be supported though increased focus on discharge and flow in the system - GHC have been working in collaboration with three VCSE organisations (Young Gloucestershire, POhWER and Independence Trust) to help 'bridge the gap' between inpatient care and community support. They are facilitating more timely and effective discharges from our mental health inpatient units.

- Improving Access to Psychological Therapies (IAPT) access has been below the planned levels throughout 2022/23 – 1113 people accessed the service in January against a target level of 1186. Referral volume continues to be below the level needed to meet this target, however has increased in January (with access figures projected to rise in February 2023 as a result). The service has also struggled to recruit the projected number of trainees required to expand the service. Both referral volume and difficult recruiting are issues that are currently are being experienced across the South West and the service is exploring ways to diversify the workforce and offer additional choice to patients to improve uptake.

- Eating disorders - All waiting times targets for routine and urgent CYP and Adult referral to treatment were missed in January, however the service was able to assess all urgent referrals within one week. There are currently 91 routine adolescent clients on the assessment waiting lists, compared to 180 at its highest peak in June 2022. The overall Eating Disorders caseload is now 998, compared to 1386 at its highest peak in July 2022. Alternative services are offered to people on the waiting list wherever appropriate with TiC+ (for routine referrals), BEAT (for those awaiting family based therapy) and ORRI (for CYP requiring treatment) all offering either treatment or support to patients outside of the eating disorder service at GHC.

- The Mental Health Investment Standard is projected to be achieved, which has supported the increased access to mental services in 22/23. Additional investment is planned for 23/24 to ensure targets around perinatal access, CYP mental health access and IAPT access (in line with the Long Term Plan expectations) are achieved.

Improving Services & Delivering Outcomes

Maternity

- Performance against key trajectories for stillbirth, neonatal deaths and brain injury continues to meet the targets set in the Long Term Plan, with current brain injury and neonatal death (for babies born after 24 weeks) under 1/1000, and stillbirth rates at 1.5/1000 births (against a target of 2.5/1000) as of January 2023.

- Cheltenham Birth Unit and Postnatal beds at Stroud Maternity Hospital continue to be closed due to staffing issues. An assessment will be completed in April to review opening these settings. The Continuity of Care pathway expansion has been paused, again due to staffing levels. Current provision continues to support 8.5% of pregnancies (22/23 YTD), with the majority of women from ethnic minorities or deprivation deciles 1 and 2 – who are most likely to benefit from the approach.

- Work around Smoking Cessation continues, with a systemwide smoke free pathway being developed. A Smoking Cessation Lead Midwife has been appointed and will start in the role in May 2023. Smoking in pregnancy training has now been incorporated into mandatory training, including using CO monitoring at every contact. An additional maternity support worker role will provide additional support to women in areas with high smoking rates. This will be rolled out as a quality improvement project, to assess impact as the role commences.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Appendix 1

Waiting list analysis (snapshot January 2023)

@One_Glos
www.onegloucestershire.net

Improving Services & Delivering Outcomes

Appendix: Waiting list analysis (snapshot January 2023)

Analysis

- Elective waiting list for Gloucestershire ICB (all specialties at all providers).
- Considers deprivation (defined by standardised comparison of Core20 population to whole Gloucestershire population).
- Considers Ethnicity (currently unstandardised).

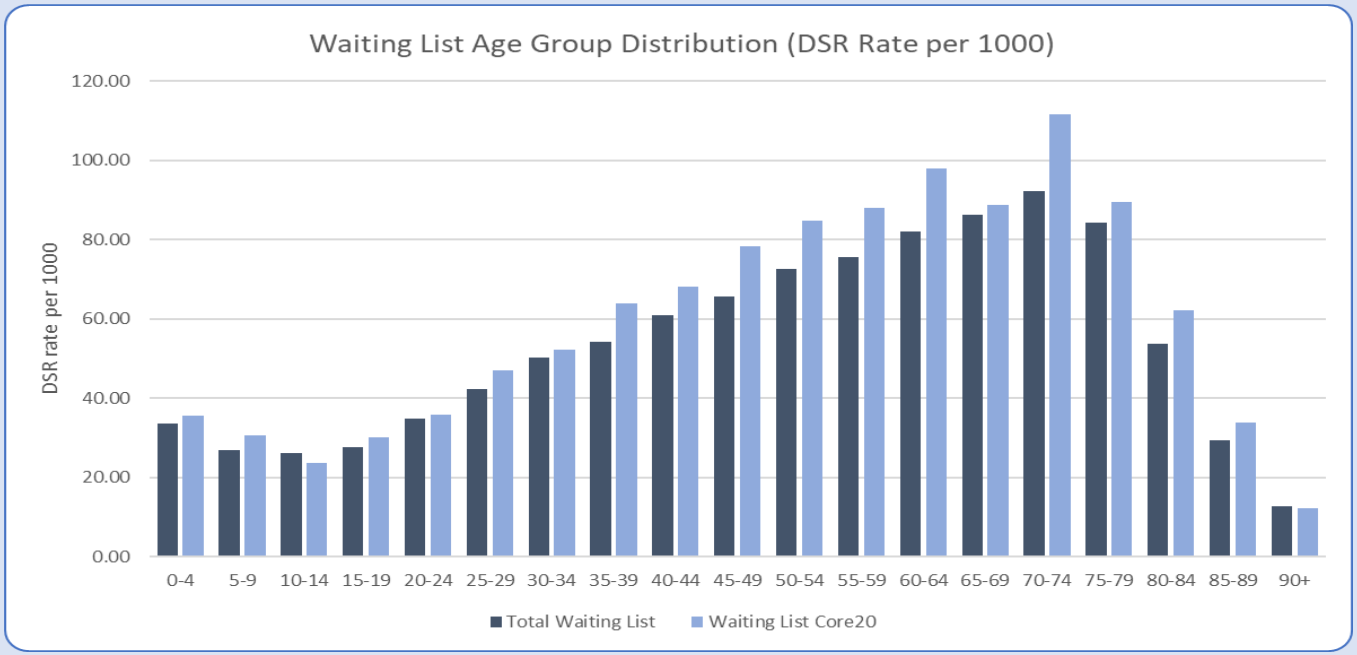
Caveats

- Carried out at a fixed point in time (date of snapshot – January 2023).
- Does not consider severity of patient/ prioritisation or reason for referral.
- Considers each referral as a separate count (i.e. patients on multiple waiting lists will be counted on each list).
- Does not account for ethnicity variation in Core20 population.

Improving Services & Delivering Outcomes

Analysis: Deprivation

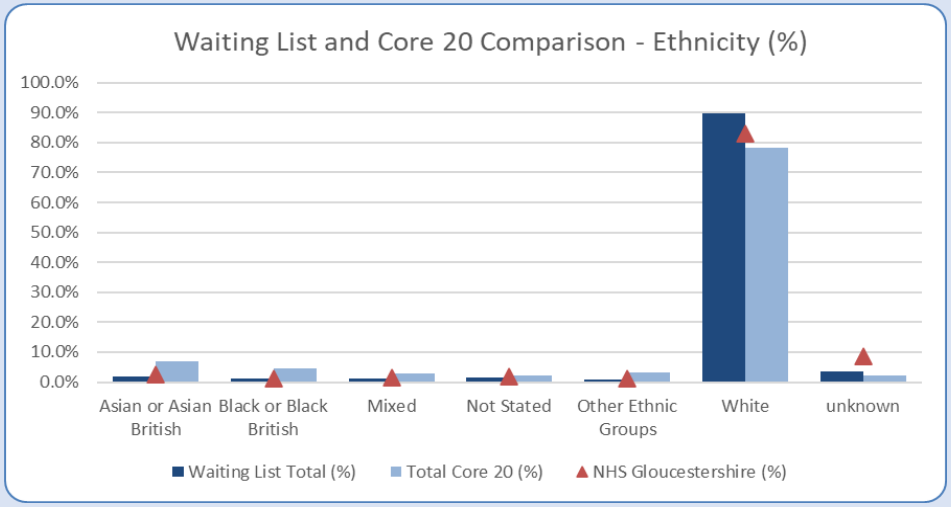
- The Directly Standardised Rate (DSR) per 1000 population of those in the Core20 group was 113.5 compared to the total waiting list of 101.2 DSR per 1000 population. Suggests health needs of the Core20 group are higher – particularly in older age groups:

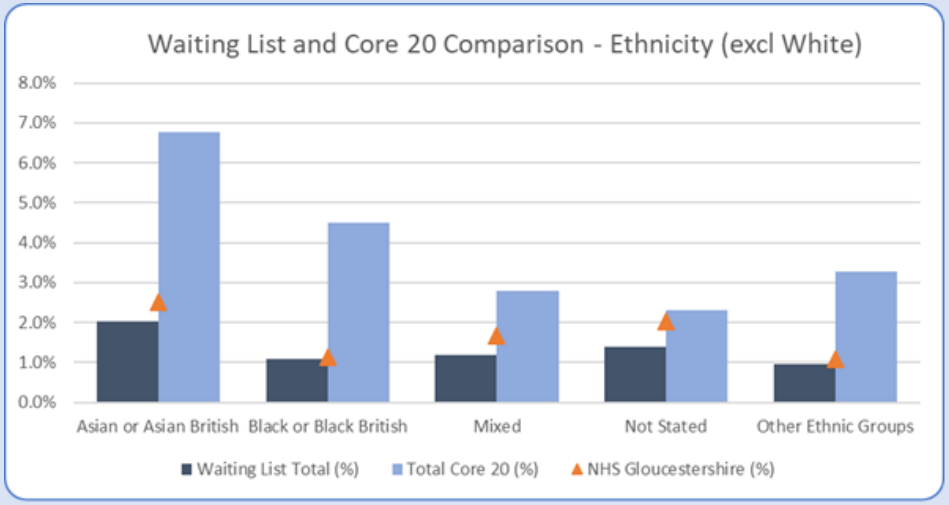


Improving Services & Delivering Outcomes

Analysis: Ethnicity

- There was a higher percentage of white ethnic groups in the total waiting list cohort (89.7%) compared to the Core20 group (78.2%).
- The ethnic make-up of the two cohorts shows a higher number of Asian/Asian British in the Core20 group (67.7 per 1000 population) compared to the total waiting list group (20.15 per 1000 population).





Improving Services & Delivering Outcomes

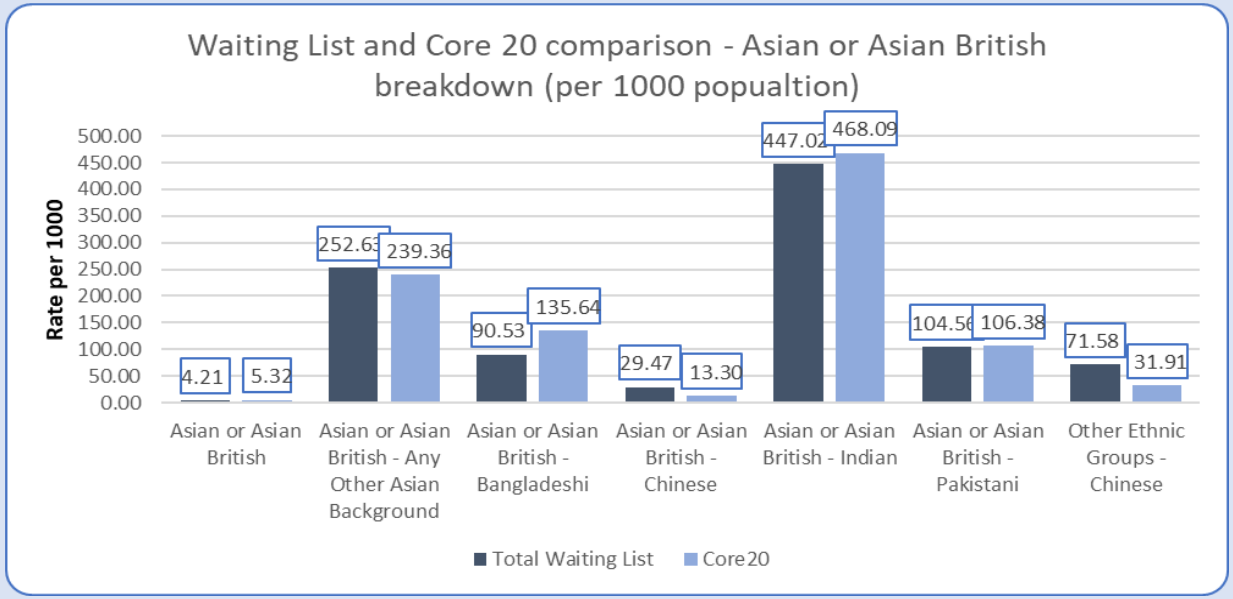
Analysis: Ethnicity

- When breaking this down further the largest difference is shown in the rate of Bangladeshi patients in this group (135.64 per 1000 population) compared to the total waiting list (90.53 per 1000 population).

- When looking at Bangladeshi patients in isolation and looking at the speciality split the biggest differences between the total waiting list and the core20 group were in respiratory medicine service where 9.8% were waiting in the core20 group compared to 4.7% in the total waiting list. Incidence and mortality rates from respiratory disease are higher in areas of social deprivation leading to worse health outcomes (NHS England).

- In Gloucestershire 15.5% of the most deprived decile have a respiratory condition compared to 9.9% of the Gloucestershire total between January 2022 and December 2022 (Respiratory CPG dashboard).

- The Colorectal service also showed 7.8% Bangladeshi patients waiting in the core20 group compared to 3.1% in the total waiting list group.



Improving Services & Delivering Outcomes

Analysis: Waiting Time (Weeks)

- There were no significant differences in waiting weeks between the total waiting list and the Core20 cohort (p>0.05). This is also true when splitting the waiting list down and isolating age groups under 18 (p>0.05), 18-64 (p>0.05) and over 65's (p>0.05).

Waiting Bands

Waiting Week Band	Total Waiting List			Core20		
	Total	Waiting List Total (%)	Crude rate per 1000	Total Core 20	Total Core 20 (%)	Crude rate per 1000
0 < 18 Weeks	47,096	66.6%	665.6	3,658	65.9%	659.0
18 < 26 Weeks	8,857	12.5%	125.2	717	12.9%	129.2
26 < 40 Weeks	9,016	12.7%	127.4	752	13.5%	135.5
40 < 52 Weeks	3,718	5.3%	52.5	269	4.8%	48.5
52 < 78 Weeks	1,877	2.7%	26.5	142	2.6%	25.6
78 < 104 Weeks	121	0.2%	1.7	12	0.2%	2.2
104+ Weeks	69	0.1%	1.0	1	0.0%	0.2

- Waiting time analysis was also carried out looking at ethnicity – again, no significant differences were seen in wait times for the current snap shot.

Improving Services & Delivering Outcomes

Summary

- Initial analysis suggests higher use of elective care from the Core20 population compared to the wider Gloucestershire population in line with expectations due to population health of this group.
- No obvious differences between waiting times for any ethnic or deprivation group compared to the wider population.
- Further work on standardisation required to understand impact of ethnicity (bearing in mind population differences between Core20 and total Gloucestershire populations).
- Further work on specialty level analysis for elective waits and outcomes is planned, also focussing on links to long term condition management and use of emergency care.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Our Themes

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)

@One_Glos
www.onegloucestershire.net

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People

Our local work plan continues to be based around the key pillars within the national People Plan

Growing for the Future

- International recruitment – approval given by NHSE for funding support for on-going nurse recruitment for 2023/24 (80 nurses for GHFT and 15 mental health nurses for GHC).

- One Gloucestershire Allied Health Professional recruitment and showcase event being held on 22nd March 2023 in conjunction with University of Gloucestershire.

Looking After Our People

- Health & Wellbeing Workshop took place on 10th March 2023 to begin scoping a joint vison and areas for collaborative working.

Belonging in the NHS

- System wide Reciprocal mentoring programme - delay to launch of programme due to Industrial action

- Inclusive Leadership training mobilised for all ICB staff

New Ways of Working

- Optioneering workshop held with HEE and system partners on future nurse recruitment pipelines

- Development of draft proposals for Health Education England Monies for 2023/24 pending confirmation of next year's allocation.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Our Themes

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)

@One_Glos
www.onegloucestershire.net

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality: Assurance

Community and Mental Health

- The Trust continues to make good progress with the actions arising from the CQC core inspection. The Trust wide action plan is 66% complete with 34% on target for completion within agreed timescales. For services not inspected in 2022, a programme of peer review and self-assessment work is being undertaken to provide support and assurance that these services are meeting regulatory requirements.

- A piece of "closed culture" related analysis work has been undertaken by the Trust in regard to its services to highlight high risks areas and identify how the Trust will monitor, safeguard, and mitigate against the risk of a potential closed culture.

- Data relating to long length of stay in community hospitals continues to be monitored by the Trust with acknowledgement of the detrimental effect that prolonged hospitals stay have on patients. Due to flow and capacity challenges across the system, the Trust report that they are often seeing delayed discharge and are completing a focused piece of work around delay related harm.

Urgent and Emergency Care

- Work continues 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.

- The transformation programme is owned and led by Gloucestershire with support from Newton to provide capacity, experience and expertise. The potential for system working to improve the quality, experience and outcome for the patients has been recognised and demonstrated through the results of the recent work of the UEC CPG.

- However, significant challenges remain across UEC and current delivery workstreams. Each workstream has clear targets, outcomes and benefits but it was recognised that there needed to be quality indicators as well. Work has now commenced with Newton to develop patient outcome measures for the UEC work programme.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality: Assurance

Primary Care

- **PPG** - The ICB are proactively taking a number of steps to address the recommendations in the CQC report. A detailed action plan has been developed and being implemented, we are closely monitoring delivery and reviewing progress against the recommendations with regular assurance meetings taking place between the ICB Quality team. Two site assurance visits to the PPG OOH base have taken place to monitor progress with service improvements.

- **POD** - The ICB Quality Directorate are also supporting preparations for POD delegation which includes the completion of the Safe Delegation Checklist (SDC). Concerns remain regarding the unanswered queries that have been submitted to NHSE and the lack of information regarding quality, safety and safeguarding amongst the POD providers in county. The ICB have been invited to attend a meeting with NHSE POD Delegation Quality colleagues to discuss a recently circulated draft Quality Framework and will continue to work with NHSE to develop this as we move towards full delegation status.

Maternity

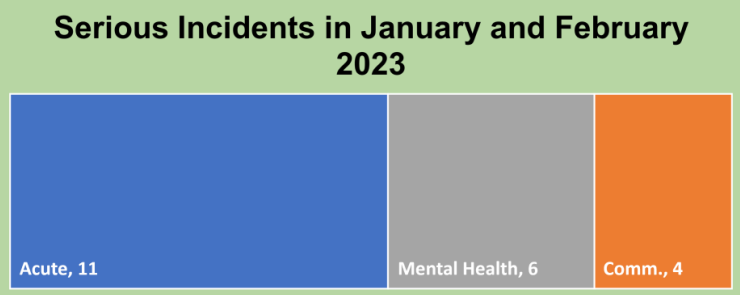
- The ICB/LMNS met with GHT and CQC to monitor actions relating to the section 29A notice; good progress has been made and the meetings have now been stood down.
- Due to staffing issues the Aveta Birth Unit remains closed to intrapartum care; clinics and other work continues to operate from the freestanding birth unit during the day. Stroud Maternity Unit postnatal beds have been closed due to staffing difficulties since 30th September and will be reviewed weekly.
- Ockenden update; using the regional template the LMNS and GHT are reviewing capacity with the aim of undertaking a gap analysis and monitoring against action plans.
- Maternal death review is being undertaken, the LMNS is involved in the review with the aim of identifying any trends where action can be taken.
- Assurance dashboards at regional and locally are being developed so that trends and benchmarking can be used to improve the service.
- An Independent Senior Advocate (ISA) post is to be advertised soon. This role helps parents-to-be, new parents and families to have a voice and provide help.

28

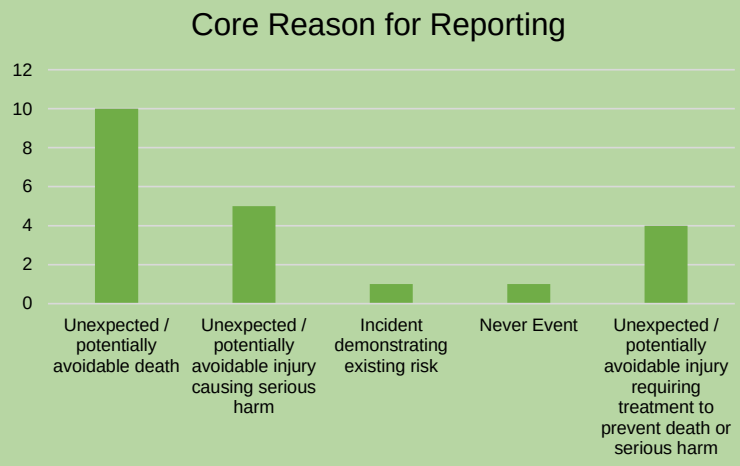
Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality: Safety



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.



Incidents declared under the current framework

- One incident declared by GHNHSFT was classed as a Never Event. This involved the wrong site of an injection where a needle had slipped below a knuckle. The patient came to no harm.
- One Serious Incident related to the sad death of a Somerset patient who was staying in a residential facility in Gloucester. It has been agreed that GICB will mange the SI on behalf of Somerset ICB.

Mortality

- Mortality at GHNHSFT continues to be a concern with the Trust remaining a national outlier for the Standardised Hospital Mortality Indicator (SHMI). While there was a slight reduction from 1.1.25 to 1.124, this is still a concern.
- The issue was discussed at the GHNHSFT Hospital Mortality Group with further analysis requested to fully understand where action may be required.

Patient Safety Incident Response Framework (PSIRF)

- On 28th March NHS Gloucestershire will be hosting a 'Conversation Café' event in conjunction with the West of England Academic Health Science Network. The event aims to build relationships and spark curiosity and conversation around PSIRF.

- The new framework is due to be introduced across the NHS in the autumn and it is anticipated will lead to systemic changes to how the system manages safety, investigations and learning from incidents.

Learning from Patient Safety Events

- Progress is being made on the roll out of the new 'Learn from Patient Safety Events (LFPSE) system. This will apply across the system and is due to be implemented by September.
- NHSE are yet to reveal the reporting part of the system, but it is hoped this will enable us to review events from a national to a PCN level.

29

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality: Experience

Friends and Family Test results: April – December 2022

		Apr-22 Provider	May-22 Provider	Jun-22 Provider	Jul-22 Provider	Aug-22 Provider	Sep-22 Provider	Oct-22 Provider	Nov-22 Provider	Dec-22 Provider
GHT Inpatients	% Positive	88%	87%	87%	89%	No data	89%	88%	No data	No data
	% Negative	7%	8%	7%	6%	No data	6%	7%	No data	No data
GHT A&E	% Positive	63%	67%	70%	68%	71%	69%	69%	71%	70%
	% Negative	27%	23%	20%	23%	18%	23%	22%	20%	20%
GHC Mental Health	% Positive	81%	81%	83%	84%	79%	89%	78%	81%	82%
	% Negative	8%	10%	10%	8%	11%	7%	12%	7%	7%
GHC Community	% Positive	95%	95%	95%	96%	96%	95%	95%	94%	94%
	% Negative	3%	2%	3%	2%	2%	2%	2%	3%	4%

[The 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. The last five month's published results can be found opposite.

General Practice FFT

- Following a suspension during the pandemic FFT results for Primary Care (GP practices) have been published since July 2022.
- In November 2022, 31 Gloucestershire GP practices submitted no FFT data; in December 2022, 37 practices submitted no data.
- Overall % satisfaction with Gloucestershire GP practices was 92% in November 2022 and 93% in December 2022 (in December the England average was 90%).

30

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality: Effectiveness

The System Effectiveness Group (SEG) was held on Monday 13th March

The SEG has reviewed the following policies which will be forwarded to the Quality Committee for final sign off with recommendations - skin lesions, Upright MRI Scans and continuous glucose monitoring. The Group have agreed the adoption of the national CQUINs (below) which will have a Quality Improvement focus. The group are also planning to work on the assessment and documentation of Pressure Ulcers as a system, to improve the consistency and Quality of information and preventative care.

The new CQUIN guidance for 2023/24 was recently published setting out the national schemes for all settings. (NHS England » 2023/24 CQUIN)

The chart opposite shows the overview of this year's CQUINS, which the SEG will be taking forward.

The group showed ambition to move beyond the numbers and KPIs and look at the real different the schemes can make to patients, especially around reducing variation.

Acute		Specialised Acute		Mental Health	Specialised Mental Health	Community	Ambulance
Flu vaccinations for frontline healthcare workers	Assessment and documentation of pressure ulcer risk	Flu vaccinations for frontline healthcare workers	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers
Compliance with timed diagnostic pathways for cancer services	Identification and response to frailty in emergency departments	Supporting patients to drink, eat and mobile (DrEaMing) after surgery	Improving the quality of shared decision-making conversations	Outcome measurement across specified mental health services	Outcome measurement across specified mental health services	Malnutrition screening in the community	
Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Supporting patients to drink, eat and mobile (DrEaMing) after surgery	Achieving the national standard of patients with chronic limb threatening ischaemia undergoing revascularisation within 5 days of admission	Treatment of non-small-cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Reducing the need for the use of restrictive practices in adult inpatient/older adult MH setting	Reducing the need for the use of restrictive practices in CYPMH inpatient settings	Assessment, diagnosis and treatment of lower leg wounds	
Recording of and response to NEWS2 score for unplanned critical care admissions	Prompt switching of intravenous to oral antimicrobial treatment					Assessment and documentation of pressure ulcer risk	

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Our Themes

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)

@One_Glos
www.onegloucestershire.net

Finance and Use of Resources

Financial Overview & Key Risks: Overview

- All organisations are forecasting delivery of a break-even financial position at year-end in line with the plan. There remain some uncertainties and risks that are currently being managed and although organisations are planning to break-even, there may be small variances within organisational positions once annual accounts are finalised.
- Financial Planning for 2023/24 and future years is currently underway, which includes a detailed analysis of each organisation's underlying financial position, the categorisation of delivery of efficiency programmes as recurrent and non-recurrent and work to look at pressures both inflationary and demand led for 2023/24. A draft submission of the financial plan for 2023/24 has been submitted to NHSE on February 23rd with a final submission on the 30th of March.
- Within the ICS year-to-date (YTD) surplus position of £1.6m, GHFT has a favourable variance to plan of £1.5m which is due to a number of factors including a reduction in COVID related expenditure,
- GHC is showing a YTD favourable variance to plan of £1.0m, due to number of factors including additional development income from the ICB that has seen delays in related expenditure, and a surplus from the South West Provider Collaborative.
- Elective Services Recovery Funding is shown as breakeven, with reporting to month 10 (flex position) now showing a really small under-delivery for the system as a whole with NHS providers under-delivering and Independent Sector providers over-delivering against the planned position.
- Within the ICS's capital envelope, capital expenditure is due to break-even against the budget for the year, which was set based on the original capital plan. GHC report that they are well on track to hit year-end plan and GHFT are still expecting to land on the planned position.

**International Financial Reporting Standard 16 sets out the principles for the recognition, measurement, presentation and disclosure of leases, in order to report information that faithfully represents lease transactions, and provides a basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases.*

Finance and Use of Resources

Financial Overview & Key Risks: Key Financial Issues & Risks

- Under-delivery of savings and efficiency plans are currently projected for GHFT of £2.9m and £0.5m for the ICB
- The system continues to monitor / mitigate under-delivery with over-delivery of other schemes and / or identification of new schemes
- Within the ICB's Medicines Optimisation programme, the project relating specifically to Direct Oral Anticoagulation (DOACs) medications is under-delivering. The project team are forecasting a £1.0 m shortfall against a £2.365m target. Whilst a number of practices have implemented DOAC prescribing switches, pressures currently within Primary Care mean that further switches above that which we have previously predicted for the period January 2023 to March 2023 are unlikely as GPs prioritise clinical care ahead of cost saving initiatives.
- The ICB's savings programme on CHC Electronic Call Monitoring continues to be reviewed to determine the level of risk of full delivery in this financial year.
- Workforce remains a key driver of overspends in the financial position across the system with vacancies within GHFT, GHC and the wider care sector. Vacancies are leading to increased use of bank and agency staffing, particularly within GHFT, and increased associated costs for agency premiums as well as costs associated with ongoing recruitment and resultant pressures on existing staff when temporary staff cover shifts. Increased use in GHFT is also due to demand pressures in urgent and emergency care especially for registered mental healthcare nurses (RMNs). The system is putting in place additional mental health nursing posts to help manage the position, as the first step in the development of an approach by Directors of Nursing to ensure the delivery of improved care.
- NHS England informed all ICSs of the implementation of agency expenditure limits from September 1st 2022 onwards for 2022/23, reporting of which can be seen on the last page of this report. Gloucestershire ICS's agency expenditure limit was calculated as 70% of 2021/22 expenditure, resulting in a cap of £20.2m. Currently the ICS's providers are forecasting to spend £36.1m in 2022/23, which is a 24.9% increase on last year's agency expenditure. HR and Finance staff are working with Operational and Clinical colleagues across the ICS, as well as at a regional level, to explore how agency expenditure can be reduced during this financial year, with a particular focus on ensuring aligned agency rates and caps across a number of neighbouring ICSs.

Finance and Use of Resources

Financial Overview & Key Risks: Key Financial Issues & Risks

- The annual plan for ESRF is based on the ICS achieving the 104% delivery target. After nine months of confirmed activity (the 'freeze' position), actual delivery is around 105.2% against a YTD weighted-target of around 105.1% of 2019/20's activity. Elective Activity with Independent Sector providers is currently being delivered above planned levels, which is contributing to the delivery of Elective Recovery for the ICS, and additional funding has been received by the ICB from NHS England for the over delivery by the Independent Sector Providers. Although not affecting the ICS's ESRF position, the under delivery of elective activity for out of county commissioners has led to a reduction in out of county contract income for GHFT.

- Work is continuing to review the delivery of planned care from all providers to determine the impact on waiting lists, and developing the outturn run rate for elective activity going into 2023/24 as the basis for the development of 2023/24 activity and finance plans to deliver 2023/24 Elective Recovery targets

- CHC forecast is now an overspend of £1.7m. An improvement of £0.8m from month 10. The reported overspend is primarily in domiciliary care, and on-going work is being undertaken in conjunction with GCC colleagues to understand the drivers with a risk that this may increase further and impact on the 2023/24 financial position.

- Children's Placements are expected to lead to a forecast overspend (£2.8m). Two new placements were approved in Month 8 with a cost of £1m. In addition, there are two placements in Trevone House with an estimated cost of £2.3m.

- 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.

- The ICB has now received a share of the historic surplus, totalling £13.9m, with remainder being held by NHSE.

Finance and Use of Resources

Finance and Use of Resources: Dashboard

Month 11 2022/23 - February 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	Full-Year Plan Surplus / (Deficit) £'000	Forecast Outturn Actual Position Surplus / (Deficit) £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000
Gloucestershire Hospitals NHS Foundation Trust	(720)	786	1,506	(0)	0	0
Gloucestershire Health and Care NHS Foundation Trust	(8)	954	961	(0)	0	0
Gloucestershire CCG / Integrated Care Board	0	(844)	(844)	0	0	0
System Surplus/(Deficit)	**(728)**	**896**	**1,624**	**(0)**	**0**	**0**

Month 11 2022/23 - February Efficiency Programme	Year to Date Efficiency Plan £'000	Year to Date Efficiency Achieved £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Full-Year 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	16,986	14,555	(2,431)	19,038	16,138	(2,900)	85%	RED - High Risk
Gloucestershire Health and Care NHS Foundation Trust	6,254	6,214	(40)	6,822	6,822	0	100%	GREEN - Low Risk
Gloucestershire CCG / Integrated Care Board	9,984	9,196	(788)	11,097	10,625	(472)	96%	AMBER - Medium Risk
Total	**33,224**	**29,965**	**(3,259)**	**36,957**	**33,585**	**(3,372)**	**91%**	AMBER - Medium Risk ↓ RED - High Risk

Month 11 2022/23 - February Other Metrics	GHFT	GHC	GICB	ICS
Better Payment Pratice Code (total paid within 30 days or due date by value)	95%	96%	100%	98%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	13,168	1,865	0	15,033
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

Finance and Use of Resources

Elective Services Recovery Fund

ICS-Commissioned Activity	M9 Year to Date - FREEZE			M10 Year to Date - FLEX			Forecast Outturn		
	Baseline Plan	Actual	Variance	Baseline Plan	Actual	Variance	Baseline Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost-Weighted Activity	140,540	140,753	212	156,815	156,773	(42)	190,049	190,049	0
Elective Recovery Funding							**19,257**	**19,257**	**0**
Cost Weighted Activity % of Baseline by PoD									
Elective Ordinary (EL)	104.5%	88.4%	-16.1%	105.3%	88.0%	-17.3%	104.1%	104.1%	0.0%
Day Case (DC)	104.2%	107.7%	3.5%	104.2%	107.4%	3.2%	109.2%	109.2%	0.0%
Outpatient Procedure (OPPROC)	91.1%	100.9%	9.8%	89.4%	99.9%	10.5%	97.9%	97.9%	0.0%
First Outpatient Appointment (OPFA)	104.2%	96.9%	-7.3%	104.3%	96.5%	-7.8%	104.0%	104.0%	0.0%
Outpatient Follow-Up Appointment (OPFUP)	88.1%	123.1%	35.0%	88.1%	122.4%	34.2%	91.7%	91.7%	0.0%
Elective Pathway Activity	**101.5%**	**102.5%**	**0.9%**	**101.3%**	**102.1%**	**0.7%**	**101.6%**	**101.6%**	**0.0%**
Advice and Guidance (A&G)	479.4%	358.8%	-120.6%	476.2%	356.0%	-120.2%	470.5%	470.5%	0.0%
Total ICS-Commissioned Activity	**105.1%**	**105.2%**	**0.2%**	**105.2%**	**105.2%**	**0.0%**	**104.8%**	**104.8%**	**0.0%**
Cost Weighted Activity % of Baseline by PoD									
Gloucestershire Hospitals NHSFT	101.9%	99.0%	-2.9%	101.6%	98.8%	-2.8%	101.9%	101.9%	0.0%
NHS Out-of-County Providers	94.4%	91.9%	-2.5%	94.7%	91.5%	-3.2%	94.9%	94.9%	0.0%
Independent Sector Providers	107.8%	137.7%	29.8%	107.8%	134.9%	27.1%	107.7%	107.7%	0.0%
Elective Pathway Activity	**101.5%**	**102.5%**	**0.9%**	**101.3%**	**102.1%**	**0.7%**	**101.6%**	**101.6%**	**0.0%**
Advice and Guidance (A&G)	479.4%	358.8%	-120.6%	476.2%	356.0%	-120.2%	470.5%	470.5%	0.0%
Total ICS-Commissioned Activity	**105.1%**	**105.2%**	**0.2%**	**105.2%**	**105.2%**	**0.0%**	**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

It is important to note that the M9 data is 'flex', so is likely to improve as uncoded activity is accurately reconciled. Additionally, Advice and Guidance data contains some estimation, so has potential to change in either direction.

The annual plan for ESRF is based on the ICS achieving the 104% delivery target, although with a lower trajectory in Q1. After nine months of confirmed activity (the 'freeze' position), actual delivery is around 105.2% against a YTD weighted-target of around 105.1% of 2019/20's activity.

Work is underway to review the delivery of planned care from all providers to determine the impact on waiting lists, and how any under-delivery on ESRF targets will affect performance in 2023/24.

Finance and Use of Resources

Savings & Efficiencies

Month 11 2022/23 - February Efficiency Programme	Year to Date Efficiency Plan £'000	Year to Date Efficiency Achieved £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Full-Year 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	16,986	14,555	(2,431)	19,038	16,138	(2,900)	85%	RED - High Risk
Gloucestershire Health and Care NHS Foundation Trust	6,254	6,214	(40)	6,822	6,822	0	100%	GREEN - Low Risk
Gloucestershire CCG / Integrated Care Board	9,984	9,196	(788)	11,097	10,625	(472)	96%	AMBER - Medium Risk
Total	**33,224**	**29,965**	**(3,259)**	**36,957**	**33,585**	**(3,372)**	**91%**	AMBER - Medium Risk ↓ RED - High Risk

- GHFT schemes are now forecasting an under-delivery of £2.9m. This is a slight improvement from the previously reported position of £3.2m. Work continues with operational and clinical colleagues to recover this position and/or seek further opportunities to bridge this gap, which are included in the financial recovery position
- GHC has identified more recurrent savings in efficiency schemes, and delivered all non-recurrent savings required
- Based on Operational Lead updates and latest available data, the ICB's £11.1m savings programme is anticipated to deliver £0.5m less than planned. This position has remained unchanged from January.

Finance and Use of Resources

Capital: Organisational Positions, Challenges & Opportunities

Month 11 2022/23 - February Capital Expenditure	Year to Date Plan £'000	Year to Date Actual Position £'000	Year to Date Variance to Plan (Under) / Over Delivery £'000	Full-Year Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan (Under) / Over Delivery £'000
Gloucestershire Hospitals NHS Foundation Trust	47,302	48,624	1,322	51,742	64,910	13,168
Gloucestershire Health and Care NHS Foundation Trust	13,455	14,581	1,126	17,665	19,530	1,865
Gloucestershire CCG / Integrated Care Board	0	0	0	1,472	1,472	0
Total System CDEL (NHS)	**60,757**	**63,205**	**2,448**	**70,879**	**85,912**	**15,033**
IFRS16 Lease Capital						
Gloucestershire Hospitals NHS Foundation Trust	0	1,006	1,006	15,355	2,806	(12,548)
Gloucestershire Health and Care NHS Foundation Trust	9,721	2,589	(7,132)	9,721	3,281	(6,440)
Total System Capital including IFRS16 Leases (NHS)	**70,478**	**66,800**	**(3,678)**	**95,954**	**91,999**	**(3,955)**

Capital Expenditure Category	£'000	£'000	£'000	£'000	£'000	£'000
Equipment	3,224	2,929	(295)	18,457	5,365	(13,092)
IT	9,730	9,189	(541)	10,509	16,232	5,723
Plant & Machinery	0	1,038	1,038	0	1,591	1,591
New Build	40,453	35,542	(4,911)	42,718	43,958	1,240
Backlog Maintenance	3,604	3,087	(517)	4,350	5,813	1,463
Routine Maintenance	1,849	2,348	499	2,917	2,589	(328)
Net Zero Carbon	300	0	(300)	500	0	(500)
Fire Safety	675	375	(300)	730	684	(46)
Fleet, Vehicles & Transport	1,144	30	(1,114)	3,167	194	(2,973)
Forest of Dean	9,500	11,257	1,757	11,500	13,455	1,955
GP Surgery Developments	0	0	0	1,106	1,106	0
Brokerage	0	0	0	0	0	0
Other	0	1,006	1,006	0	1,012	1,012
Total	**70,478**	**66,800**	**(3,678)**	**95,954**	**91,999**	**(3,955)**

Funding Sources	£'000	£'000	£'000	£'000	£'000	£'000
System Capital	35,127	29,987	(5,140)	42,630	42,658	28
National Programme	24,415	30,840	6,425	24,678	37,398	12,720
Donations & Government Grants	466	1,630	1,164	1,281	3,567	2,286
Lease Liability - IFRS16	9,721	3,595	(6,126)	25,076	6,087	(18,988)
Residual Interest	0	0	0	0	0	0
IRFIC	749	748	(1)	817	817	0
CCG Capital Allocation	0	0	0	1,472	1,472	0
Total	**70,478**	**66,800**	**(3,678)**	**95,954**	**91,999**	**(3,955)**

Within the ICS's capital envelope, capital expenditure is due to break-even against the budget for the year, which was set based on the original capital plan. Additional allocations have now been received for a number of schemes for both GHC and GHFT, for which additional capital allocations have been received, and which now show as forecast variances. These additional schemes are listed overleaf

Aside from this main allocation, a number of leases, treated as capital under IFRS16, may not be taken out by GHC within this financial year, leading to an overall lower capital spend, although current guidance suggests that this will not lead to a variance as the CDEL will only be allocated nationally as leases are committed.

GHC's YTD over-delivery relates to materials purchased early for Forest of Dean scheme.

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

Finance and Use of Resources

Capital: Organisational Positions, Challenges & Opportunities

Within the ICS's capital envelope, capital expenditure is due to break-even against the budget for the year, which was set based on the original capital plan.

Additional allocations have now been received for a number of schemes for both GHC and GHFT, for which additional capital allocations have been received, and which now show as forecast variances.

GHC	£'000
Front Line Digitisation	1,671
Wotton Lawn - Clinic Rooms Refurbishment	215
Capital Programme Slippage	(21)
GHC Total	**1,865**

GHFT	£'000
Paediatric MH UEC	362
MRI Acceleration Software Upgrade	165
PSDS 3a Salix (Grant Funded)	3,241
Community Diagnostic Centres	1,941
Diagnostic Digital Capability Programme	1,205
Cyber 2022/23 – Firewalls	49
Front Line Digitisation - 2nd Tranche 2022/23	2,200
Demand and Capacity	3,072
TIF 5th Orthopaedic Theatre	1,465
Health Improvement Breast Screening	84
Endoscopy - Increasing Capacity	339
Gamma Camera - Donated Asset Slippage to 2023/24	(955)
GHFT Total	**13,168**

Gloucestershire ICS Total	**15,033**

Finance and Use of Resources

COVID Expenditure

Month 11 2022/23 - February COVID Expenditure	Prior Year Expenditure £'000	Year to Date Actual Position £'000	Forecast Outturn Position £'000	Full-Year Plan £'000
Gloucestershire Hospitals NHS Foundation Trust	15,357	226	226	7,452
Gloucestershire Health and Care NHS Foundation Trust	2,350	967	1,022	851
Gloucestershire CCG / Integrated Care Board	7,588	0	0	0
Total System (NHS)	**25,295**	**1,193**	**1,248**	**8,303**

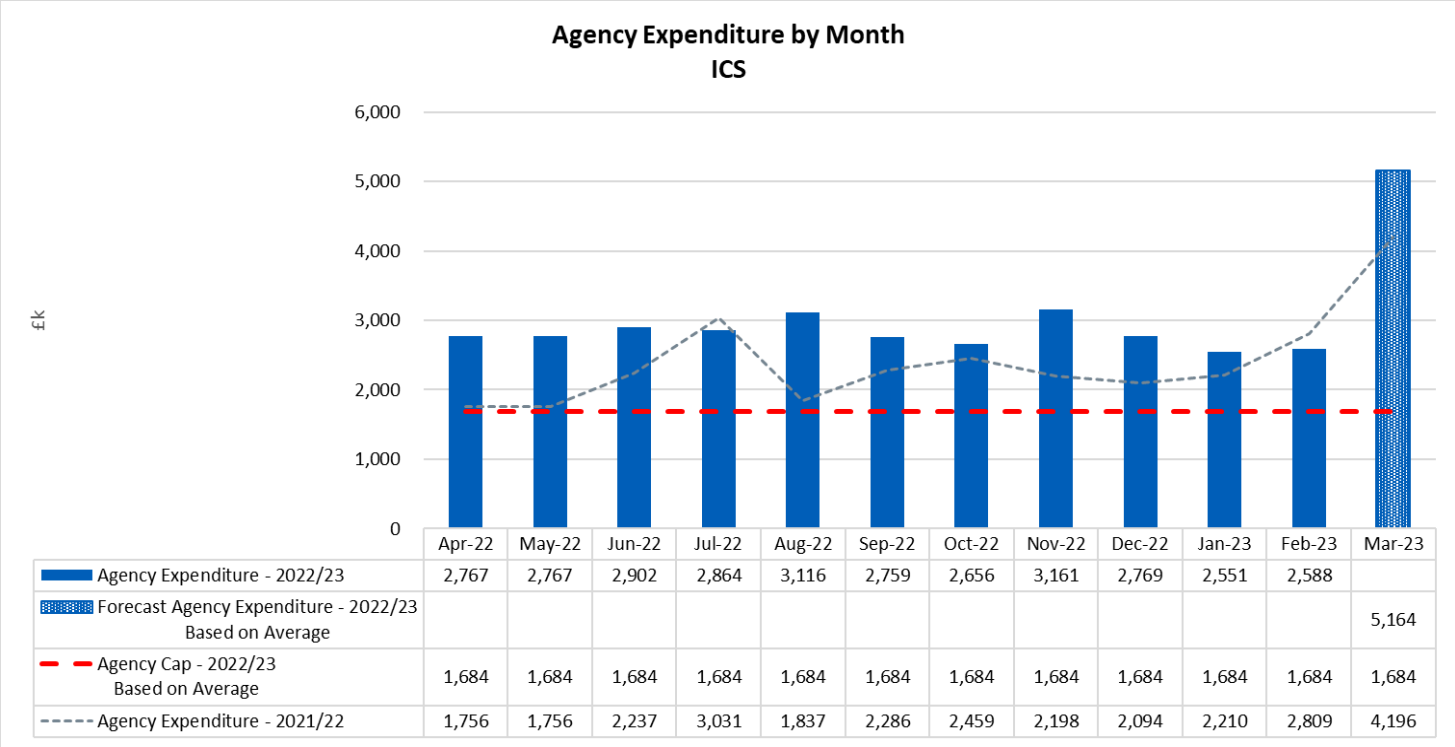
System Surplus/(Deficit) COVID Expenditure	Prior Year Expenditure £'000	Year to Date Actual Position £'000	Forecast Outturn Position £'000
Expand NHS Workforce	5,859	505	559
Existing workforce additional shifts to meet increased demand	3,721	5	5
Backfill for higher sickness absence	237	119	119
Remote management of patients	177	0	0
Segregation of patient pathways	2,708	0	0
Decontamination	78	11	11
Additional PTS costs	557	0	0
Long COVID	595	0	0
Remote working for non-patient activities	177	0	0
International quarantine costs	7	0	0
Deployment of final year student nurses	22	0	0
GP Services – Covid expansion fund	1,303	0	0
Hospital Discharge Programme	5,521	0	0
Testing programme	2,962	0	0
Vaccination programme	1,371	554	554
Total System (NHS)	**25,295**	**1,193**	**1,248**

- Planned expenditure on COVID-related costs in 2022/23 was around a third of that spent in 2021/22, with a number of programme areas no longer expected to require expenditure in 2022/23.
- At ICS level, the latest YTD figures available show expenditure being significantly below the full year plan

**YTD figures are as at M11 for both GHFT and GHC*

Finance and Use of Resources

Agency Expenditure



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Agency Expenditure - 2022/23	2,767	2,767	2,902	2,864	3,116	2,759	2,656	3,161	2,769	2,551	2,588	
Forecast Agency Expenditure - 2022/23 Based on Average												5,164
Agency Cap - 2022/23 Based on Average	1,684	1,684	1,684	1,684	1,684	1,684	1,684	1,684	1,684	1,684	1,684	1,684
Agency Expenditure - 2021/22	1,756	1,756	2,237	3,031	1,837	2,286	2,459	2,198	2,094	2,210	2,809	4,196

Forecast Agency Expenditure 2022/23	**£36.063m**
Agency Expenditure 2021/22	**£28.869m**
Agency Cap 2022/23	**£20.209m**
Draft Agency Cap 2023/24	**£25.609m**

- Gloucestershire ICS's agency expenditure limit was calculated as 70% of 2021/22 expenditure, resulting in a cap of £20.2m. Currently the ICS's providers are forecasting to spend just under £36.1m in 2022/23, which is a 24.9% increase on last year's agency expenditure.
- Organisations have been working on plans to improve recruitment and retention of substantive and bank staff in order to reduce agency expenditure, and these plans will form part of the wider ICS planning process.
- ICSs have been notified of a draft agency cap for 2023/24, which stands at £25.609m for Gloucestershire ICS

One Gloucestershire
Transforming Care, Transforming Communities

NHS

ICB Finance Report

March 2023

@One_Glos
www.onegloucestershire.net

Finance and Use of Resources

Financial Overview and Key Risks: Overview

- NHS Gloucestershire ICB month 11 position is showing a forecast outturn position of breakeven which is as per plan. There remain some uncertainties and risks that are currently being managed. The ICB has now received a share of the historic surplus, totalling £13.9m, with remainder being held by NHSE.

- Prescribing continues to show significant cost pressures mainly due to No Cheaper Stock Obtainable (NCSO). The net forecast position is £3.0m overspend which includes an assumption of additional resource notified by NHSE which will maintain the current position and mitigate the additional risk that had been identified. The 22/23 YTD actual costs for NCSO are £3.3m, with a FOT of £3.7m compared to 2021/22 costs of £0.6m. Other prescribing cost pressures relate to national increases of Category M Drugs for the remainder of the financial year and is expected to be an additional £0.63m on costs.

- CHC has a forecast overspend of £1.7m currently. This overspend is primarily in domiciliary care, and on-going work is being undertaken in conjunction with GCC colleagues to understand the drivers of costs. The forecast spend for Hospital Discharge scheme 1 (£500m) is planned to be fully spent. (Total £4.604m). The forecast spend for Hospital Discharge Fund scheme 2 (£200m) is £1.5m which we will have additional allocation in M12.

- Children's Placements are expected to lead to a forecast overspend (£2.8m). Two new placements were approved in Month 8 with a cost of £1m. In addition, there are two placements in Trevone House with an estimated cost of £2.3m.

- Mental Health Investment Standard (MHIS) achievement is forecast to be 100%, with spending expected to reach the target level of £97.13m for this financial year.

- The draft system financial plan for 2023/24 was submitted on 23rd February with the final submission due 30th March. Work is ongoing on the analysis of the ICB's underlying financial position and identifying further efficiencies to close the remaining financial gap.

Finance and Use of Resources

Financial Overview and Key Risks: Overview

Existing and emergent pressures

- Children's external joint funded (s256) individual care packages / placements are forecast to overspend. The costs relate to nursing costs at the wellbeing suite in Trevone House and also two additional placements have been verified.

- Based on Operational Lead updates and latest available data, the ICB's £11.1m savings programme is anticipated to deliver £0.5m less than planned. This position remains unchanged from that reported in Month 10 (January 2023).

- Elective Activity with Independent Sector providers is currently being delivered above planned levels, mitigating the under-delivery by NHS Providers, which is contributing to the delivery of Elective Recovery for the ICS, and these additional costs of delivery are currently being funded by underspends in other areas. While not currently a financial pressure, any failure to deliver on ESRF overall in the ICS could make these additional IS costs an unfunded pressure

- Emergent pressures are currently covered by underspends within various areas.

Key Financial Risks

- Inflation exceeds 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.

Finance and Use of Resources

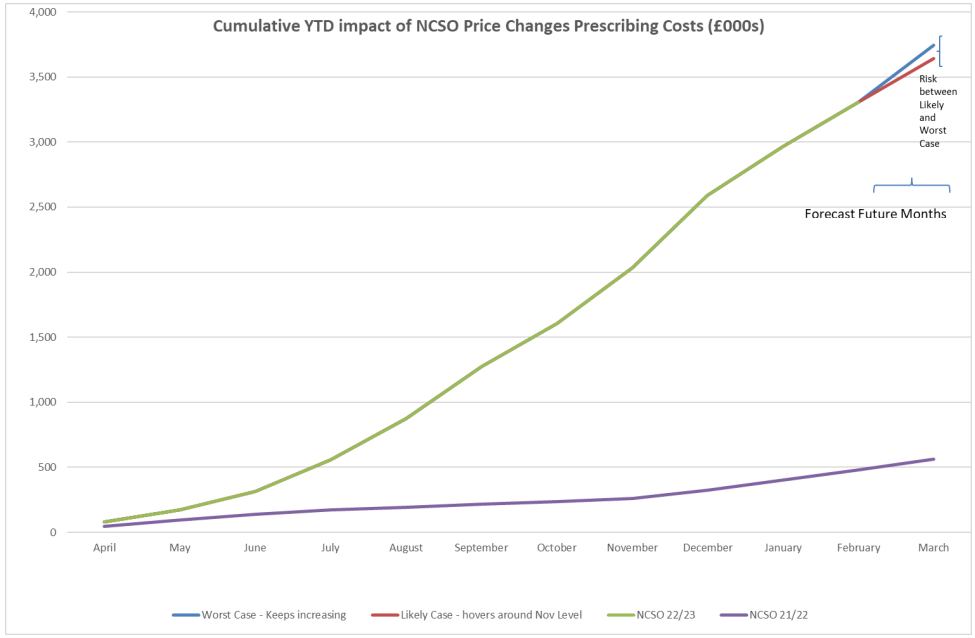
ICB Allocation: M11

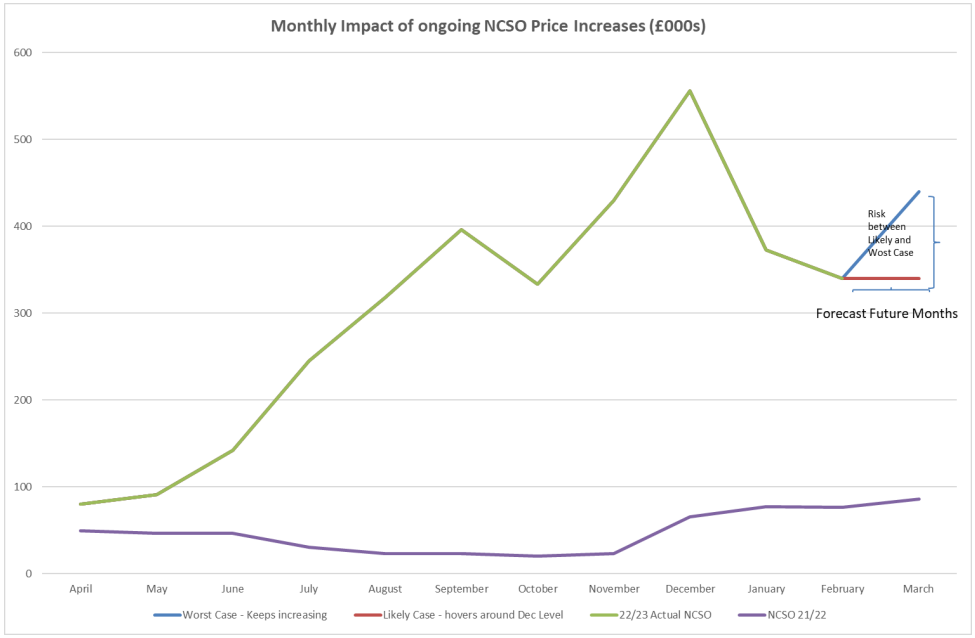
- The ICB's confirmed allocation as at 28th February 2023 is £942m for M4-12 of the financial year.
- Due to the split between the CCG and ICB in 2022/23, a part of the allocation will show in the CCG and the remainder in the ICB.
- Final allocation for CCG was £277m, when adjusted for a M1-3 underspend that now forms part of the ICB's M4-12 allocation
- The ICB has now received a proportion of the historic surplus £20,474k totalling £13,938k. The remainder is being held by NHSE.

Organisation	As reported M10 £'000	CCG M1-3 Surplus Adjustment £'000	M11 Additional Allocation £'000	2022/23 Allocation £'000
CCG Allocation M1-3	286,977	(10,017)		276,960
ICB Allocation M4-12	914,483	10,017	3,958	928,458
TOTAL IN-YEAR ALLOCATION	**1,201,460**	**0**	**3,958**	**1,205,418**
CCG carry forward historic surplus	13,938			13,938
TOTAL ALLOCATION	**1,215,398**	**0**	**3,958**	**1,219,356**

Finance and Use of Resources

ICB Prescribing: No Cheaper Stock Obtainable – M11





- The graphs have been completed to illustrate the 22/23 NCSO costs compared to 21/22 costs.
- The forecast position is £3.0m overspend. The 22/23 YTD actual costs for NCSO are £3.3m (Month 9 actual plus 2 month estimated), with a FOT of £3.7m compared to 2021/22 costs of £0.6m.
- The total cost of NCSO is expected to fall in January but this is offset by the increases in Cat M drug prices. The likely case assumes that NCSO costs remains consistent at the current high level.

Finance and Use of Resources

ICB Statement of Comprehensive Income: In-Year Position

Month 11 2022/23 - February Statement of Comprehensive Income	Year to Date Plan £'000	Year to Date Actual Position £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Full-Year Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan Favourable / (Adverse) £'000
Acute Services	525,710	525,708	2	573,133	572,941	192
Mental Health Services	107,360	105,632	1,728	117,023	116,018	1,005
Community Health Services	105,210	105,045	165	120,503	123,519	(3,016)
Continuing Care Services	68,180	67,105	1,075	74,449	76,152	(1,704)
Primary Care Services	124,972	126,263	(1,291)	136,109	139,051	(2,942)
Delegated Primary Care Commissioning	100,259	99,190	1,069	109,739	109,763	(24)
Other Commissioned Services	22,763	22,706	57	19,717	24,099	(4,382)
Programme Reserve & Contingency	21,929	29,927	(7,998)	26,571	17,510	9,060
Other Programme Services	14,278	10,748	3,531	14,360	14,104	256
Total Commissioning Services	**1,090,661**	**1,092,322**	**(1,661)**	**1,191,603**	**1,193,158**	**(1,555)**
Running Costs	12,729	11,911	817	13,815	13,815	0
TOTAL NET EXPENDITURE	**1,103,390**	**1,104,234**	**(844)**	**1,205,418**	**1,206,973**	**(1,555)**
ALLOCATION	**1,103,390**	**1,103,390**	**0**	**1,205,418**	**1,205,418**	**0**
Outside of Envelope	**0**	**0**	**0**	**0**	**1,555**	**(1,555)**
Underspend / (Deficit)	**0**	**(844)**	**(844)**	**0**	**0**	**0**

Finance and Use of Resources

ICB Statement of Financial Position

	Closing Position as at 28/02/2023 £'000	Opening Position as at 01/07/2022 £'000
Property, Plant & Equipment	1,178	1,495
Intangible Assets	0	0
Total Non-Current Assets	**1,178**	**1,495**
Trade & Other Receivables	6,507	6,142
Cash & Cash Equivalents	4,149	21
Total Current Assets	**10,655**	**6,163**
TOTAL ASSETS	**11,833**	**7,658**
Trade & Other Payables	(84,374)	(52,886)
Provisions	(3,428)	(5,552)
Total Current Liabilities	**(87,803)**	**(58,438)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**(75,970)**	**(50,781)**
Non-Current Liabilities	0	(143)
Total Non-Current Liabilities	**0**	**(143)**
TOTAL ASSETS LESS TOTAL LIABILITIES	**(75,970)**	**(50,924)**
General Fund	75,970	50,924
Reserves	0	0
TOTAL EQUITY	**75,970**	**50,924**

Finance and Use of Resources

ICB Savings & Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB)
2022/23 EFFICIENCIES PROGRAMME - AS AT MONTH 11

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)	2,100	1,046	(1,054)	2,365	1,372	(993)	58.00%	RED - High Risk
	Primary Care Medicines Savings; Medicines Optimisation (MO) Value Savings; and Medicines Optimisation (MO) Variation Projects	1,170	1,564	394	1,450	2,117	667	145.97%	GREEN - Low Risk
PRIMARY CARE MEDICATION OPTIMISATION - TOTALS		3,270	2,610	(660)	3,815	3,488	(327)	91.43%	
CONTINUING HEALTHCARE	Electronic Call Monitoring (ECM)	740	739	(1)	806	806	-	100.00%	AMBER - Medium Risk
	End of Life Care (EoL) - >12 Weeks	518	573	55	518	573	55	110.62%	GREEN - Low Risk
	Placement Review (Top 20 Most Expensive @ 2%)	182	-	(182)	200	-	(200)	0.00%	RED - High Risk
CONTINUING HEALTHCARE - TOTALS		1,440	1,313	(127)	1,525	1,380	(145)	90.48%	
OTHER	1.1% Contract Efficiency, Running Cost Savings and Additional Efficiencies	5,274	5,274	-	5,757	5,757	-	100.00%	GREEN - Low Risk
OTHER - TOTALS		5,274	5,274	-	5,757	5,757	-	100.00%	
2022/23 ICB SAVINGS PROGRAMME - TOTALS		9,984	9,196	(788)	11,097	10,625	(472)	95.76%	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

Finance and Use of Resources

ICB Savings & Efficiencies

Overall Position

- Based on Operational Lead updates and latest available data, the ICB's £11.1m savings programme is anticipated to deliver £0.5m less than planned. This position remains unchanged from that reported in Month 10 (January 2023).

Medicines Optimisation

- We continue to see a sustained over-delivery on Medicines Optimisation Projects and this indicates a projected forecast outturn of £3.690m against a £3.815m planned saving for the Medicines Optimisation Programme for the 2022/23 financial year. However, with drug price changes and drug rebates not being as we initially modelled and with the timeliness of ePact data (2 to 3 months in arrears), we are being prudent in reporting a forecast outturn position of £3.488m (a £0.327m shortfall against plan).

Continuing Healthcare (CHC)

- The overall position of the CHC efficiencies programme remains unchanged from that reported in Month 10 (January 2023) and shows forecast delivery of £1.380m against a plan of £1.525m.

- Electronic Call Monitoring (ECM) has up until recently given a positive indication that it will deliver above plan. However, as previously reported there are ongoing concerns around some of the information contained within the last four monthly reports received from Gloucestershire County Council (GCC) and therefore work is currently taking place to provide additional assurance on this. Proposed revised reports are being developed that should provide assurances of the savings recorded. In view of the work being progressed around assurance, we are currently reporting this scheme as 'Amber' which reflects concerns around the monitoring process and reporting the forecast outturn to be a balanced position (i.e. delivery to plan).

- The position of the top 20 most expensive care packages remains unchanged from that reported last month. Given the volatility that we have seen to date, we are not expecting this scheme to deliver any savings in 2022/23 or beyond.

- Factoring in all of the above, we are anticipating overall delivery of the CHC efficiencies programme to be £1.380m against a plan of £1.525m (a shortfall of £0.145m). If concerns regarding the stability of the latest ECM reports are confirmed we would expect to change the position to reflect a further reduction in the level of delivery.

Agenda Item 10

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**Fit For The Future (FFTF) Decision-Making Business Case**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	FFTF Phase 1 Decision-making Business Case was approved by CCG in Mar 2021; FFTF2 Output of Engagement report received Sept 2022 and benefits & costs discussed in Jan 2023.				
	ICB, ICS & Partners	**Date**			
	ICB Board	18/03/21 & 26/01/23			
	ICS Resources Steering Group	16/12/22 & 17/02/23			
	ICS Programme Development Group	10/02/23			
	ICS Strategic Executive	16/02/23			
	GHNHSFT Board	09/03/23			
Executive Summary	The purpose of this Decision Making Business Case (DMBC) is to present the case for change and secure approval for the reconfiguration of five specialist hospital services; these are: • Benign Gynaecology* • Diabetes and Endocrinology* • Non-interventional Cardiology • Respiratory* • Stroke* *Four of these services are operating in the preferred configuration as Temporary Service Changes as agreed with Gloucestershire Health Overview and Scrutiny Committee				
Key Issues to note	The DMBC sets out the rationale for proceeding with five resolutions in the context of the outcome, findings and feedback received from: • The public, patient and staff involvement process (May- July 2022); • The South West Clinical Review Panel (Aug 2022); • Gloucestershire Health Overview and Scrutiny Committee (October 2022), and; • NHS England South West Regional Team (October 2022). A full Integrated Impact Assessment has been completed for the proposed service reconfigurations, comprising Equality Impact Assessment, Health inequalities impact assessment and a Health impact assessment. Full appendices are included for completeness.				
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	A detailed risk log is maintained as part of the programme management approach used to manage the FFTF programme.				

Management of Conflicts of Interest	The programme has been conducted in line with the relevant conflicts of interest policies.			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	The only additional financial investment required to implement FFTF Phase 2 relates to the establishment of a Respiratory High Care unit at Gloucestershire Royal Hospital, which requires a revenue investment of £274,000 and a capital investment of £21,000.			
Regulatory and Legal Issues (including NHS Constitution)	The FFTF programme proposes significant service change at scale for our system, and as such represents a considerable body of work delivered in the context of the statutory and legal frameworks that govern all programmes seeking to undertake major service change in the NHS. By their nature, these proposals and recommendations are of significant interest to a range of stakeholders, some of whom may seek to challenge decisions taken on future service configurations through legal channels.			
Impact on Health Inequalities	FFTF Integrated Impact Assessment considers the impact of the service change proposals on people with protected characteristics who live in our health and care community. A summary of the findings is set out in the DMBC, with the full assessment provided in the Appendices for review by decision makers.			
Impact on Equality and Diversity	As above, full details can be found in the appendices to the DMBC			
Impact on Sustainable Development	There is no direct impact or detriment on sustainable development identified for the FFTF programme			
Patient and Public Involvement	The FFTF programme has conducted extensive patient and public involvement work throughout the duration of the programme. The proposals set out in the DMBC are informed by all of the feedback that has been received, throughout the duration of the programme.			
Recommendation	The Committee/Board is requested to: • **Approve** Decision Making Business Case (DMBC) • **Approve** the DMBC resolutions • **Approve** the programme proceeding to implementation,			
Author	**Micky Griffith**		**Role Title**	**FFTF Programme Director**
Sponsoring Director (if not author)	**Ellen Rule, FFTF Programme Executive Lead and Deputy CEO/Director of Strategy & Transformation, NHS Gloucestershire**			

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
FFTF1	Fit for the Future – Phase 1
FFTF2	Fit for the Future – Phase 2
DMBC	Decision-making Business Case
RSG	ICS Resources Steering Group
NHSE	NHS England

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Phase 2 Decision-making Business Case

Version 1.1

March 2023

Work in Progress – subject to decision-making

Fit for the Future 2

Developing specialist health services in Gloucestershire

Contents

Document Control

Author:	Micky Griffith, Programme Director, Fit for the Future
Location:	\\glos.nhs.uk\GCCG\Hub\Strat and Planning\Sustainability & Transformation Plan\10. One Place Programme\12. Fit for the Future\Phase 2
Status:	v 1.1

Version[1]	Date	Author/Reviewer	Comments
1.0	20/02/23	Micky Griffith	Draft for SROs to review
1.1	01/03/23	Micky Griffith	Incorporate SRO comments/amends

Document Distribution:

Forum/Audience	Date	v#	Comments
GHNHSFT Board	09/03/23	1.1	
NHS Gloucestershire ICB	29/03/23	1.1	
Publication onto Get Involved in Gloucestershire website	01/04/23	1.1	

[1] See section 2.6 for document iterations.

1 Executive Summary

1.1 Strategic Statement

We, the health and social care organisations in Gloucestershire have committed to working together as an Integrated Care System (ICS) to improve the health of local people through supporting them to take more control of their own health, with a greater focus on prevention and self-care (people looking after themselves when they can), and ensuring we deliver the right care, in the right place at the right time. Fit for the Future is a key enabler to our right care, right place, right time objective.

Prioritising Self Care and Prevention means that we are using our data to understand the health needs of local people and working to improve long term health and wellbeing. Health and wellbeing are influenced by more than just health services, so as an ICS we work as an active partner in the public sector to improve health through better housing, better education, better employment, better transport and keeping people safe.

Evidence and experience tell us that people can find it harder to improve their own health or to access our services when they have other challenges in their lives. These include living with deprivation, disability, or a mental health condition. Our commitment is that we will ensure our services are easier to access for people with health inequalities, both ensuring our services recognise and deliver parity of esteem for mental health and provide additional support when people need it.

Delivering the right care in the right place at the right time means that when care can be delivered at home or close to home, it will be. When people need to come to a centre to get care, our aim is to minimise the distance needed to travel to get there, as it can be hard to get around our county particularly with a long-term health condition.

Sometimes however, we will need to prioritise achieving a better health outcome over trying to minimise travel for people. Health care for some conditions is increasingly high tech and needs highly trained staff and expensive equipment to keep pace with the best in the world. When specialist care is needed our aim is to increasingly deliver this through *Centres of Excellence*, that separate emergency and planned care and centralise services where we can consolidate skills and equipment to provide the very best care.

The NHS is going through the most challenging period of its 75-year history to date. Gloucestershire's health and care system, like other parts of the country, is in the process of recovering from the pressures that the COVID pandemic placed on our services, staff and local communities. There are also the added challenges of recent industrial action and a rise in seasonal illness.

Living within our means to make the best use of every Gloucestershire pound means a commitment to work together to put the patient first in everything we do, developing our workforce, and streamlining our services and organisations where possible to ensure everything we deliver is as efficient as it can possibly be.

We know we still have a long way to go, but we believe that the proposals in this second phase of Fit for the Future (FFTF2) will help us to keep moving in the right direction. We are confident that our plans for service development, including some that are temporary service changes made in response to the pandemic, will deliver benefits in the long-term.

1.2 Why we think that change is needed

Our strategic statement set out above is a summary of our ICS strategic response to the triple challenges facing health and care services delivery as described in the NHS Five Year Forward view, the health and wellbeing gap, the care and quality gap and the finance and efficiency gap.

The Fit for the Future (FFTF) Programme and *Centres of Excellence* approach described in this document are specifically looking to address issues and risks arising from the historic configuration of hospital services across Cheltenham General Hospital (CGH) and Gloucestershire Royal hospital (GRH), part of Gloucestershire Hospitals NHS Foundation Trust and located eight miles apart.

Since merging to form a single Trust in 2002, a number of services have now been centralised including those in the first phase of FFTF[2], paediatrics ophthalmology, oncology and urology. For a number of other specialties, the FFTF programme is seeking to address issues and risks arising from continuing to deliver services across both sites. These include pressures on workforce, quality and safety as resources become ever more stretched to cope with increasing demand. At times, this means services can be compromised in terms of their potential to develop the same standard of specialist care across both sites. We believe reconfiguring some of our services more efficiently across the two sites to improve clinical linkages between services will deliver improvements against the care and quality gap.

We aim to address the health and wellbeing gap by increasing the quality and health outcomes that our hospital services deliver, increasing the specialist services offer in our county and supporting the identified health needs of our population.

1.3 Proposals

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[3] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.

[2] Details in section 3.5

[3] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

This Decision-Making Business Case (DMBC) sets out the rationale for proceeding with these resolutions in the context of the extensive work that has been undertaken through the Fit for the Future Programme. This includes consideration of the outcome, findings and feedback

- The public, patient and staff involvement process (May- July 2022);
- The South West Clinical Review Panel (Aug 2022);
- Gloucestershire Health Overview and Scrutiny Committee (October 2022), and;
- NHS England South West Regional Team (October 2022).

This DMBC has been drafted on the basis of decisions taken by the Board of Gloucestershire Hospitals NHS Foundation Trust (November 2022) and the NHS Gloucestershire Integrated Care Board (November 2022).

Details of the patient, staff, efficiency, and effectiveness benefits of each resolution can be found in the individual service sections, which directly or indirectly support our ICS objectives set out in our response to the NHS Long-Term Plan including:

- Ensuring people with specialist health conditions can access outstanding hospital care
- Delivering high quality, joined up services with the right care, staff skills and equipment in the right place
- Delivering care that is fit for the future through the development of outstanding specialist hospital care in the future across the CGH and GRH sites
- Developing and supporting our workforce and meeting the challenge of recruiting and keeping enough staff with the right skills and expertise.

1.4 Decision-making business case structure

Fit for the Future (FFTF) Phase 2 builds on the learning from Phase 1, and this document is designed to meet the requirements set out in the NHS England (NHSE) *Planning, assuring and delivering service change for patients (March 2018)* and *Addendum (May 2022),* and in accordance with the South West Clinical Senate review process.

- **Section 2** sets out the purpose and scope of this Decision-making Business Case (DMBC) and the process we are undertaking.
- **Section 3** introduces our system, our challenges and our Integrated Delivery Plan priorities including FFTF.
- **Section 4** describes our FFTF2 public, patient and staff engagement activities and includes feedback from our engagement survey.
- **Section 5** provides information affecting all of the service change proposals including the options appraisal process, overall bed impact, and requirements relating to inter-hospital site ambulance transfers.
- **Sections 6 to 10** present detailed information on the five FFTF2 service proposals including the current service model, the case for change, preferred option evaluation, clinical evidence, benefits; workforce, “blue light” impact, responses to Clinical Senate review, engagement themes and responses.

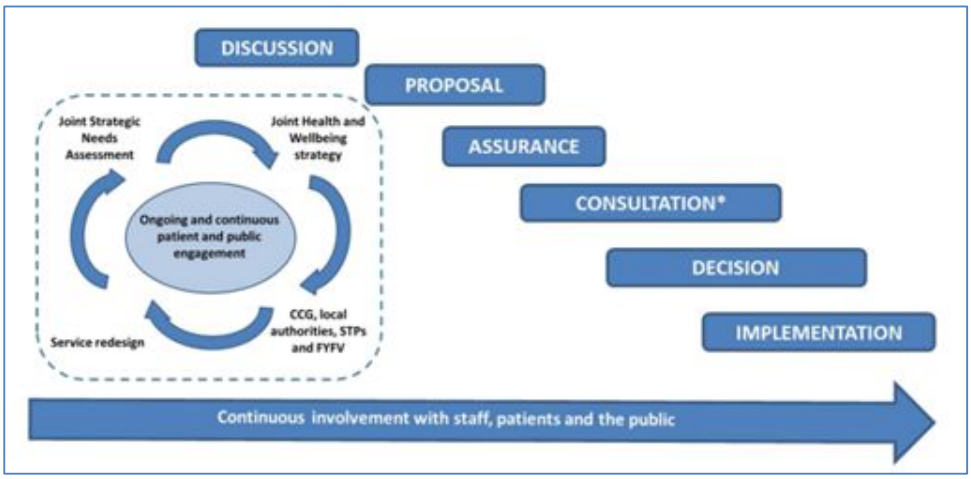
- **Section 11** describes our approach to integrated impact assessment and a summary of Equality Impact, Health Inequalities Impact and Health Impact assessments.
- **Section 12** provides the economic and financial analysis.
- **Section 13** provides details of our internal and external governance and decision-making processes.
- **Section 14** sets out the resolutions to be approved.
- **Section 15** provides our implementation structure and high-level schedule.

2 Purpose of the document

2.1 The process we are undertaking

As with all service reconfiguration programmes, we have worked closely with NHS England (NHSE) through the regional office and are guided by the *Planning, assuring, and delivering service change for patients (March 2018)* and *Addendum (May 2022)*[4]. This guidance is designed to be used by those considering, and involved in, substantial service change to navigate a clear path from inception to implementation. It supports commissioners and providers to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

Service change has several phases from setting the strategic context to implementation. A summary of these (from the guidance), is set out below:



2.2 Single-step business case

As noted in the guidance[3], public consultation may not be required in every case and the decision about whether public consultation is required should be made considering the views of the local authority.

The ICB is therefore able to depart from the NHSE Guidance provided it has good reason to do so. When deciding if consultation would be required for FFTF2, the ICB considered the following factors:

- The extensive amount of engagement that had already been carried out and the positive response to the proposals.
- The ICB had produced an Output of Engagement report of the kind that would normally be produced following public consultation
- The Output of Engagement Report was considered by the Health Overview and Scrutiny Committee (HOSC) in October 2022; The committee discussed next steps and considered whether further public involvement would provide additional information, such as alternatives or impacts, that could influence decision making. The committee did not raise any concerns with the engagement undertaken to date and the approach suggested by the ICB, and requested that updates be brought to

[4] NHS England » Planning, assuring and delivering service change for patients

future meetings of the committee regarding the implementation of Fit for the Future 2 service changes

- Discussions had taken place with the SW Regional NHSE team, and NHSE were content that no further public involvement (including consultation) was expected. This would also mean that NHSE Stage 2 assurance process was not required.
- Of the five FFTF services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes and have been well publicised.
- It was also relevant that ICBs must be mindful of the cost of undertaking public consultation, when resources are stretched, and it is incumbent on public bodies to manage resources efficiently and effectively.

The subject of further FFTF2 public involvement, including consultation, was discussed at the ICB public meeting on 30/11/22 (having previously been considered by the GHNHSFT Board on 10/11/22). Details of the papers and minutes of the meeting can be found at Board Meetings : NHS Gloucestershire ICB (nhsglos.nhs.uk).

On the basis of the particular facts and circumstances stated above, and in full understanding of its duties, the ICB Board took a formal view that there should be no further public involvement in Phase 2 of the FFTF programme. The Board agreed that next steps should be taken to bring a decision-making Business Case (DMBC) to the March 2023 Board meeting.

In the light of this decision there is not a requirement for a Pre-Consultation Business Case (PCBC) to be approved by the ICB and therefore as we now have a single-step business case process, for the benefit of decision-makers and for completeness, some information usually included within a PCBC is contained within this DMBC.

2.3 Purpose and scope of DMBC

This Decision Making business case (DMBC) is concerned with the configuration of hospital services across Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), specifically between Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

This DMBC is based on the evidence compiled in the business case submitted to the South West Clinical Senate (and copied to NHSE), feedback from FFTF2 public, patient and staff engagement and includes the outputs from the engagement report[5] and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of outcomes.

The DMBC will present and summarise the extensive work completed to date, with the following purposes in mind:

- To present our response to the FFTF2 engagement and involvement;
- To demonstrate that options, benefits, and impact on service users have been considered, and;
- To confirm the recommendations for service change in order to enable decision- makers to determine if these proposals should be implemented

[5] The full FFTF2 Output of Engagement Report can be found in Appendix 1

2.4 Intended audiences and their decision-making roles

This DMBC is written by the Gloucestershire Fit for the Future Programme for the following audiences:

- The NHS Gloucestershire Integrated Care Board (GICB) which will decide whether the proposed service changes should be implemented based on the evidence presented. The ICB is the legally accountable Authority so has final responsibility for approving next steps.
- The Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) who will confirm organisational level support for the proposed changes to clinical services including formal approval of the case in terms of finance, workforce, and implementation plans.
- NHS England and Improvement (NHSE&I) who have undertaken a Stage 1 review of FFTF2, received the pre-consultation business case submitted to the South West Clinical Senate and confirmed that a Stage 2 assurance process was not required[6].
- The Gloucestershire Health Overview and Scrutiny committee (HOSC) who will continue to scrutinise the proposals in line with their responsibilities.

For the purposes of transparency, the final version of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

2.5 Document Status

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Until published as part of publicly available Board papers, this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

[6] See section 2.2

2.6 Document Iteration

This document has been developed through an iterative process designed to meet the needs of the various stages of internal and external assurance. The table below presents both the document types and the approval/ review forum to date; culminating in a DMBC:

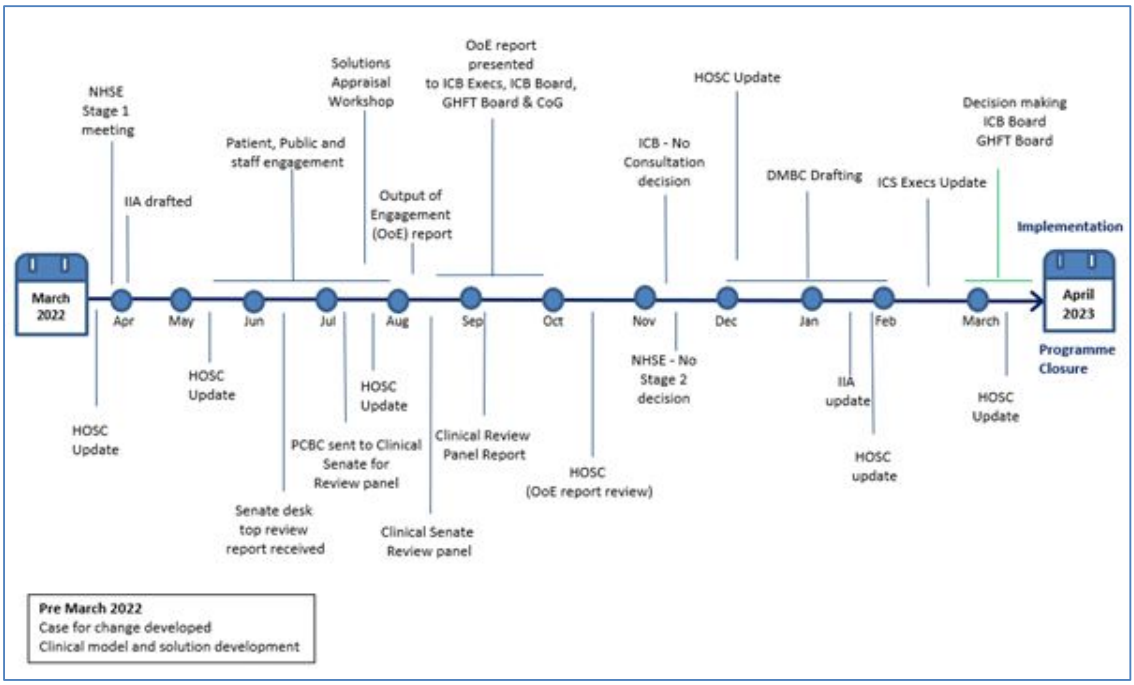
Forum/Audience	Date	Document name and version
NHSE	31/03/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Council of Governors	23/03/22	Glos. ICS Stage 1 Information (v1.2)
ICS Lay & NED Network	12/04/22	Glos. ICS Stage 1 Information (v1.2)
GHNHSFT Board	14/04/22	Glos. ICS Stage 1 Information (v1.2)
GCCG Governing Body	21/04/22	Glos. ICS Stage 1 Information (v1.2)
ICS Executives	05/05/22	Glos. ICS Stage 1 Information (v1.2)
HOSC	17/05/22	FFTF2 Information (v1.3)
South West Clinical Senate (Desk-Top Review)	19/05/22	FFTF2 Information (v1.4)
South West Clinical Senate (Clinical Review Panel)	28/07/22	FFTF2 Pre-Consultation Business Case[7] (v1.6)
GHNHSFT Board	09/03/23	FFTF2 DMBC (v1.1)
Gloucestershire ICB	29/03/23	FFTF2 DMBC (v 1.1)

In addition to the above, the FFTF2 Output of Engagement Report (Appendix 1) was reviewed and discussed at the following meetings and published on the ICS Get Involved in Gloucestershire website:

Forum/Audience	Date	v#
Integrated Care System Strategic Directors	18/08/22	1.2
GHNHSFT Board	08/09/22	1.2
GHNHSFT Council of Governors	22/09/22	1.2
NHS Gloucestershire Integrated Care Board	28/09/22	1.2
HOSC	18/10/22	1.3

[7] The decision not to consult was taken after the Clinical Review Panel (see section 2.1)

2.7 FFTF2 Programme Timeline



Key Points

- **Our proposals are guided and informed by the NHSE *Planning, assuring and delivering service change for patients (March 2018)* and *Addendum (May 2022)***
- **Following discussion with NHSE and HOSC, the decision was taken to undertake a single-step business case process and move to decision-making (DMBC) following extensive public, patient and staff involvement.**
- **Due to the single-step business case process this DMBC includes information that would usually be included in a Pre-Consultation Business Case.**
- **This DMBC includes information previously submitted to the South West Clinical Senate for review and contains Senate feedback.**

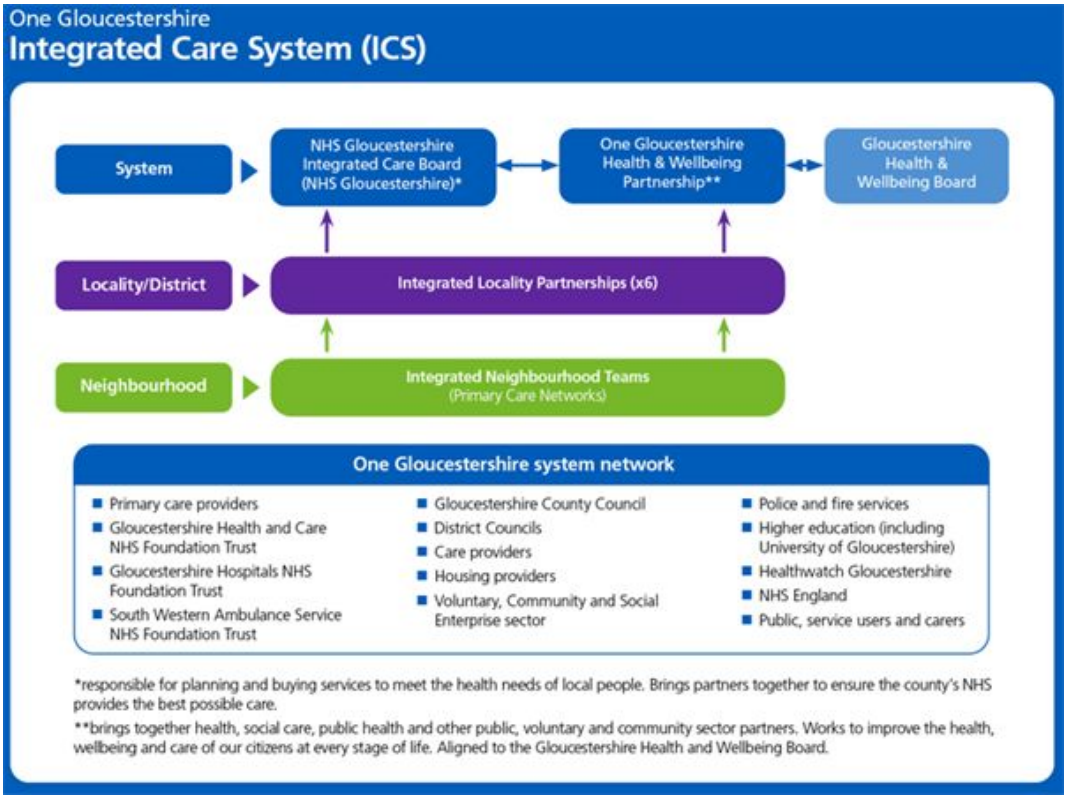
3 Introduction to the System

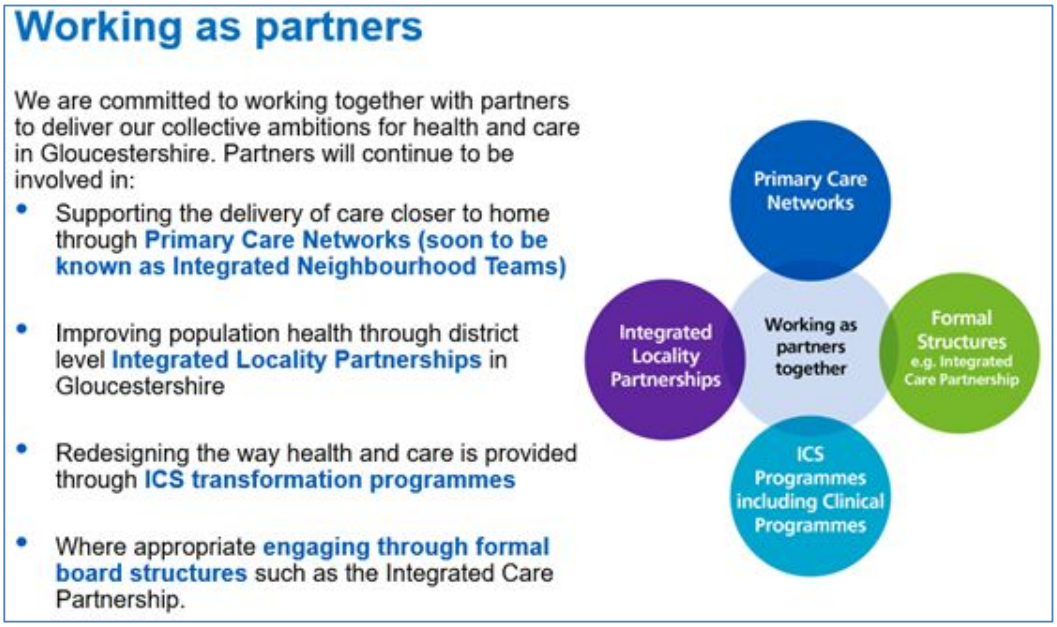
3.1 One Gloucestershire Integrated Care System

Our One Gloucestershire Integrated Care System (ICS) is a partnership that brings together NHS, social care, public health and other public, voluntary and community sector organisations, which became a legal entity on 01/07/22.

Introduction to the System

Our NHS Gloucestershire Integrated Care Board (NHS Gloucestershire) is responsible for planning and buying services to meet the health needs of local people. It also brings partners together to ensure the county's NHS provides the best possible care. It works alongside our One Gloucestershire Health and Wellbeing Partnership - ensuring a joined-up approach across the NHS, public health, social care and the wider public, voluntary and community sector.

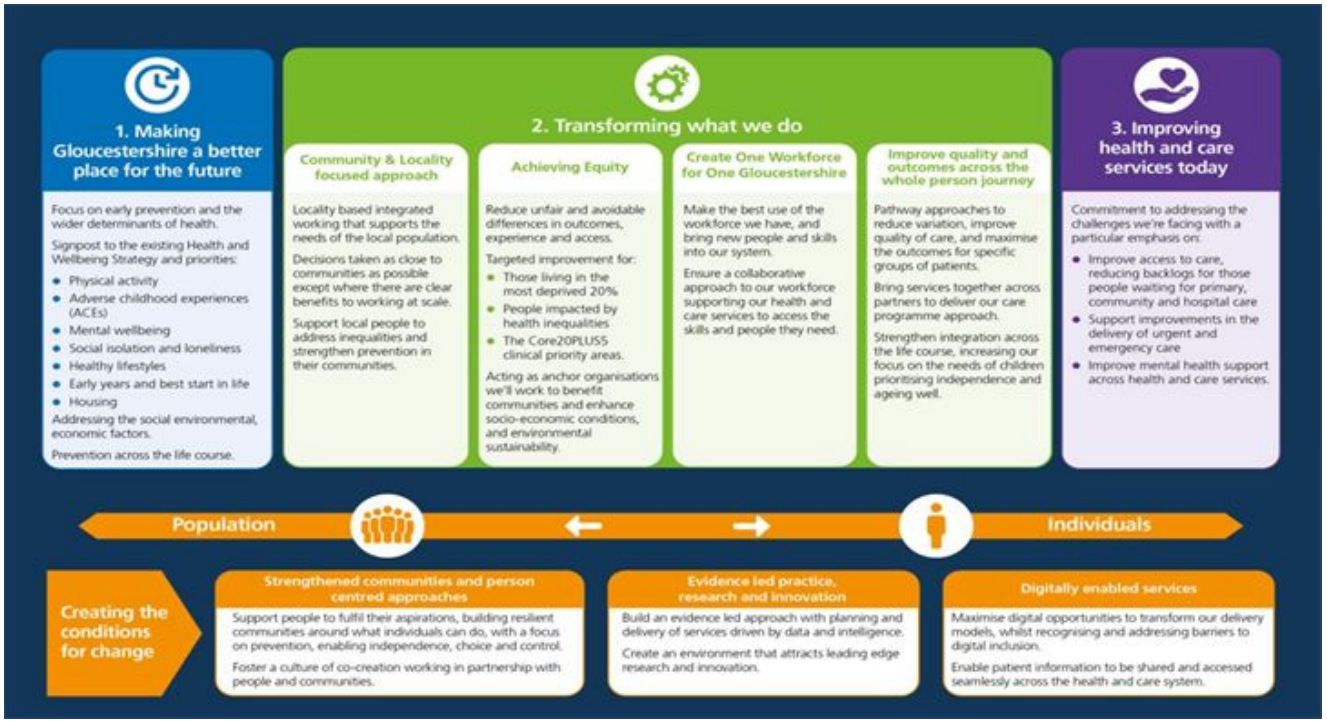




We know that by working together we can build a healthier Gloucestershire; supporting people to live well and providing high-quality joined-up care when people need it. We are ambitious for our county. We want to work with our communities, to improve health and wellbeing.

3.1.1 *One Gloucestershire Integrated Delivery Plan*

Our Integrated Delivery Plan sets out our priority programmes and the activities that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. The plan has been formed from delivery plans that have been developed for each of our Integrated Care System transformation programmes, setting out objectives for the future[8]. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the years ahead.



[8] Further details can be found at Our priorities in Gloucestershire : NHS Gloucestershire ICB (nhsglos.nhs.uk)

3.1.2 *ICS Clinical Programme Groups*

The ICS Clinical Programme Groups (CPGs) are well established in a number of disease areas, working with system partners and lay representatives to ensure optimal clinical pathways for the people of Gloucestershire.

The aim of the programme is to deliver whole pathway transformation across key clinical programme areas, utilising a structured 'Clinical Programmes Approach' based on the principles of improvement science. A fundamental priority is to deliver the best value healthcare for our population.

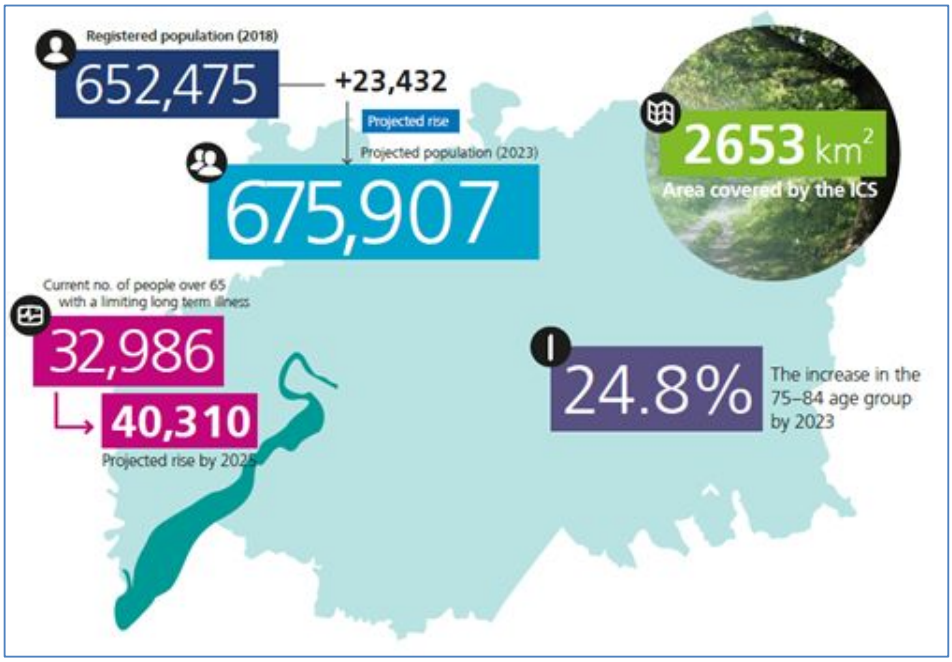
The programme takes a pro-active approach to preventing disease, diagnosing and treating and managing the condition from its early stages. We build on the strong foundations of the clinical programme approach to deliver truly integrated care- both within physical and mental health; challenging system partners to remove barriers to care delivery and reduce the health inequality gap.

We work with all partners to ensure that the clinical programme approach is contributing to eradicating health inequalities, through analysis of data and proactive engagement with service users and the communities we serve through prevention, early diagnosis and timely access to support throughout their lives and be supported at their most vulnerable times to access personalised care, including end of life.

As part of a collaboration between our priority programmes, CPGs and FFTF came together to set up and support service Task and Finish groups in 2021, covering stroke and frailty.

3.2 Local Health Context

The FFTF programme undertakes an integrated impact assessment (see section 11), for the individual services in scope, however, a summary of countywide demographic information is provided below.



The health of people in Gloucestershire is generally better than the England average. Gloucestershire is one of the 20% least deprived counties/unitary authorities in England, however about 12.6% (13,320) children live in low income families. Life expectancy for both

men and women is higher than the England average although it is 8.4 years lower for men and 5.4 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

Gloucestershire has a lower proportion of 0-19-year olds and 20-64-year olds when compared to the national figure, whilst the proportion of people aged 65+ exceeds the national figure. As is the case in many parts of the UK, the number of older people in the county has steadily increased over the last 10 years. Projections suggest this trend will continue, with the number of people aged 65+ projected to increase by 77,000 or 59.4% between 2016 and 2041.

According to the 2011 Census [9]16.7% of Gloucestershire residents reported having a long-term limiting health problem; this was below the national figure. As age increases the proportion of respondents reporting a limiting long-term health problem increases. Given the ageing population, the number of people with a limiting long-term health problem is likely to increase in the future.

The three leading causes of death for our population are cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%). Age is the leading risk; however, the burden of disease in these categories is associated with four additional key risk factors: poor diet, physical inactivity, smoking and excess alcohol consumption.

Poor mental and emotional wellbeing also have a key part to play. Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse rates than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will more fully involve individuals in their own health and care by making shared decision-making a reality by intensively training our clinicians to give people the support and information they need for effective self-management and involving their families and carers to support them in making the changes needed to keep healthy. There is clear evidence that most people want to be more involved in their own health and that, when they are, decisions are better, health outcomes improve, and resources are allocated more efficiently.

3.2.1 *Population and Demand Growth*

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). We have reviewed the age-group, gender, and locality profiles of patients for each of the proposals in scope and applied the appropriate growth rates to our baseline activity to assess the impact of cumulative growth for the period 2022 to 2031.

The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID)

[9] See section 11 for rationale regarding use of 2021 census

pandemic. As with all systems, the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of resources; for example, when comparing 2019 with 2021 we have seen a >25% reduction in average surgical bed numbers used (and a reduction as a proportion of total) and a 50% increase in number of beds occupied by Medically Fit for Discharge/ Not Meeting the Criteria to Reside (MFFD/NMCTR).

Given the multi-factorial nature of current resource demands, including COVID, elective recovery, continuing Urgent & Emergency Care demand, and uncertainty as to their impacts, this DMBC has not attempted to inflate resource demand (including bed demand and capacity, see section 5.7), based on an unmitigated position. Our modelling takes account of the last three years, our pre-COVID demand and our plans for the future.

If these proposals are approved and the programme shifts to implementation over the coming years, decisions will take account of the position at the time, and the developing recovery paradigm.

Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE, excluded these impacts from our baseline data, staffing models, resource requirements and finances.

3.2.2 *Joint Strategic Needs Assessment & Joint Health and Wellbeing Strategy*

The Gloucestershire Joint Health and Wellbeing Strategy 2019-2030[10] (JHWS) sets out the plans to address our seven Health and Wellbeing Board priorities:

- Physical activity
- Adverse childhood experiences (ACEs)
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Early years and best start in life
- Housing

As an ICS we recognise that our JHWS is intrinsically linked to our response to the NHS Long-Term Plan (LTP) and the services included within this document should not be seen in isolation from all the other developments that support the delivery of our JHWS and address the issues and challenges identified in our Joint Strategic Needs Assessment 2017 (JSNA)[11] . Our JSNA does highlight that Gloucestershire has an ageing population, with a higher and growing number and proportion of older people and this is developed as part of our Case for Change

3.3 Local Providers Context

The One Gloucestershire ICS structure is presented in section 3.1 and includes the following organisations, NHS Gloucestershire Integrated Care Board, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire County Council, South Western Ambulance Service Foundation Trust and Gloucestershire Health and Care Services NHS Foundation Trust.

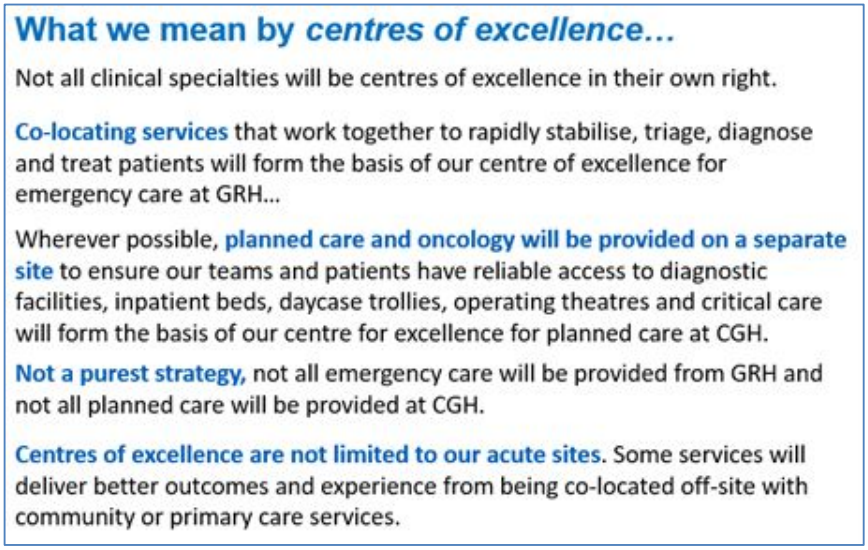
[10] Gloucestershire Joint Health and Wellbeing Strategy 2019-2030 can be found in Appendix 2

[11] Gloucestershire Joint Strategic Needs Assessment (2017) can be found in Appendix 3

3.4 Introduction to the Fit for the Future Programme

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future.

Our FFTF Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites. Our *Centres of Excellence* vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics, and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve care for everyone.



3.4.1 *National drivers/context*

This section sets out the national context in which this FFTF2 business case has been developed.

The *Centres of Excellence* programme envisions that some specialties will have a greater separation of urgent care and planned care to improve availability of beds, access to appropriate senior staff, ensure fewer cancelled operations and improve waiting times. The benefits of separating planned and unplanned activity are cited by a number of sources.

The Royal College of Surgeons of England (RCS) recommends separating planned surgical admissions from emergency admissions (ideally on a single site), suggesting that this can result in earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital-acquired infections and length of stay (particularly medical emergencies) wherever possible.[12] The King's Fund also states that professional guidance, as well as the available research evidence, support the separation of planned from emergency surgery (either geographically or through the provision of dedicated facilities and staff).

The NHS Long Term Plan[13] states that separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing emergency care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. NHS England has confirmed that it will continue to support hospitals that wish to pursue this model.

The NHS England Transforming Urgent and Emergency Care Services in England guide for local health and social care communities (2015) states that:

- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke, major trauma and heart attacks.
- In an emergency, patients should be seen by a senior clinical decision maker as soon as possible. This improves outcomes and reduces length of stay, hospitalisation rates and cost.
- Acute assessment units (which co-ordinate tests and input from the different hospital specialist teams) enhance patient safety, improve outcomes and reduce length of stay.

3.5 Fit for the Future: Phase 1

FFTF Phase 1 completed its Stage 2 review in September 2020 and the Decision-Making Business Case (DMBC) was approved in March 2021. The reconfigurations agreed in Phase 1 are presented overleaf, including their implementation status which is linked to GHNHSFTs Strategic Site Development (SSD) programme. This has allowed us to phase the implementation of the proposals contained within FFTF, ensuring that the necessary facilities and infrastructure are in place to support the reconfiguration of services.

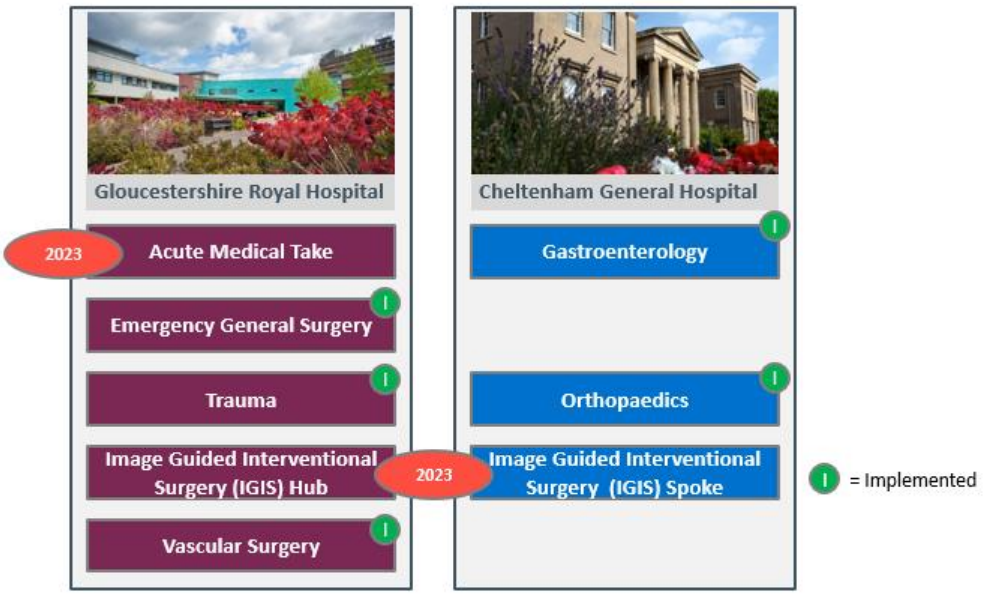
[12] RCS referenced in King's Fund (2014) https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/elective-surgical

[13] NHS (2019) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

The SSD programme includes two additional theatres and a Day Surgery Unit at CGH; the new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. GRH will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment. The current timescales (subject to change) for completion of key GSSD developments are:

- GRH Gallery wing – creation of additional inpatient ward facilities -– Completed
- CGH Day case unit - April 2023
- GRH Catheter Labs - September 23
- CGH Theatres - October 2023
- GRH Expanded Emergency Department (ED)
    - Phase 2A (New Minors/Fractures) and 2B (Majors) – Completed
    - Phase 5b (Existing ED refurbishment) –June 2023.
- GRH Acute Medical Unit
    - AMU 2 (single side room with ensuite) –February 2023
    - AMU 1 (x15 bed spaces) –May 2023.

FFTF Phase 1 Service re-configurations



The benefits to services included in Phase 1 were designed to:

- Improve health outcomes for patients
- Make sure patients are always assessed by the right hospital specialist (e.g., doctor) with timely decisions about their treatment and care
- Ensure there are always safe staffing levels, including senior doctors available 24/7 and teams have the best equipment and facilities
- Reduce waiting times and limit the number of operations that are cancelled
- Support joint working between services to reduce the number of hospital visits people have to make

- Create flagship centres for research, training and learning - attracting and keeping the best staff in Gloucestershire
- Deliver more specialist services in Gloucestershire to enable people to receive care locally rather than travelling to Bristol, Birmingham and Oxford as they do now.

For the services implemented we are delivering many of the benefits described in our FFTF1 DMBC; details can be found in Appendix 4b. We continue to work on the realisation of the FFTF1 benefits and these will be added to as we implement the remaining FFTF1 service reconfigurations in 2023.

All our Phase 1 documents (including the DMBC) can be found at Fit for the Future: Developing specialist hospital services in Gloucestershire – OneGloucestershire.net

With these Phase 1 changes agreed and the principle of a greater separation of emergency and planned care established, the programme developed Phase 2 reconfigurations that fit with this model, which are subject of this decision-making business case.

3.5.1 *Planned General Surgery*

The only FFTF Phase 1 service not covered above is Planned General Surgery. Prior to the DMBC approval process, GHNHSFT Trust Leadership Team (TLT) explored in detail the configuration options for Lower GI (colorectal) surgery, and it was evident as a result of the debate, which considered feedback received during FFTF1 public engagement and consultation, that there was an alternative, potentially even better option, that includes the best elements from the two options presented during consultation and notably the opportunity to deliver even more planned elective surgery from the Cheltenham Hospital site.

The recommendation was that further work should begin with the General Surgery team to define this new, emerging option. Since then, significant work has been undertaken and further proposals presented, and decisions made, by TLT (November 2022). The latest position is that the division are developing a decision-making business case to cover the following:

1. The creation of dedicated Gastrointestinal day surgery lists at CGH.
2. The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.
3. Co-location of all resectional Upper Gastrointestinal Surgery at GRH
4. Co-location of all Colorectal resectional surgery at GRH.

The benefits of this proposal include greater numbers of patients within the Centres of Excellence model making use of the new Day Surgery unit in Cheltenham, reduction of cancellation for bed pressures- especially when the new theatres are completed in 2023 and the creation of highly specialised units to maximise efficient theatre lists and reduce cancellation.

It should be noted that there are no dependencies between this last remaining FFTF Phase 1 service change and our proposals in FFTF Phase 2.

3.6 Fit for the Future: Phase 2

'Fit for the Future - 2' is not only about the continued development of the '*Centres of Excellence*' approach and how we organise specialist hospital care at CGH and GRH, in some cases it's also about how we can improve the wider journey of care (pathway) for the person who needs services or support.

The services we focus on in FFTF2 are:

- Benign Gynaecology *[14]
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

Each of the services will be covered in detail in their individual sections. In developing our FFTF2 programme we sought to look at the whole pathway for some services rather than a focus only GHNHSFT services, as was the case in FFTF1.

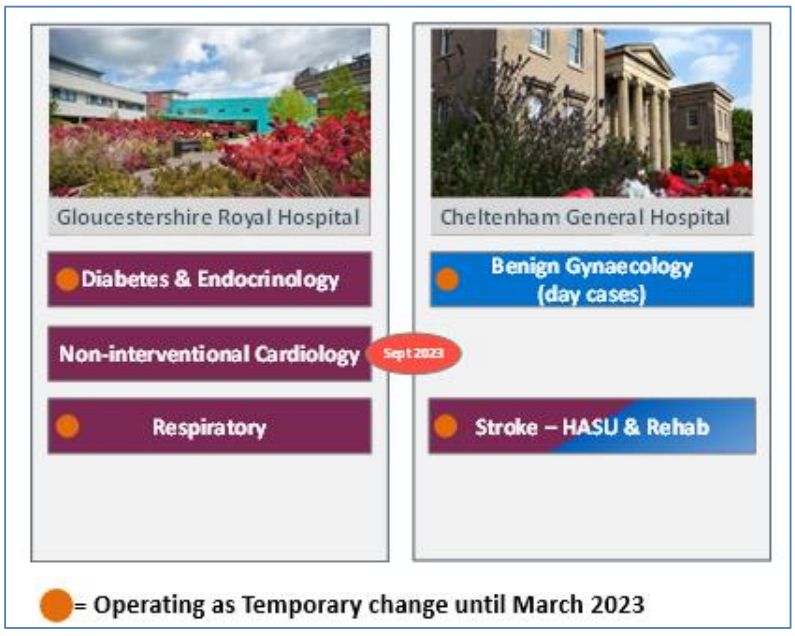
When we are looking at how, when and where we support, or provide healthcare to someone, there are a number of things we need to think about:

How we can provide the very best care for people at each stage of their illness or injury i.e., very specialist care for people when they are very unwell, rehabilitation support for people to help them recover and regain their independence, e.g., from an operation or other treatment and - in many cases - follow up care and support over the longer term

Opportunities to join up care (integration) - improve communication and make care simpler and smoother across services and communities. This could be:

- between related services in a hospital
- between GP surgeries and community or hospital services
- between health and social care services and;
- between the NHS, social care and other key community partners, e.g., local councils, voluntary and community groups and others.

How we tackle health inequalities, i.e., ensure that we improve health outcomes for everyone - regardless of where they live in the county and their social, environmental or economic circumstances.



[14] *Currently subject to Temporary Service Change (for details see individual service sections)

One of the services included in our FFTF2 engagement (see section 4), was Frailty/Care of The Elderly as we wanted to take the opportunity to hear from the public, patients and staff about their experiences of current services. However, the potential developments and improvements to the frailty pathway would not be subject to the statutory duty requirements co-ordinated by the FFTF Programme. For this reason, Frailty/Care of The Elderly is not included in this DMBC.

The only other temporary service change not covered in FFTF2 is the re-location of the Medical Day Unit at CGH. It was not part of our FFTF2 engagement and is being managed as a separate process.

It is also important to state what Fit for the Future 2 (FFTF2) is not about. It is not about:

- Saving money. The priority is quality of care and health outcomes
- FFTF1 - the public consultation in 2020, past decisions and the service changes that are now being implemented
- The Accident and Emergency Department in Cheltenham, which remains a 24-hour A&E (nurse led service overnight 8pm to 8am).

Key Points

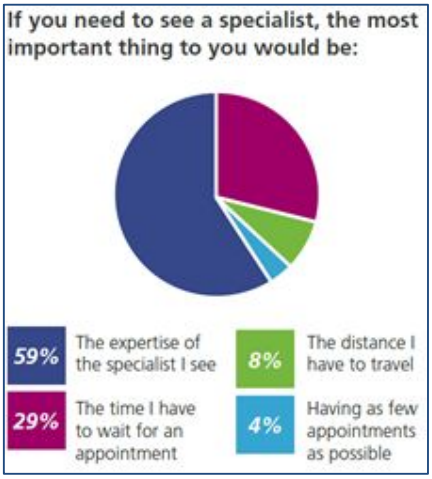
- **Fit for the Future (FFTF) is a key element of our ICS Integrated Delivery Plan**
- **FFTF links with our ICS Clinical Programme Groups to deliver whole pathway transformation.**
- **FFTF is part of our response to the NHS Long Term Plan delivering our Centres of Excellence vision for the future configuration of specialist hospital services at GRH and CGH.**
- **The FFTF Programme has two phases (FFTF 1 & 2), working closely with the GHNHSFT Strategic Site Development, to deliver benefits to our population.**

4 Public, Patient and Staff Engagement

In this section we seek to demonstrate that the Fit for the Future2 (FFTF2) programme has built on the extensive engagement and consultation activities for FFTF Phase 1, which clearly identified that there is high recognition of *Centres of Excellence* amongst those responding to our surveys. In addition, many respondents to our FFTF1 Consultation felt that the centralising of services would optimise care quality, increase staff retention and learning for staff which would result in reduced waiting times and cancellations.

Furthermore, as part of developing our local plans for Gloucestershire over the last few years, we have been asking staff, patients, carers, public and community partners, what matters to them about local health and care services

- 69% of respondents agreed we should bring some specialist hospital services together in one place
- A significant proportion felt the expertise of the specialist was more important than distance to travel (see opposite).



It is our contention that FFTF2 has engaged inclusively[15], innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services. In doing so we believe we have met the requirements of NHSE Guidance:

- Robust public involvement;
- To be proactive to local populations;
- To be accessible and convenient;
- To consider different information and communication needs, and;
- To involve clinicians.

Our learning from the Phase 1 consultation highlighted the benefits of new channels of communication with the public (as a result of COVID restrictions), and our engagement for Phase 2 included blended approach of face to face and virtual.

The FFTF2 public and staff engagement programme started in May 2022 (until 31/07/22), to seek views on the future provision of specialist hospital care in Gloucestershire. The full Output of Engagement report can be found in Appendix 1, and details all the engagement activities, full demographic analysis of survey respondents and all quantitative data. As stated in section 2 the report has been widely shared and formally reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and Gloucestershire Health Overview and Scrutiny Committee (HOSC).

A brief summary is presented in this section.

[15] See Appendix 1 OoE - section 5.5 Engaging people with protected characteristics and others identified in the Integrated Impact Analysis and individual service IIAs (Appendix 13)

4.1 Engagement Materials

The engagement programme produced and utilised the following:

Engagement Booklet (Long)	Engagement Booklet (Short)
Engagement Booklet (Easy Read)	Display materials
An Engagement questionnaire/survey (online and hard copy)	Range of videos (with local clinicians explaining each of the service proposals)
Frequently asked questions	

4.2 Engagement activities

A range of communications channels have been used including:

Gloucestershire Hospitals: Facebook Live (@GlosHospitals)	Targeted engagement to address the homogeneity of participants
'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform	GHNHSFT staff FFTF2 events plus presentations and awareness raising at team, divisional and Trust-wide meetings
NHS Information Bus Tour	Public events
A phased communication campaign for GHNHSFT staff using existing channels (CEO briefing etc.), weekly FFTF2 service focus emails, posters across both hospital sites, booklet drops to teams and Q&A sessions.	Presentations to Integrated Locality Partnerships; ILPs are operational and strategic partnership of senior leaders of providers and local government, supporting integration at PCN level
Healthwatch Gloucestershire	Presentations to local councillors
Presentations to PCN clinical leads	Media releases and stakeholder briefings
Media (print and social) advertising	

4.2.1 *Staff Communication and Engagement*

Details of staff engagement activities referred to above are provided in Appendix 1 and feedback themes from staff are included in both this section and in the individual service sections.

It is important to note that, following feedback from staff during FFTF1 we adapted our survey categorisation nomenclature and also enhanced and improved our staff engagement campaign for FFTF2. We had a very good response from staff to our survey, at 43% respondents (i.e., excluding those not completing or "preferring not to say").

Informal feedback from staff has been that FFTF2 staff engagement was better than FFTF1.

4.3 Quantitative Analysis

Full details are in the individual service sections (6-10) and indicate a strong level of support for all service ideas, summarised in the table below:

Service	Support	Oppose
Benign Gynaecology	92%	8%
Diabetes and Endocrinology	98%	2%
Non-interventional Cardiology	99%	1%
Respiratory	97%	3%
Stroke	84%	16%

4.4 Qualitative Analysis - Engagement feedback themes

Details of the responses and themes is provided for each of the services in sections, however, a number of themes were consistent across all services; these included:

4.4.1.1 Public and Patients themes

- Support for Centres of Excellence approach
- Travel and Transport
- Car parking
- Ward environment

4.4.1.2 Staff themes

- Benefits of the Centres of Excellence approach
- Travel and Transport
- Car parking for patients
- Health inequalities
- Interdependencies with other clinical services
- Improved integration with primary and community services

4.5 Other Stakeholders

4.5.1 *Neighbouring ICBs and Health Boards*

The FFTF Programme team have been in contact with neighbouring ICBs at the start of our engagement to encourage them and their residents to participate. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) are finalised.

The overall activity numbers for FFTF2 are considerably lower than FFTF1 and the impact on patients registered outside Glos. is similarly reduced. We also look at patients per practice and have contacted the practices direct (those >4). This is summarised in the table below.

ICB and Health Boards	Activity	Practices >4
Aneurin Bevan University Health Board	65	3
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	16	13
NHS Coventry and Warwickshire Integrated Care Board	2	1
NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	6	2
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	29	24
NHS Herefordshire and Worcestershire Integrated Care Board	200	41

4.5.2 *Health Overview and Scrutiny Committee*

Throughout both the Fit for the Future Programmes regular updates on the FFTF programme and engagement have been provided to the Gloucestershire Health Overview and Scrutiny Committee (HOSC), with the Output of Engagement report will be presented and discussed with members in October 2022.

4.5.3 *MPs*

The ICS Executives are in regular communication with local MPs, and this has included proposals within scope of the Fit for the Future Programme.

Key Points

- **Fit for the Future 2 (FFTF2) built on the extensive engagement and consultation activities for FFTF Phase 1**
- **FFTF2 has engaged inclusively, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services.**
- **Engagement responses indicate strong support for our proposals.**

5 Information for all FFTF2 Service Proposals

As described in Section 3.6 there are five services in scope for Fit for the Future (FFTF) Phase 2 and, whilst all are aligned to our strategy, the drivers for change vary across each service.

This section provides information on aspects common to all proposals whilst the following sections provide information for each individual service change proposal, covering:

- The "current state" service model
- Clinical engagement
- Case for change, the problem we are seeking to address
- Clinical evidence
- Our preferred option for "future state" and the work done to assess
- Benefits
- Interdependencies
- Workforce
- Learning from temporary service change period (where applicable)
- South West Clinical Senate review
- Engagement feedback
- Addressing themes from engagement.

5.1 South West Clinical Senate Review

The FFTF programme has worked closely with the South West Clinical Senate through Phases 1 and 2 and greatly values the Senate's input to provide an independent clinical review of large-scale service changes, to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. The senate also check whether proposals for large scale service change meet the Department of Health's tests for service change, particularly the clinical model and the evidence base (and the bed test where relevant).

Details of the Senate Clinical Review Panel (including the full report) would usually be contained with a PCBC but, as detailed in section 2.2, we are using a single-step business case and therefore have included both the report and a summary in the DMBC.

5.1.1 *Senate Review Process*

The review is undertaken in two stages:

1. **Stage 1 Sense-Check /Desktop Review by Senate**: completed via desktop by a small (4-6) 'virtual' panel of Senate Clinicians. The Desktop Review Report (received 28/06/22) raised a number of questions and details of these and our responses are presented in the relevant service sections).
2. **Clinical Review Panel** (10/08/22): This brings together a panel of out of area clinicians relevant to the service areas and our clinical leads for the proposed models to present the model of care, followed by questions and discussion with the panel. The Clinical Review Report (received 15/09/22), is in Appendix 5, a brief summary is provided in the section below, and our comments are presented in the relevant service sections.

5.1.2 *Clinical Review Panel summary*

Full details can be found in the report and those specific to each service are contained in the relevant sections, however there were a number of general findings:

- The Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

- The Panel did not have any concerns about the proposals from an access, equality, or diversity perspective.
- Some of the proposed service changes were introduced as temporary measures as part of the response to the COVID pandemic and the Trust has had the opportunity to learn from this.
- Some of the proposed service changes have impacts outside the services included in the scope and these have been considered alongside the specific proposals.
- The panel was reassured that the Trust has ensured that all specialities providing specialty medical consultation services at CGH have included this work in consultant job planning. The panel believes that it is essential that this continues in the future.

The panel report also included specific points that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. Details can be found in the report (Appendix 5) but can be summarised as:

- The management and monitoring of inter-site ambulance transfers (see section 5.6)
- Preparations for the centralisation of the acute medical take to GRH including medical cover at CGH, SWASFT protocols and acuity of Emergency Department walk-in patients (see section 15)
- Workforce (see section 5.4)
- Bed modelling (see section 5.7)
- Stroke (see section 10), and
- Communication (see section 15.4)

5.2 Options Evaluation Process

5.2.1 *A structured process was used to identify options*

The Fit for the Future Programme has, from the outset, had a clear process in place to develop its clinical models through a combination of innovative ways to involve local people and staff (from a survey and 'drop in' events, independently facilitated workshops, an engagement hearing, and culminating in an inclusive and transparent solutions appraisal process), a clear governance structure and agreed and delivered outputs.

The process was initially developed as part of Phase 1; details are available in the Phase 1 Pre-Consultation Business Case (Fit for the Future | Get Involved In Gloucestershire (glos.nhs.uk) and has been adapted for Phase 2. This is a two-stage process using hurdle/ essential criteria to a long-list and then desirable criteria to the medium/short-list to identify the preferred option. In a summary our process involves:

- **Building a clear Case for Change** - This involved describing the local population's health and care needs now and into the future, setting out how services are currently provided and highlighting the challenges faced by current health and care services now and in the future as they seek to meet the needs of our local population.
- **Defining evaluation criteria**, against which different *Centres of Excellence* models for the future have been assessed. These were heavily shaped by feedback from the pre-consultation engagement phase.
- **Developing best practice care pathways and models of care**. This first involved drawing on local, national and international exemplars.

- The **shortlisted options** have been evaluated against the agreed criteria; detailed in individual service sections.
- The **preferred options** have been tested for safety, feasibility and viability both internally (by the ICS and organisational governance) and review by the South West Clinical Senate and NHSE.

5.2.2 *Hurdle Criteria*

Hurdle criteria are applied by the individual services (with support from the FFTF programme team) at a dedicated service meetings and confirmed by the relevant Divisional meeting. The criteria were developed in Phase 1 following engagement feedback and are:

- Address the issues identified in the Case for Change
- Supports the delivery of high-quality care across Gloucestershire, ensuring provision of a clinically safe service.
- Achievable and able to be delivered in a timely and sustainable way.
- Affordable and offers best value for money, making the most of the Gloucestershire pound
- Supports sustainable ways of working and facilitates both recruitment and retention of our workforce.

5.2.3 *Desirable Criteria*

There are a number of domains (each with a sub-set of questions), including:

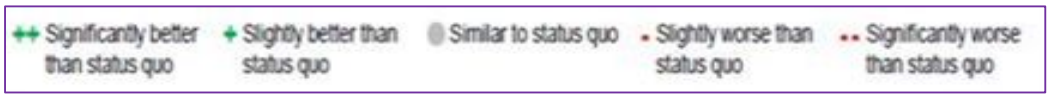
Quality of care (10 questions)
This section included questions to evaluate clinical effectiveness, patient outcomes, patient and carer experience, continuity of care, the quality of the care environment, self-care, patient transfers, travel time impact and the management of risk.
Access to care (10 questions)
This section included questions to evaluate the impact on patient choice, simplifying the offer to patients, travel burden for patients, carers and families, waiting times, supporting the use of new technology to improve access, improving or maintaining service operating hours and locations, impact on equality and health inequalities and accounting for future changes in population size and demographics.
Deliverability (8 questions)
This section included questions to evaluate the expected time to deliver, meeting the relevant national, regional or local delivery timescales, access to the required staffing capacity and capability, support services, premises/estates and technology to be successfully implemented.
Workforce (12 questions)
This section included questions to evaluate the impact on workforce capacity / resilience, optimising the efficient and effective use of clinical staff, cross-organisational working across the patient pathway, flexible deployment of staff and the development of innovative staffing models, staff health and wellbeing, recruitment and retention, maintaining or improving the availability of trainers, enabling staff to maintain or enhance their capabilities/ competencies, the travel burden for staff and clinical supervision.

Strategic fit (2 questions)
This section included questions to evaluate compatibility with the One Gloucestershire vision and the NHS Long Term Plan
Acceptability (1 question)
This question seeks to evaluate if the model has satisfactorily considered the FFTF engagement feedback.

5.2.4 *Assessment Process*

The process used by the FFTF programme is to arrange workshops, both in person and virtual (as requested by our FFTF Lay Reference Group), consisting of clinical and operational staff from each service, members of the public, stakeholders, GPs and organisational and system leadership.

The proposals are assessed using the desirable criteria and the assessment method we use is to compare proposals to the status quo and record if:



Scorers were provided in advance with a range of information for each of the services being evaluated including:

- Service description
- Service Change Proposal
- Case for Change
- Impact summary
- Evidence to support scoring – description of “what would be better” and “what would be worse” for every question
- Clinical Senate Desk-top Review feedback
- Integrated Impact Assessment including travel impact analysis

The scoring is normally a two stage process:

1. **Online questionnaire**: all the information is sent in advance and scorers complete individual assessments (including comments), of the solutions/models they had been allocated, prior to the workshop.
2. **Workshop consensus**: in-person workshops are held with each table reviewing a number of service proposals where:
    - scorers were given copies of their assessments
    - facilitators share the online results for each question
    - A discussion takes place referencing the workshop information and comments
    - A consensus score and any comments are agreed and recorded

Unfortunately, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on one of the workshop dates. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in

agreement with NHSE, for two of the service change proposals we reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in the relevant service sections.

The overall status is presented below:

Stroke	Evaluated in virtual workshop and consensus scores agreed
Respiratory	Evaluated in virtual workshop and consensus scores agreed
Diabetes and Endocrinology	Evaluated in virtual workshop and consensus scores agreed
Non-interventional Cardiology	Evaluated individually online and reviewed/ summarised by Programme Director
Benign Gynaecology	Evaluated individually online and reviewed/ summarised by Programme Director

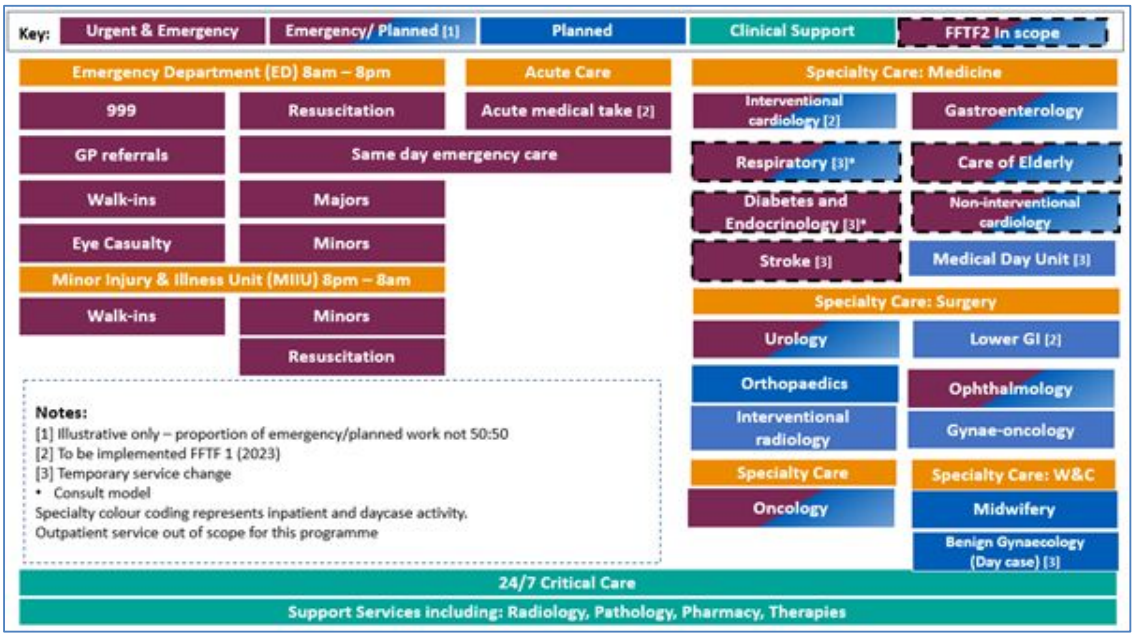
5.3 GHNHSFT Service locations

For context and completeness, we have included a summary of the "current state" and "future state" services at each site. This is, however, made complex as we need to take account of:

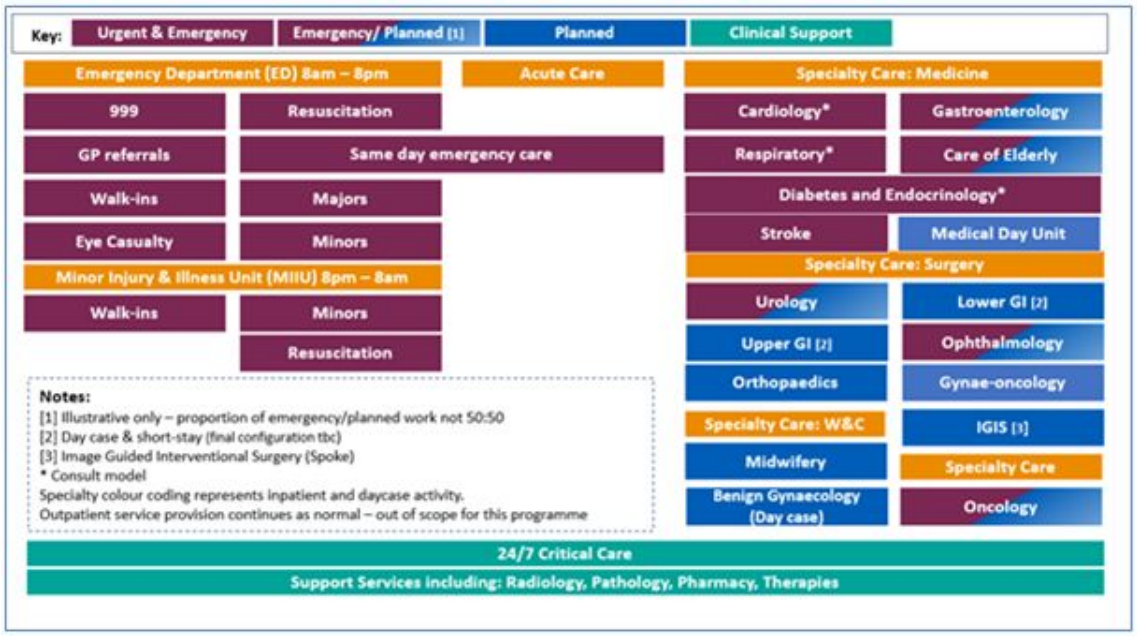
- FFTF1 services that are to be implemented in 2023
- FFTF2 services that are operating as temporary service changes.

The schematics below represent the "current state" location of services as of February 2023 and the "future state" when FFTF1 and FFTF 2 services are implemented.

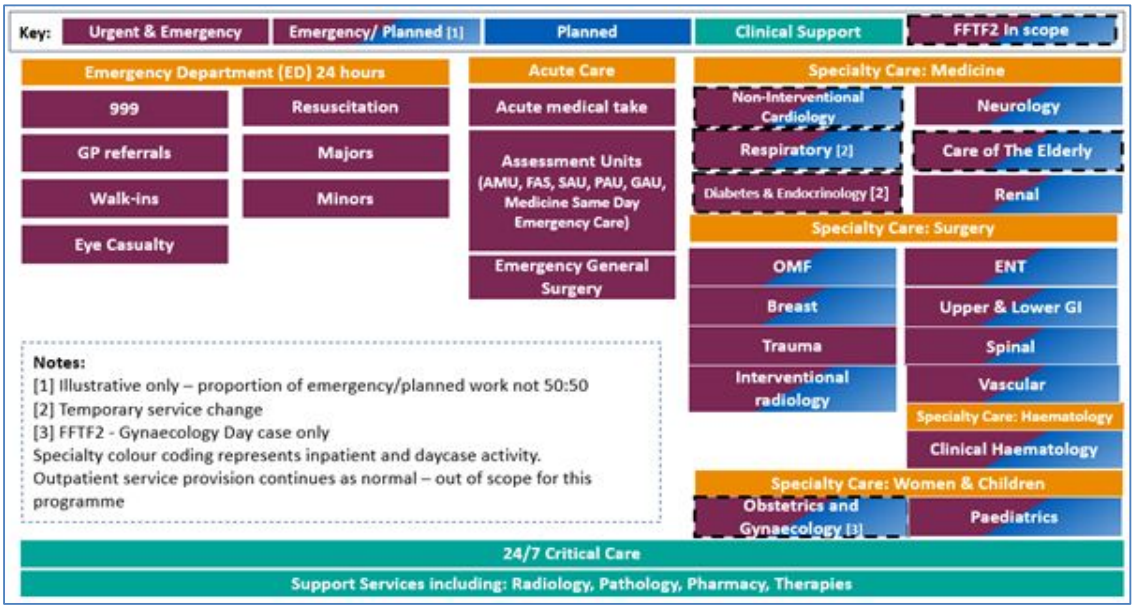
5.3.1 *Cheltenham General Hospital (CGH)- current state*



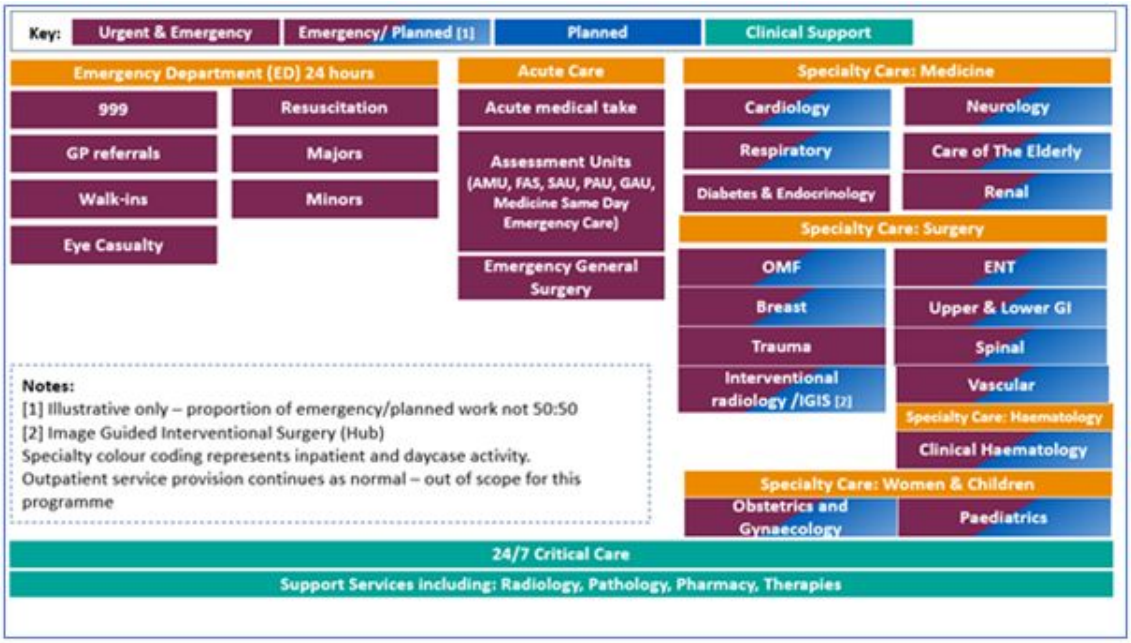
5.3.2 *Cheltenham General Hospital (CGH)- future state*



5.3.3 *Gloucestershire Royal Hospital (GRH)- current state*



5.3.4 *Gloucestershire Royal Hospital (GRH)- future state*



5.4 Workforce

The ICS partners, as sponsors of this DMBC, are fully cognisant of the indispensable role that our staff have in the delivery of the proposed changes. GHNHSFTs People and Organisational Development Strategy sets out the trusts' direction of travel to 2024 in terms of its staff and is centred around the ethos of *"Caring for those who Care".* The NHS Long Term Plan sets out how we will transform models of care over a 5 year period with the People Plan 2020/2021[16] setting out the workforce transformation needed to deliver 21st century care including an initiative to "release time to care", all linked to the NHS Long Term Plan. Great emphasis is also placed on staff development, health and wellbeing and work life balance including a far more flexible approach to working patterns etc.

We are committed to supporting and developing our staff and fully endorse the NHS Long Term Plan ethos of ensuring we have "…*enough people with the right skills and experience so that staff have the time they need to care for patients well"* **(NHS long Term Plan).** All of this has underpinned our approach in respect of the workforce plans for Centres of Excellence.

We recognise that changes to location and ways of working can have a positive and negative impact on job satisfaction, morale, retention and travel time and cost. Staff affected will include those working directly in the services in scope and there may be some changes for staff working in support services.

Defining the long term configuration, co-location with other clinical services and supporting estate and equipment investment will help to improve recruitment and retention in services in scope. A change in site will also have a differential impact on staff with some colleagues seeing an increase in travel time and costs and some seeing a reduction.

[16] NHS people has been further prioritised in the national planning guidance for 2021/22 and 2022/23, and work continues to develop for the longer term

5.4.1 *Staff Engagement if a decision is made to implement proposed models*

As indicated in the section above, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022). Staff working arrangements have been agreed and put in place. If a decision is made to approve the proposals in this DMBC, in addition to the staff engagement detailed in section 4, further staff engagement will be undertaken for all services, either confirming the current locations and working arrangements (four services) or the proposed service change (1 service); the methodology is described below.

Managers will use team and one to one meetings to understand individual and team preferences on location or specialty. Staff wishing to remain within their current Division, e.g., Surgery, Medicine etc., will be accommodated and, wherever possible, within their current specific speciality. The objective will be to accommodate preferences wherever possible, i.e., stay on the same ward or site, stay together as a team or stay with the specialty (so move with the service) and this will be achieved through vacancy management which will form part of any implementation plan.

As staff are required to work across sites, relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns which will need to be accommodated and these will be raised with the HR Advisory and HR Business Partner (HRBP) team to resolve, e.g., travel issues and child care.

A staff briefing document will be provided to Managers to support these conversations and ensure consistency of message and will be sent to Staff Side for review. Feedback on the proposals will be captured on a standard form. A Frequently asked questions (FAQs) will also be provided.

Our approach is to encourage staff to talk to their line manager throughout the process to discuss individual issues or circumstances and if further support is required staff can seek advice from the HR Advisory Service, staff side representative or for staff wellbeing and psychological support through the GHNHSFT 2020 Hub.

To support the process, we will ensure regular communication between each affected HRBP with oversight by the Director of People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary.

5.4.2 *Workforce Planning Approach*

The FFTF Programme, working with HR, clinical and operational colleagues, uses a workforce planning approach to model the workforce requirements of service change proposals. This was followed for FFTF1, where there were significant workforce changes and has been used proportionately for FFTF2, in recognition of the significantly smaller scale of workforce changes.

Critical to workforce planning is identifying demand and capacity and this has been central to the work underpinning this DMBC. Workforce planning is an essential element of any Business Planning Cycle and as such a crucial building block in the Operational planning for FFTF and establishing Centres of Excellence. In line with NHS directorate and Trust guidance the overall test is that we comply with the Safer Staffing requirements as detailed in National Quality Board (NQB) guidelines.

Ratio of staff to patients

When considering ratio of staff to patients a number of the NHS related recognised measuring tools were applied dependent upon speciality/professional staff group/expertise etc. GHNHSFT has an established process in terms of review of nursing (both registered and unregistered) that is undertaken annually with a bi annual review. In addition, an essential component of workforce planning is the "do ability" factor including:

- Application of uplift to ensure adequate cover for absence such as annual leave and training
- Legal compliance such as working time directive
- Rotas particularly in relation to sustainability of a rota

5.4.3 *Recruitment and Retention*

A key theme for the public, and core to our Case for Change, is the impact of proposed changes on clinical staff numbers, recruitment and retention and examples of our workforce challenges are detailed in the individual service sections, noting the scale of recruitment for Phase 2 is only 3.5 FTE, linked to Respiratory High Care (section 9).

The development and appraisal of our proposals have included the requirement to support sustainable ways of working and facilitate both recruitment and retention of our workforce.

If proposals are approved a planned phased approach to recruitment will be applied; with identified sources of pipeline and any marketing/advertising identified and planned. In terms of *best for patient and best for staff* having substantive staff in place is best all-round and therefore any required recruitment will be structured in such a way to minimise the use of locum/agency/bank.

In the FFTF2 service specific sections we detail how each proposed new clinical option will positively impact our workforce challenges including centralisation of services to avoid splitting resources across two hospital sites which we believe contributes to quality, workforce, financial and performance issues which affect patient outcomes and staff recruitment and retention and efficient use of resources.

5.4.4 *Training – including new roles/ways of working' realignment of skills and upskilling*

We are committed to providing training, development and support to our staff. Any change in job role/area or working conditions such as equipment etc. would be identified and individual and personalised skills analysis work undertaken to identify skills and any gaps/upskilling required.

Where specialities are centralised on a particular site this will enhance the training and support offered to staff. It will also form closer working relationship and peer support which is a positive. For mentors this will prove invaluable in terms of easier access to those they are mentoring and vice versa.

5.4.4.1 Developing Advanced Clinical Practitioner roles

At GHNHSFT there has, for many years been opportunities for advanced level working with Consultant Nurses in Vascular, Trauma and Orthopaedics, Oncology, and Neurology and a Consultant Physiotherapist in MSK and a new appointment Consultant Paramedic in Emergency Department. There have previously been many Nursing, Therapy and Pharmacy Staff undertaking a variety of roles extending their scope of practice with variation in titles and educational pathways. However, since development of a GHNHSFT shared decision-

making council in December 2020 to discuss and debate further there resulted in successful completion of a Trust Policy in Advanced Practice first version September 2021. The Policy aligned to Health Education England definitions and education and supervision guidance has allowed scoping. A new One Gloucestershire Advanced Practice Lead Role from April 2022 drives a current workplan to formalise and develop the Advanced Clinical Practitioners (ACP) role within a safely governed framework.

Health Education England published the first Multi-Professional Framework for Advanced Practice in 2017. Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.

The benefits of this structure are that there is a defined level of practice within clinical professions such as nursing, pharmacy, paramedics and occupational therapy. This level of practice is designed to transform and modernise pathways of care, enabling the safe and effective sharing of skills across traditional professional boundaries.

Advanced clinical practitioners (ACPs) are healthcare professionals, educated to Master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for. ACPs are deployed across all healthcare settings and work at a level of advanced clinical practice that pulls together the four ACP pillars of clinical practice, leadership and management, education and research.

A definition of ACP, its underpinning standards and governance, can be found in the Multi-professional framework for advanced clinical practice in England. The framework ensures there is national consistency in the level of practice across multi-professional roles that is clearly understood by the public, advanced clinical practitioners, their colleagues, education providers and employers.

The roles undertaken by advanced clinical practitioners are determined by the needs of the employer aligned to strategic workforce plans. Currently at GHNHSFT there are small number of stablished ACP roles aligning to HEE definition but there are developing teams of ACPs, Acute Response Team, also teams are currently being developed in ED, Critical Care, Same Day Emergency Care (SDEC), General Surgery, Respiratory and Neonatal Medicine

The NHS Long-Term Plan highlights how advanced clinical practice is central to helping transform service delivery and better meet local health needs by providing enhanced capacity, capability, productivity and efficiency within multi-professional teams. We have a dedicated One Gloucestershire Advanced Practice Lead Role since April 2021 reporting to system workforce leads. The role supported by SW Faculty Health Education England supports a drive in development and implementation of safely governed trainee and established roles. A unified framework for role development, progression, education pathways and supervision aligned to HEE guidance is being developed GHNHSFT to inform multi professional clinical, operational and education leads.

5.4.5 *Staff Support through change*

As indicated, of the five services that are the subject of FFTF Phase 2, four of the proposed changes are already in place as part of Temporary Service Changes (some since June 2020 and others from Feb 2022).

However, if the proposals are supported, confirmation that four of the changes are to become permanent and the one remaining service change will still have an impact on

individuals and groups of staff. A significant element of Managing Change is to support those individuals who are both directly and indirectly affected, one of the main being communication and underlining the need for staff involvement. This is an inclusive process not exclusive.

To support the process, we will ensure regular communication between each affected service line team, Chief Nurse and HRBP with overall oversight by the Director for People and OD. This will ensure that we have early sight of any issues including if the messaging has been adequate and consistent and if there are any issues to implementation. Any inconsistencies or areas of concern will be escalated to the Divisional Tri and relevant HRBP and the team will be proactive in meeting colleagues and staff groups where necessary. Any such change would be undertaken in line with the relevant HR policies.

How change affects individuals can differ greatly and that is why in line with our trust ethos of *Caring for those Care* individual personal needs will be considered. Whilst our underling needs must be to ensure we are able to meet the needs of the service in terms of patient safety and patients we will also balance this with the needs of our staff.

Through staff engagement we will identify individual wants and needs, managing this in line with our trust policies and procedures which are aimed to resolve matters wherever possible by consent.

Staff will be afforded support, and this will be made available and tapered to individual needs. This will also include confidential support links such as 2020 Staff Advise and Support Hub; Working Well (colloquially referred to as Occupational Health) and Staff Support.

5.4.6 *Staff Travel*

Remodelling of services across our two main hospital sites will ultimately have an impact on staff travel to and from work. Staff will experience

- No change as a result of reconfiguration.
- Positive change resulting in shorter travel times.
- Negative change resulting in increased travel time to get to and from their work place.

As described above, as most staff are required to work across sites within their service line relocation is not anticipated to be a contractual issue, but we recognise that there may be individual needs or concerns and our programme of staff engagement will provide opportunities for these to be addressed.

5.5 Impact of Changes on Junior Doctor Rotas and Training

5.5.1 *Engagement with the Deanery*

Historically, the main concern from trainees was a significant imbalance between CGH and GRH in workload and opportunity. This meant less than ideal training experience for trainees on either side – too much emergency work in GRH to get to clinics and too little experience in CGH for the number of trainees placed there. Part of the aim of reconfiguration is to better manage the emergency workload and even-out the opportunities for specialist trainee experience. The Medical Clinical Tutor and Deanery Representative have been in contact with the training Programme Director for Medicine to discuss how we are responding to the concerns raised. Further work is ongoing with the Director of Medical Education, Training programme directors and Clinical Tutors to review the training opportunities that the future configuration of services and will provide. This will

then be shared and discussed with the Programme Directors and Heads of School for Medicine.

The main upcoming change in postgraduate medical education is expansion of foundation trainee numbers over the next 3 years. Currently programmes are being designed to considering where trainees will be placed.

5.5.2 *General advice from the Deanery:*

It is important to maintain foundation trainee post numbers across the trust and all the work schedules for posts affected will be reviewed to ensure suitable learning opportunities are still open to them. The learning objectives for foundation doctors are set through a national curriculum, overseen by the UK foundation programme office and the GMC, and include:

- Foundation year 1 doctors require immediately available support from people with the skills to manage problems they might face (so that could be the Acute Care Response Team or DCC team).
- There is no precise specification for particular hours of the day or night, but posts should provide opportunities for experience to achieve the learning outcomes.
- Foundation year 1 doctors require immediately available support from people with the skills to manage patient care. F2s take on more responsibility for leading and managing patient care but still need to be able to access support for problems they might face (so that could be the Acute Care Response Team or Dept. of Critical Care team).
- There is no rule that requires training to be provided on one site. Many trainees will need to work at several sites to achieve their learning outcomes. Moving between sites should be justified on training grounds rather than service grounds and doctors in training must have induction to all areas and appropriate clinical supervision at all times. If doctors need to move sites during a shift, we need to think about how they will do that safely (and return back afterwards) and without interrupting continuity of patient care.
- Training posts must allow trainees to achieve the learning outcomes set in their curriculum. Colleges may set expectations for proportions of elective/emergency work, but this isn't universal across programmes and will be a guide.
- The risk of prioritising service over training is the withdrawal of training posts and loss of trainees.

Details of the trainee posts affected by FFTF Phase 2 changes are presented overleaf and the impact of FFTF2 planned and proposed service changes on Out of hours Doctor rotas in Appendix 6.

	FY1Trainees	SHO (FY2, CT1 & 2)	ST3 and above
Cardiology, Diabetes & Endocrinology. Respiratory & Stroke.	Rotas for foundation doctors are largely unchanged with foundation doctors working with their allocated teams during the day. Out of hours rotas were altered 2 years ago to enable cross site working which will continue which gives access to the advantages that each site offers. However, there will be greater numbers working in GRH.	With these services co-located the SHOs will have greater access to registrar support; this should improve learning opportunities and training. Rotas for out of hours shifts are worked at both sites which is unchanged, however more shifts will be at GRH.	With these services co-located the Registrars will have greater access to consultant support; this should improve learning opportunities and training. Out of hours rotas are unchanged.
Gynaecology Surgery (Day-Case only)	All foundation doctors will remain at GRH- training will be unchanged	All SHO doctors will remain at GRH- training will be unchanged	Registrars who are assisting surgical day case lists will travel from GRH to CGH. However, the inconvenience of the short journey will be offset by the reduction in cancelled lists; therefore, offering improved training opportunities.

5.6 Inter-site Ambulance Transfers

The Trust and the ICB have contracts in place with independent providers to deliver patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites.

As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Examples of patient cohorts used in our activity modelling include the following:

Stroke	• Patient attending ED at GRH who were transferred to the stroke ward at CGH • Patients on a stroke ward at CGH transferred to another specialty ward at GRH • Patients transferred from an inpatient ward at GRH to a stroke ward at CGH
Respiratory	• Patient attending CGH ED and admitted to respiratory ward at GRH
Cardiology	• Patient attending ED who were admitted to a cardiology ward at CGH and GRH
Diabetes	• Patient attending ED at CGH who were transferred to GRH

It is estimated that the service changes set out in FFTF Phase 1 and 2 equate to approximately 10 patient transfers per day. This assessment has been based on activity data showing the number of patients attending the Emergency Departments at CGH and GRH who are then transferred to the other hospital site for admission and inpatient transfers between the two hospitals. We have also included an assessment of the number of walk-in patients attending the ED at CGH who are then admitted to a cardiology ward. For comparison we have also reviewed the patient transfer activity during COVID, when there were a substantial number of service moves across the two sites. This shows that at its peak there were on average 16 transfers a day.

The Trust is currently exploring, with advice from the ICB, how best to meet this future demand, recognising that some of the service moves have either already been formally completed or have temporarily moved in response to COVID (and are therefore in our current activity). It is anticipated that we will utilise the funding approved in the FFTF1 DMBC invest in provision of a further ambulance for inter hospital transfers only, that the crew will be trained to paramedic standard, the service will operate 7 days a week. In addition, it is proposed to provide a budget to cover ad-hoc transfers, which will be an expansion of the current ambulance transfer availability.

These proposals for inter-site ambulance transfers are planned on the basis of the current demands being placed on SWASFT and the impact of demand and hand-over delays on current response times. However, further work will be required to develop SOPs with SWASFT and GHNHSFT colleagues (where these are not currently in place), to confirm the precise response on the basis of each specific patient cohort and the clinical decision-making.

The South West Clinical Senate panel report included specific points regarding inter-site transfers that would need to be factored into the implementation plans, for both Phase 1 and Phase 2 of the FFTF Programme. These are listed below and will be picked up as part of the Cross Division Task and Finish Group (section 15.3.1):

- The Panel recommended that the Trust monitors the time taken and impact of transferring patients in both directions between sites when clinically necessary.
- The Panel recommended that the expected patient flows between the hospitals should be modelled and included in the proposals
- The Panel recommended that there should be a programme in place to review all inpatient transfers so that learning is captured, to help minimise the number of avoidable transfers.

- The Panel recommended that there should be central coordination of this service to ensure that journeys in both directions are used optimally and that empty return journeys are minimised.

5.7 Bed Demand and Capacity Modelling

5.7.1 *Approach*

As part of Phase 2 we undertook a full refresh of our bed demand and capacity modelling and this was combined with an extensive engagement process across GHNHSFT including clinical teams, operational Directors, Divisional Boards, our Clinical Advisory Group, a dedicated Cross-Divisional working group and senior Executives. A specific Decisions Summit was convened to discuss and agree bed numbers and ward allocations. This initially confirmed the vast majority of ward allocations, and these were presented to the South West Clinical Senate in August 2022. Subsequently, as part of the system operational planning cycle a further revalidation process has been undertaken by operational teams, as well as triangulation with BI reporting to assure alignment.

Appendix 7 presents full details by ward and service of the 2019/20 baseline, the proposed individual service and ward changes (both FFTF and non-FFTF) and the expected future state once all moves are completed.

A short summary of the key elements from the bed modelling are provided in the sub-sections below.

5.7.2 *Bed Capacity/ Availability*

Separate to the FFTF programme there have been a number of developments at GHNHSFT (see Appendix 7), affecting the numbers of beds (i.e. capacity), these include the impact of:

- Strategic Site Development
- An increase in Assessment Units
- Other operational changes

5.7.2.1 GHNHSFT Strategic Site Development (SSD) Programme

As part of the Trust's strategic site development (SSD) programme changes at GRH include the extension of the Same Day Emergency Care (SDEC) area, which provides an improved same day emergency care provision, the extension of the Acute Medical Assessment Unit, which will increase the bed space by 16 beds and enable the centralisation of acute medicine at GRH along with improved Mental Health provision and the conversion of non-clinical space within Gallery Wing to create a new 24-bed ward.

5.7.2.2 Assessment Units

A significant factor affecting both bed demand and capacity is the increasing move towards provision of Assessment Units. These units all have a similar function, providing timely care for patients with a fast-track through to the specialist team and quicker treatment. They all reduce attendances to ED and will work more closely with GPs and paramedics using Cinapsis to bypass ED, where clinically appropriate.

Our plans are to extend and expand the use of Assessment Units and the details, including context, performance and proposals, for each are provided in Appendix 7 and include:

- **GRH**: Surgical Assessment Unit (SAU) and Vascular Assessment Unit (VAU)
- **GRH**: Frailty Assessment Service /Unit (FAS/FAU)
- **GRH**: Gynaecology Assessment Unit (GAU)

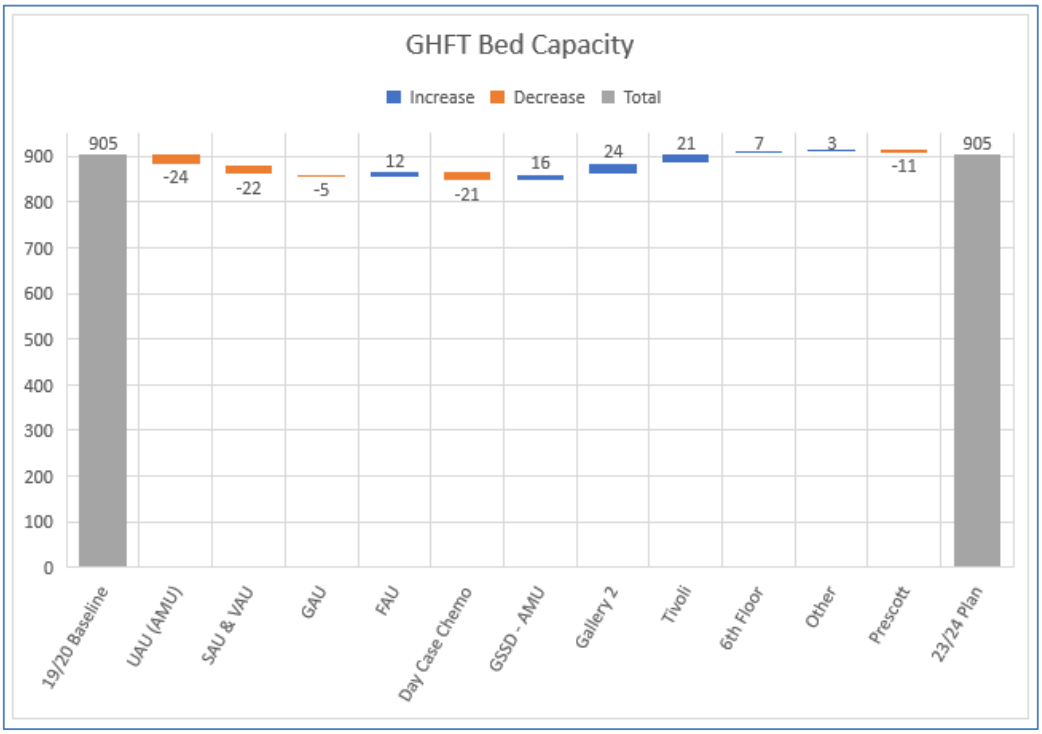
- **CGH**: Urology Assessment Unit (UAU)

5.7.2.3 Operational Changes

These include:

- **CGH**: Day Case Chemotherapy - provision of Systemic Anti-Cancer Therapy (SACT)
- **GRH**: 6th Floor Developments
- **CGH**: Hazelton/Tivoli Ward
- **CGH**: Prescott from 35 to 24 beds. The use of the ward is currently being reviewed (a process which is not part of FFTF).
- **GRH & CGH**: There are a small number of bed reductions due to either IPC, patient experience or previous unfunded escalation capacity that have been removed from the bed capacity stock modelled.

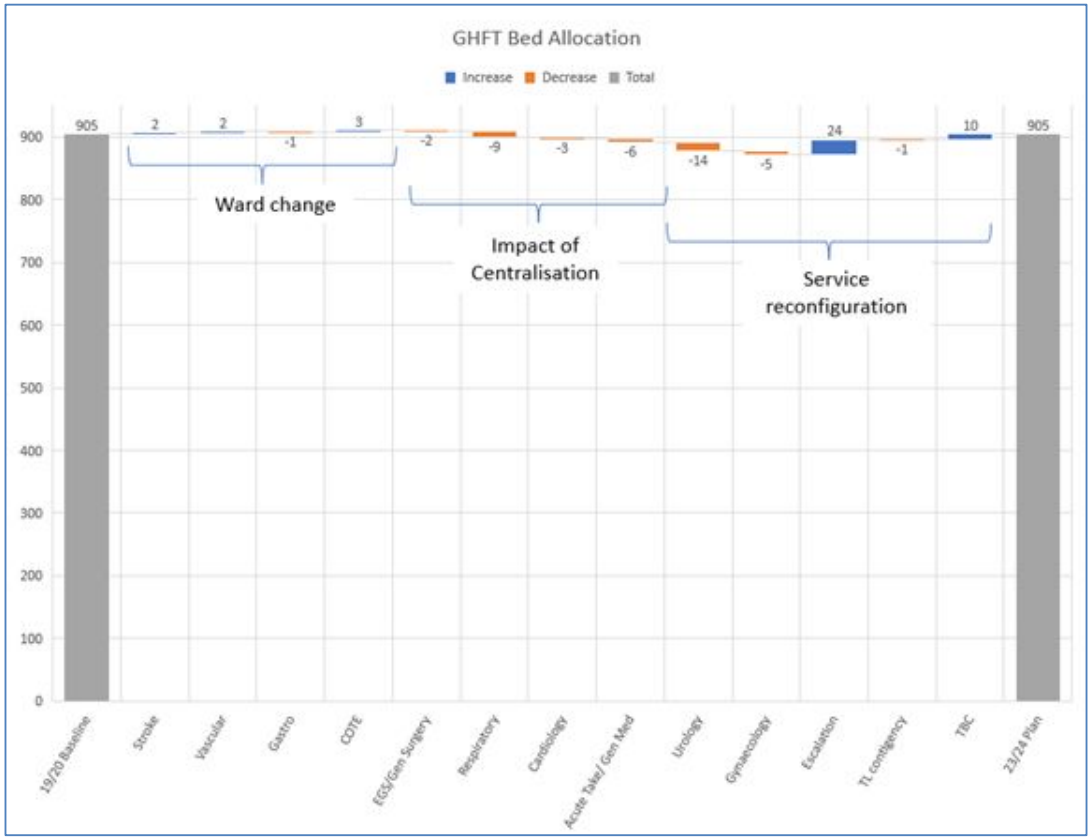
The overall impact of the above changes on bed capacity for the Trust as a whole is presented in the below.



5.7.3 *Bed Demand Impacts and Capacity Allocations*

Once the bed capacity has been determined, the bed modelling process then seeks to allocate the available capacity to the individual services/ specialities to ensure that the FFTF proposals can be accommodated on the two sites. This process takes account of the previous/ current demand and factors in any changes such as:

- FFTF1 & 2 Centralisation impacts – including efficiency improvements that result in a reduction in beds required e.g. reduced length of stay.
- Service reconfigurations – a change in the way services are operated.
- Ward changes - A small number of bed changes result from the allocation of different services to different wards.



It should be noted that Stroke and Vascular were already centralised prior to being relocated as part of FFTF.

5.7.4 *Department of Critical Care (DCC)*

5.7.4.1 Background

Implementing service change proposals in Phase 1 and Phase 2 of FFTF has an impact on the capacity requirements of the Trust's two DCC units, particularly the timing of the centralisation of acute medical take to GRH, planned for September 2023 when the GSSD new build is completed. Overall, there will be a shift in DCC activity from CGH to GRH.

As with acute bed modelling (section 5.7.1), the past 36 months (since March 2020), has seen a significant change in the demand distribution and commensurate use of DCC beds on both GRH and CGH, due to both COVID patients and reductions in elective activity. This makes DCC modelling complex, so to take account of these exceptional circumstances we have used a range of information and data to inform our DCC demand and capacity modelling.

A full refresh of the DCC bed model has been undertaken for the years 2018-2021, split by specialty capturing the daily average (from the 4 hourly census), patient activity, new admissions and bed days per admission. This is used to calculate an average bed demand per specialty per month.

The detailed paper outlining the work the DCC, Divisional, Business Intelligence and FFTF Programme teams have undertaken to model the impact of all the proposed changes, identify the scale of the capacity challenge and describe and appraise a range of mitigations can be found in Appendix 8.

A brief summary of the mitigations and impact is presented overleaf.

5.7.4.2 GRH DCC Potential Mitigations

Transfer from DCC at GRH to DCC at CGH of patients who are likely to stay on DCC for two weeks or above.

This is undertaken for clinical reasons; the CGH DCC is less busy and able to offer a better patient experience and access to rehabilitation. The clinical team has established a consultant led retrieval service, which is able to provide a transfer service with very low risk of harm. This process is already in place but could be expanded. The number of additional patients who could be effectively transferred would be 3 a month (as assessed by clinical teams) these patients would stay an average of 10 days each. Giving a monthly mitigation of one bed GRH. This initiative has already been started and is reflected in some of recent modelling. However, there may be capacity to increase this if services are able to continue their review at the CGH site. There is an estimation that to extend this model might gain 0.5 of a bed at GRH.

Respiratory High Care

The creation of a dedicated High care Unit within the respiratory wards will decrease the number of patients into DCC. The BI team have produced a report showing GRH DCC Admissions 01/01/2017 to 31/01/2020 with Primary or Secondary Reason for Admission System = Respiratory showing:

- Advanced Respiratory Days = Number of days receiving advanced respiratory care i.e., mechanical ventilation; and
- Basic Respiratory Days = Number of days receiving basic respiratory care i.e., CPAP, Non-Invasive Ventilation (NIV), NHFO etc

From this report it has been calculated that 990 bed days on DCC for patients who received NIV alone in a 3-year period would be saved. An average of 330 bed days a year, one bed if spread out over the year. This could be higher as the calculations do not include the time on NIV for patients who were also ventilated but these numbers are smaller.

Respiratory patients are more likely to be unwell during the winter months. Although the numbers have been averaged over a year, the greatest impact on DCC at GRH will be in the winter; which is when the demand is highest and therefore this option would be highly effective; numbers range from 0-7 patients. A very effective temporary Respiratory High Care was set up for COVID patients. However, the patients for whom the new service is designed were not included in the trial and so would give greater DCC capacity.

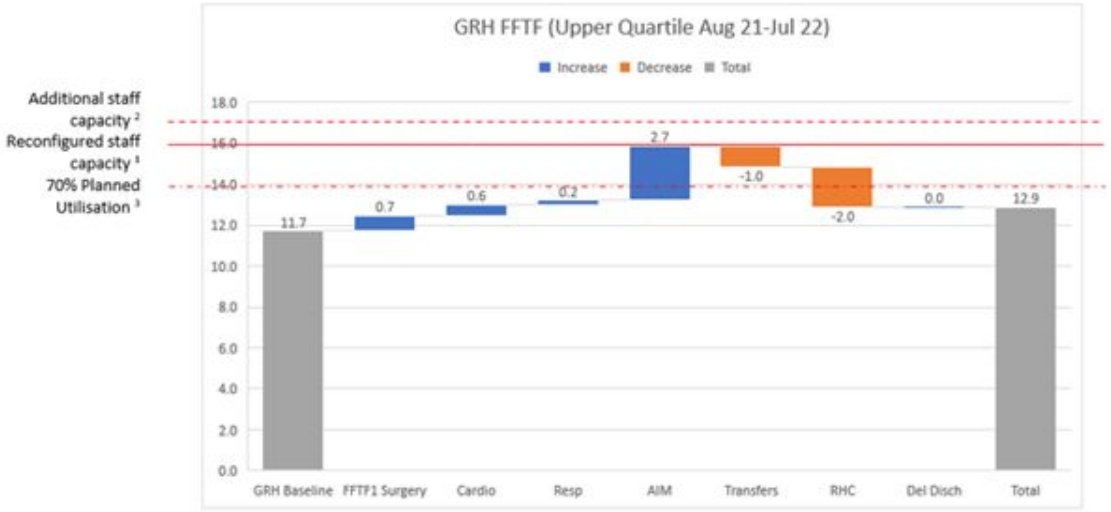
Reduce delayed discharges

Analysis shows that on average roughly 2 beds are taken up by patients that shouldn't be in DCC. This increases to 3 beds during peak hours (10-5). However, it should be noted that this is a long-term issue resulting in the difficulty of discharging patients from hospital who although medically fit have further social and care needs, resulting in the inability to discharge patients from DCC to the ward. Work would be required across the integrated healthcare sector to reduce the number of patients without criteria to reside before any impact on DCC could be anticipated; **this has therefore not been included as a mitigation.**

Other mitigations are included in Appendix 8.

An extract of the analysis presented in Appendix 8 representing the current best estimate of activity and mitigations is presented overleaf. A key set of performance metrics have been agreed and will be monitored by the Cross Division Task and Finish Group (see section 15.3.1).

Mitigated demand at GRH using upper quartile activity for all services (including baseline) combined (excluding delayed discharge mitigation)



#1: Reconfigured staff capacity excl. contingency staffing #2: Additional staff capacity excl. contingency staffing

#3: DCC planning preference is for 70% planned bed utilisation. Note: activity presented includes both planned and unplanned

As stated in the FFTF1 DMBC this will be a key stop / go decision point for the implementation programme to confirm at the point that the Acute Take is scheduled to centralise.

Key Points

- **The South West Clinical Senate panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.**
- **The FFTF programme has developed an inclusive and transparent options appraisal process**
- **The crucial role of our staff is highlighted and our plans for staff engagement and support through change are presented along with the anticipated benefits of these proposals for recruitment and retention.**
- **The impact of our proposals on Inter-site ambulance transfers are understood and plans in place to manage and mitigate.**
- **A comprehensive bed demand and capacity modelling process has been undertaken to support these proposals.**

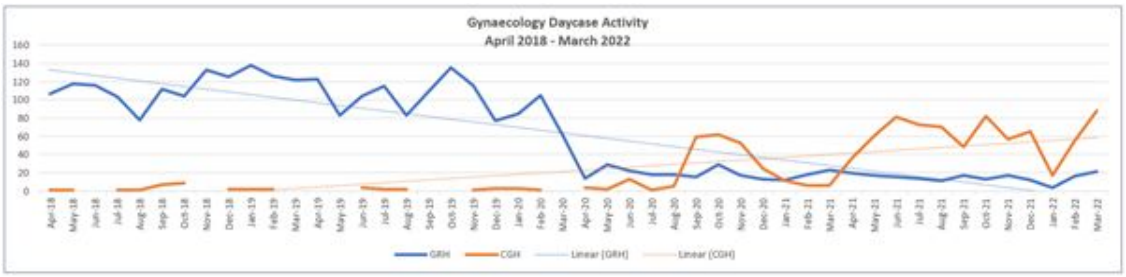
6 Benign Gynaecology

6.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Until the beginning of 2020, the majority of Gynaecology Day case operations were carried out at Gloucestershire Royal Hospital (GRH). However, during the COVID pandemic, the proportion of Gynaecology Day case surgeries carried out at Cheltenham General Hospital (CGH) significantly increased to facilitate our response to the pandemic.

The graph below evidences this shift[17] and hence our decision to include the service in our FFTF2 programme.



Outpatient appointments are provided at both acute hospital sites (Cheltenham and Gloucester), in the community and virtually when appropriate.

6.2 Activity

For the period Oct 2020 – Sept 2021 there were a total of 1143 Benign Gynaecology elective patients of which 512 were Day cases; of these 468 (90%) attended CGH and 44 (10%) at GRH.

6.3 Clinical Engagement

The clinical and operational teams were involved in the relocation of day cases to CGH during the pandemic and the discussions regarding the future proportions of activity to be undertaken at each site. The gynaecology team participated in the public, staff and patient engagement and the options appraisal process in July 2022.

6.4 Case for change: the problem we are seeking to address

When Benign Gynaecology Day case surgery was predominantly delivered at GRH there could be bed availability issues at times due to high numbers of emergency patients, resulting in patient cancellation because the day unit was required for emergency inpatients. As Benign Gynaecological day case surgery is not classed as urgent or related to cancer, the risk of cancellation is relatively high. Although the vast majority of this work may not be classed as clinically urgent; for many of the patients the symptoms experienced are unpleasant and affect the quality of their lives.

[17] During 2020/21 129 day-cases were undertaken at either the Nuffield or Winfield Hospitals, this was a temporary arrangement to enable surgery to continue during the worst of the COVID 19 pandemic

Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is evidence of a significant lower level (a reduction of up to 50%) of cancellation.

This move would also align with the Centre of Excellence strategy for CGH to become the centre for Elective work. As part of Gloucestershire Strategic Site Development (GSSD) at CGH GHNHSFT are developing two new theatres and a new ring-fenced Chedworth Day Surgery Unit. The Day Surgery Unit is expected to be completed by April 2023 and the two new theatres by October 2023, subject to construction timelines.

In summary the new unit will provide:

- A waiting area and reception
- 27 individual pre-operative pods to prepare patients for surgery (they are designed so that the doors can accommodate a trolley if necessary but not a bed- thus ensuring that the unit cannot be affected by bed pressures)
- A treatment room used initially for pain procedures and Lithotripsy but with the ability to extend this.
- A fifteen bedded post operative area for day surgery patients
- A discharge lounge.

This cohort of Benign Gynaecology patients would greatly benefit from this environment which offers individual cubicles, providing privacy and dignity and, due to the design, are ring-fenced for elective surgery.

6.5 Clinical Evidence

This type of surgery can safely be undertaken at either site as both CGH and GRH have all the support services that are required. It is for operational capacity/ efficiency and patient experience benefits that the proposed change is being undertaken.

6.6 How was preferred option evaluated?

The Gynaecology Service developed a list of options with support from the FFTF Programme Team. Given the nature of the service and proposals, there were only two options, deliver the service at GRH only or the current proposal; to maintain the majority of Benign Gynaecology Day Cases at CGH. As described in section 5.2, the next step was the application of the FFTF desirable criteria. As previously described, due to the ongoing system pressures, rising COVID and the heatwave in mid-July (when events had been booked 10 weeks in advance for clinical colleagues), GHNHSFT declared a Business Continuity Incident (BCI) on the day of one of the workshops. Given the notice requirements for clinical staff and the deadline for clinical senate submission, in agreement with NHSE, we have reverted to using the on-line responses from scorers and these have been reviewed and summarised by the FFTF Programme Director for inclusion in this section.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was ***reverting back*** to the original configurations, i.e., reversing the current temporary service change.

	Revert Benign Gynaecology Day Cases from the majority at CGH back to all at GRH	
Quality	Scores	Similar to slightly worse than status quo
	Comments	• If care reverts back to GRH there is a higher chance that you will have a mix of patients on a ward due to urgent care pressures and this may impact on the quality of care for patients. • New day surgery unit is completed and open, there will be a better patient experience in terms of the environment and the impact that has on privacy and dignity.
Access	Scores	Similar to slightly worse than status quo
	Comments	• 17% of patients are negatively affected but this is for a single day as day-case. Option for some patients in East to continue to be treated at GRH. • If service moves back to GRH there is a higher likelihood of cancellation therefore increasing waiting times for the patients. • Less cancellations = more capacity
Workforce	Scores	Similar to slightly worse than status quo
	Comments	• No difference as status quo but new DSU will improve working environment. • A dedicated unit should aid recruitment and training. • Potential for GRH urgent care pressures to impact on availability of trainers. • Resources used are the same for the same activity • Now that staff are settled in CGH moving back to GRH will be more disruptive.
Deliverability	Scores	Similar to significantly worse than status quo
	Comments	• Change has been made so resource would be required to re-schedule all activity back to GRH • Better to stay at CGH and use the new day unit than to be shoehorned back into an already crowded GRH.
Strategic Fit	Scores	Similar to slightly worse than status quo
	Comments	• reverting elective activity to GRH is not aligned with CoEx strategy. • New DSU will improve environment for patients. Public will soon accept the distinction between the 2 main hospitals CGH = Planned & GRH = Emergency
Acceptability	Scores	Slightly worse than status quo
	Comments	• 95% of respondents support the proposals. This includes staff

Based on the above assessment, the preferred option it to maintain the majority of Benign Gynaecology Day Cases at CGH.

There is minimal impact on pathways. Referral into the service would stay the same and the out-patient clinic appointments will continue at the same venues that they have always been.

The only change is the hospital site, with patients discharged the same day. If follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home, this would not change because the site for surgery has changed. It is not the intention to bring all day-case gynaecology to CGH; a smaller number will remain at GRH to offer choice and to achieve maximum theatre list efficiency. A small number of day-cases are also undertaken at Stroud Hospital, there are no plans to change this.

There will be no change to outpatient clinic provision which will continue to be provided at both Acute Trust and Community Hospital sites.

6.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Reduction in cancelations	Since moving the majority of Day Cases to CGH the cancelation rate has fallen by half (Oct 2020 to Sept 2021 @2.46% compared with Feb 2019 to Jan 2020 @4.75%)
Improved Patient experience	Chedworth Day Surgery Unit is expected to be completed by April 2023, providing individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery, and a post operative bedded area.

6.8 Benefits including clinical outcomes

Potential Benefits

- Although initially a short-term COVID enabling move, the relocation to CGH has been beneficial as there are significant bed pressures on the GRH site. In addition, with fewer cancellations this proposal will provide better care for patients and enable quicker elective recovery post COVID.
- Fewer patient cancellations because the new day case unit at CGH would be dedicated to planned surgery and would not be used for emergency inpatients
- Access to the new Surgical Admissions and day case unit at CGH once complete in April 2023. The innovative unit will have individual rooms to prepare for surgery providing high levels of privacy and dignity for patients
- Individual rooms are beneficial to those with disabilities and special needs as well as carers who are so essential to the care of those with dementia and learning disabilities
- It would allow a higher number of operations to take place and would enable women/people with Gynaecological conditions, that may have gone undiagnosed to undergo surgery sooner, allowing for quicker post pandemic recovery for the service
- This change would fit with the strategic vision for Centres of Excellence with a greater focus on planned care (non-emergency services) at CGH
- Whilst a transfer of these cases to CGH does not guarantee that cancellation is avoided (there are still bed pressures when demand is extremely high) there is a significant lower level of cancellation (reduced by half).

Potential drawbacks

- 18% of patients would have longer to travel[18] to CGH for day case surgery. Those affected would only need to make the extended journey on one occasion - on the day of surgery.
- This potential inconvenience for some patients should be considered alongside the potential reduction in rates of cancellation which could represent a greater stress and inconvenience to patients

6.9 Interdependencies

There are no specific interdependencies (over and above Business as Usual), related to the location of this service at CGH.

6.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

6.11 "Blue light" ambulance travel impact

These proposals relate to Day cases and therefore there is no "Blue light" ambulance travel impact

6.12 Learning from Temporary Service Change Period

This Benign Gynaecology Day case proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

6.13 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel supported the proposals for benign gynaecology services.
- The Panel noted that in many Trusts Advanced Nurse (Clinical) Practitioners (ANP/ACP) and Nurse Consultants now carry out much of the ambulatory care in gynaecology, including hysteroscopy, cystoscopy, and colposcopy and recommended that Gloucestershire explores these working practices to assist with capacity and workforce issues. Please see section 5.4.4.1 for details of the development of ACPs.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

6.14 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme

6.14.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to deliver the majority of Benign Gynaecology Day case surgery at Cheltenham General Hospital.

[18] Details of the methodology can be found in section 11.5

- **92%** of *all* respondents either **strongly supported** or **supported** the idea
- **96%** of *staff* respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	28%	45%	39%	16%	84%
A community partner	4%	50%	50%	0%	100%
A member of the public	37%	39%	56%	5%	95%
An employee working in health or social care	27%	33%	63%	4%	96%
Prefer not to say	5%	50%	33%	17%	83%
Grand Total	**100%**	**40%**	**52%**	**8%**	**92%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 6.15.

6.14.2 *Qualitative Responses - Public and Patient themes*

Theme	Survey comment examples
Reduced cancellations	• It releases women from worry over a long period of time. • Fewer cancellations and shorter waiting
New Day Case unit at CGH	• The day case unit at CGH will be good for this, and having it at a site where there is less likely to be cancellations is good • Privacy and lack of fear of constant cancellation are far more important than the inconvenience of a longer journey • Individual rooms especially for those with disabilities etc.
Centres of Excellence	• If the intention is to make Cheltenham the main day-case site, then it would seem an appropriate to relocate this service to Cheltenham. • The case makes sense • Excellent plan benefits outweigh drawbacks
Travel	• Useful to centralise system but transport will always be a problem if you expect day cases to arrive by 7.30am • I find it incredibly difficult to get to Cheltenham general and I am fit and well with my own transport. GRH is far easier to get to it's all about not having the choice
Patient experience	• Women need to feel they are being seen speedily, by a professional who will listen and expedite treatment, in the near future. • Expertise in one place. Better services. Better access to services.

6.14.3 *Qualitative Responses - Staff themes*

Theme	Survey comment examples
Clinical considerations	• Sensible if the procedure is minor and doesn't involve complications, consideration needs to be given to more complex patients with additional needs, who may require inpatient care. minor surgery suitable for CGH • For day case procedures not expecting overnight stays, I feel this appropriate
New Day Case unit at CGH	• Exciting to be having treatment in the new Day unit being built in CGH rather than the very tired unit in GRH
Reduced cancellations	• Reductions in cancellations are a necessity • Get operations done when no beds • Sounds like a robust plan to consolidate services on a single site and reduce the impact of bed availability on cancellations
Car Parking	• More car parking for our patients is needed

6.15 Addressing themes from engagement feedback

Feedback received and FFTF2 response
New Day Case unit at CGH
It is welcomed that both staff and the public see the benefits from undertaking Benign Gynaecology Day cases at the new Chedworth Day Surgery Unit (opening April 2023)
Reduced cancellations
The negative impact of cancellations on this cohort of patients is recognised by both staff and the public and the positive impact that the reduction in cancellations will have if these proposals are confirmed.
Travel
The negative impact of increased travel, particularly for patients travelling from the Forest of Dean to CGH is clearly recognised. Analysis has indicated that ~ 18% of patients will be negatively impacted, with 82% neutral or positive. For this cohort the impact is only for one day and as it is not the intention to bring all day-case gynaecology to CGH, a smaller number will remain at GRH to offer choice based on circumstances. Finally, if follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home.

Key Points

- **This service change proposal delivers the case for change through reductions in cancellations and improved patient experience.**
- **The new Chedworth Day Case unit has individual pre-operative pods, which provide privacy and dignity for patients as they prepare for surgery.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This proposal is currently implemented as a temporary service change**

7 Diabetes and Endocrinology

7.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

The Diabetes and Endocrinology (D&E) Service provides outpatient and inpatient services for the population of Gloucestershire at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH). In addition, the service provides non-Covid related clinics for Diabetes patients at The Vale, North Cotswold and The Dilke community hospitals, with D&E clinics being held at Tewkesbury and Cirencester community hospitals.

There are a small number of diabetes and endocrinology patients admitted directly to the specialty beds, primarily for management following an acute diabetic or endocrine episode. Most of the inpatients cared for by the D&E Service are General Medicine patients. Whilst up to 20% (National Diabetes Inpatient data) of the Trusts inpatients are estimated to have diabetes, this is usually not the primary reason for patients to be admitted. These patients may not necessarily need to be a on a specialist diabetes and endocrinology ward, but they may need clinical support from the D&E service.

The current service includes:

- Inpatient beds: 14 dedicated inpatient beds on Ward 9B at GRH for patients admitted via AMU.
- At CGH, the service is currently providing support to other hospital in-patients who happen to have diabetes.
- Outpatient services: General diabetes, insulin pumps, joint Renal clinics, general Endocrine, joint pituitary/neurosurgery, young adult diabetes, diabetes- podiatry clinics, antenatal clinics, lipid services

The service has 4.8 WTE consultants working across both sites. The service currently has 1.77 Band 6 WTE inpatient specialist nurses and 2.0 Band 5 WTE inpatient nurses.

The current inpatient pathway within the service for both sites is summarised below and can be found in Appendix 9:

- Patient presents at ED
- Patient admitted either direct to ward or for medical assessment (AMU or ACUC)
- Patient referred to D&E team for triage and admitted to ward (if not already) under care of D&E

Before the COVID pandemic, there were 26 beds across both GRH (14 beds) and CGH (12 beds). However, these beds were also used for General Medicine patients. It is estimated that the service requires 14 - 18 dedicated Diabetes and Endocrinology beds, with the remaining beds being used by General Medicine patients who are supported by the Diabetes and Endocrinology Team.

We have a traffic light system to prioritise admissions to the D&E ward. The highest priority would be a patient who is admitted with the diabetic or endocrine emergency; the next priority would be a patient who has a general medical problem but also has diabetes that might be slightly complex. Then a patient who has a general medical problem or straightforward diabetes condition and finally, a general medical patient who doesn't have diabetes or endocrine problems.

7.2 Activity

The total number of admissions for the service between February 2019 and January 2020 were 786 patients, with 45% of patients (357 patients) being admitted to CGH and 55% of patients (429 patients) being admitted to GRH.

7.3 Clinical Engagement

In order to develop the medium list of options for the service, a hurdle criteria workshop was held with clinical colleagues within the Diabetes and Endocrinology service and also clinical colleagues from services who work closely with Diabetes and Endocrinology. The workshop provided clinical staff members an opportunity to discuss the long list of options and decide on the medium list to take out to public and staff engagement. Furthermore, the medium list of options was shared at the Medicine Divisional Board for approval and sign off.

In addition to the hurdle criteria workshop, regular updates are provided to the Diabetes and Endocrinology Clinical Programme Group on the progress of the business case, including the options taken forward for public and staff engagement.

7.4 Case for change: the problem we are seeking to address

There is a small specialist team for diabetes and endocrine services, spread across multiple sites which has an impact on service delivery including:

- Disruption to services, caused by staff absence and sickness with staff spread too thinly across both sites.
- Increasing difficulties in providing:
    - Specialist diabetes and endocrinology inpatient service on both sites
    - A quick response to referrals from other departments within one (1) working day which delays patients transition into diabetes and endocrinology services; causing patients to stay in hospital for longer than they need to.
    - Regular daily visits to admission wards on both sites as well as Renal and Vascular wards who both receive a number of Diabetic and Endocrine patients.
    - Timely support to Emergency Departments

COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some patients and has also triggered diabetes for some patients as a result of the virus or its treatment.

The Getting It Right First Time (GIRFT) report, which is a national programme designed to improve the treatment and care of patients through in-depth reviews of services, identified staffing levels as an issue for the D&E service in GHFT. This was particularly around providing In-patient diabetic nurses 7 days a week.

In order to address this, the service is in the process of establishing a dedicated Diabetic Inpatient Nurse Team for patients with a secondary diagnosis of Diabetes. This team will work across both sites and will provide additional support. The dedicated Diabetic Inpatient Nurse Team at GRH will assist the service in addressing the recommended action, as per the 2019 GIRFT report.

The main aim is to ensure that patients from across our county experience diabetic and endocrine services that are comparable to those areas at the leading edge of care, treatment, and outcomes.

7.5 Clinical Evidence

Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay, compared to patients who are cared for by general health care professionals (SIGN (2017) Management of diabetes: a national clinical guideline. SIGN 116.) Therefore, by consolidating the service at GRH, this would facilitate the service's ability to prioritise type 1 and type 2 diabetic patients who are cared for under other specialties but who will also require specialist diabetes nursing input.

National evidence (Lancet, NHS England and Diabetes UK) has shown that COVID infection, in people with or without previously recognised diabetes, increases the risk of the emergency states of hyperglycaemia with ketones, Diabetic KetoAcidosis (DKA) and Hyperosmolar Hyperglycaemic State (HHS). Nationally, emergency admissions for DKA were 6% higher in the first wave of the pandemic compared to previous years and 7% higher in the second wave of the pandemic compared to previous years.

During COVID the Diabetes and Endocrinology service experienced an increase in ward referrals. In January 2021 there were 181 ward referrals for diabetic and endocrine patients, the majority of which were related to COVID and the use of Dexamethasone (a drug used for the treatment of severe cases of COVID and other serious infections).

Furthermore, recent research from a London NHS Trust suggested that 12% individuals (all who had type 2 diabetes and 4 of 5 who had COVID) died during their admission with DKA, compared with 2.3% pre-pandemic. Those who died had significant comorbidities or multiorgan failure at admission and were not deemed appropriate for intensive care or ventilatory support (American Diabetes Association). Thus, reflecting the importance of the Diabetes and Endocrinology service being able to support the management of patients admitted with COVID or who are recovering from COVID.

Therefore, by consolidating the service at GRH it will enable the service to support the management of patients admitted to GRH with COVID and patients recovering from COVID, through the centralisation of a dedicated diabetic and endocrine bed base at GRH, which is aligned to the Trusts policy of utilising GRH as the 'red site' for COVID patients.

In September 2019 the National Diabetes Inpatient Audit (NaDIA) was conducted in acute hospitals across England. NaDIA 2019 was a repeat of the 2010 to 2013 and 2015 to 2017 annual audits. There was no 2014 audit and NaDIA 2018 covered the hospital characteristics only.

In 2019 NADIA data reflected that GHNHSFT were in:

- The lowest quartile for average diabetes specialist nursing hours per patient.
- The second lowest quartile for average diabetes consultant hours per week per patient.
- The highest quartile for percentage of emergency admissions.
- The highest quartile for Medication, Prescription and Insulin errors.

The above NADIA data for GHNHSFT highlights areas for inpatient care which could be improved through the consolidation of the service's staff onto one site.

The Diabetes is Serious Report released in April 2022 suggests that:

- People in most deprived areas of Gloucestershire struggle the most with managing their condition (55% of patients in the most deprived areas and 37% of patients in the least deprived areas)

- Almost one third of inpatients across England with diabetes have a medication error during their hospital stay, due to lack of knowledge around diabetes from other non-specialist colleagues (NaDIA 2019).

The recommendation from the report is for ICSs to continue to invest in and support the development of specialist inpatient teams so that all hospitals can ensure minimum standards of care and people with diabetes are safe in hospital.

In respect of NICE guidance our proposals deliver the following:

- Service providers (hospitals) ensure that adults with type 1 diabetes in hospital receive advice from a multidisciplinary team with expertise in diabetes.
- Healthcare professionals (members of the multidisciplinary team) ensure that they provide advice to adults with type 1 diabetes who are in hospital and enable them to continue to administer their own insulin if they are willing and able and it is safe for them to do so.
- Adults with type 1 diabetes who go into hospital if they are ill or need an operation get advice from a team of specialists in diabetes, who will respect their expertise in managing their own diabetes. They are supported to carry on injecting their own insulin if they want to and can do so safely, although sometimes intravenous insulin will be needed instead (for example, if they cannot eat or are having an operation that affects blood glucose levels).

7.6 How was preferred option evaluated?

Hurdle criteria have been applied to the a long-list[19] with representation from Diabetes and Endocrinology, Inpatient Therapy, Pharmacy, the wider Medical Division and Vascular to assess a long list of options for the service and to better understand clinical adjacencies.

This session provided a recommended medium list of options including Option 1a – Current Service Model Split Site D&E and Gen Med Cover, Option 2a – Consolidation of IP beds to GRH, D&E and Gen Med Cover and also Option 2b – Consolidation of IP beds to GRH with no Gen Med Cover. However, Option 2b was ruled out by the medical division as it would not be feasible to remove General Medical cover. Therefore, it was agreed that Option 1a and Option 2a would be worked up for public engagement.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

[19] The long-list and hurdle assessment can be found in Appendix 9

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was ***reverting back*** to the original configurations, i.e., reversing the current temporary service change.

		Revert the dedicated Diabetes and Endocrinology Inpatient Beds from a centralised model at GRH to a split site model at GRH and CGH
Quality	**Scores**	Worse than status quo
	Comments	• Co-location better for providing the service • Always a consultant at CGH to support inpatient referrals. • Single site improves continuity of care, plus teaching. • Diabetes work with a large number of teams. Broadly makes sense to have IP in the larger of the two hospitals. • Having more D&E on one site would support the emergency care pathway. • Single site supports better training opportunities and safer working environment with better staff cover.
Access	**Scores**	Broadly similar to status quo
	Comments	• Looking at health inequalities - greater proportion of people with diabetes in Gloucester and the West of county. • Approx. 10% negative travel impact. • Making sure that barriers are removed for people impacted by travel - this is a system responsibility.
Workforce	**Scores**	Significantly worse than status quo
	Comments	• Staff survey results - current model working well. • Better for staff recruitment, especially specialist staff. • Dedicated IP service is sustainable, means IP team better able to support other specialties. • Flexibility greater on one ward. • Supports further innovative models in areas of professional practice.
Deliverability	**Scores**	Significantly worse than status quo
	Comments	• Changes already happened. • As renal and vascular ward at GRH this will be better for centralisation.
Strategic Fit	**Scores**	Slightly worse than status quo
	Comments	• slightly worse as not supporting Centres of Excellence strategy
Acceptability	**Scores**	Slightly worse than status quo
	Comments	• 98% of respondents support the proposals. • Important to have a very positive comms plan and also be willing to support those who may have negative consequences.

Based on the above assessment, the preferred option it to maintain the current consolidation of dedicated the Diabetes and Endocrinology Inpatient beds at GRH with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

7.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Disruption to services, caused by staff absence and sickness	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will enable the service to provide a more resilient staffing model. Also support the retention and in-house development of specialist Nursing staff, better for specialist SPR training and also Nurse training, and facilitate better consultant job planning.
Provide a response to referrals from other departments within one (1) working day	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will enable a consultant to cover inpatient work at GRH (currently 1-2 consultants at GRH + 1 consultant at CGH), which would allow the additional consultant to prioritise inpatient referrals from other wards. The consultant based at CGH would be able to prioritise inpatient referrals to support the 1 working day e-referral target, as opposed to waiting to see these patients post ward round and afternoon clinics. This would allow for a proactive service for patients, as opposed to the current reactive service.
Provide regular daily visits to admission wards on both sites as well as Renal and Vascular wards	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity
Timely support to Emergency Departments	Consolidating the Diabetic and Endocrinology Service's inpatient bed base to Ward 9B at GRH will provide increased Consultant capacity. Potential for acute medicine SDEC in-reach service, would be better able to cover ED/SDEC, if centralised at GRH.

7.8 Benefits including clinical outcomes

Potential Benefits

- Minimising the disruption to services caused by staff absence and sickness
- Ensuring safe and consistent staffing levels, including senior doctors - 24 hours a day - leading to safer care and shorter hospital stays
- More specialists in one place resulting in timely assessment and decision making from senior professionals when patients arrive at hospital - leading to prompt diagnosis, treatment and timely recovery
- Diabetes and Endocrine consultants would be better able to coordinate inpatient work on the improved specialist ward

- Consultants would be better able to prioritise inpatient referrals from other wards and support a timely response to inpatients from other specialties (service areas) within one (1) working day. This in turn would help patients to leave hospital sooner after care
- Supporting joint working between care professionals; including links to related wards, facilities and equipment to avoid the need for multiple visits and hospital stays
- Creating better training and learning opportunities for nurses - the majority of consultants would be on one site to help develop their skills and knowledge in this area. Improving the service's ability to develop their own Diabetes and Endocrine nurses in-house could limit future shortages of specialist nurses. Studies suggest that type 1 and type 2 diabetes inpatients who are cared for by specialist diabetes nurses are likely to have a reduced length of stay in hospital, compared to patients who are cared for by general health care professionals.

Potential drawbacks

- The proposal would increase travel times for some patients and relatives/carers in the east of the county who previously would have travelled to CGH for inpatient care and now need to attend GRH.
- The overall impact is <10% of diabetes and endocrinology patients[20], families and carers are negatively affected by centralising at GRH

7.9 Interdependencies

Diabetic and Endocrinology Services has links with the Vascular Services, Complex Foot Clinics and Obstetrics – Gestational Diabetes.

It is not anticipated that the clinical links with Vascular, Renal, Neurosurgery or Complex Foot Clinics will be adversely impacted by these proposals vascular inpatients services are at GRH and Complex Foot Clinics are outpatient based, which will remain unchanged under this proposal.

For Obstetrics Gestational Diabetes, inpatients high risk clinics are already held at GRH where the Women's Centre is located. The Gestational Diabetes education groups at CGH will continue and remain unchanged.

It is not anticipated that either proposal will have a negative impact upon Imaging services as all services are provided on both sites. In addition, it is not anticipated that there will be significant impacts for Oncology or Therapy Services.

7.10 Workforce

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed in section above and include better in-house training provision for specialist nurses, workload efficiencies would support consultants to prioritise inpatient referrals from other wards and help the service to make the best use of the staffing resource it currently has.

[20] Details of the methodology can be found in section 11.5

The services nursing staff have previously been required to work cross site, which will remain unchanged.

7.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact.

In respect of diabetes and endocrinology patients the numbers are

- 239 ambulance admissions to GRH - < 5 patients per week (Feb 2019 and Jan 2020)
- 63 ambulance admissions to CGH - ~ 1 patient per week (Feb 2019 and Jan 2020)

There is also some cross-over of D&E patients captured in the "blue light" activity analysis for the Acute Medical take in FFTF1. Furthermore, the cost of separate analysis for D&E only was over £4,500 (£70 per patient record).

Based on the factors above, the decision was taken not to model separate D&E "blue light" activity in FFTF2.

In respect of any emergency inter-site transfers, please see section 5.6.

7.12 Standard Operating Procedures (SOPs)

A SOP is currently in development

7.13 Learning from Temporary Service Change Period

This diabetes and endocrinology proposal has been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

In addition, COVID has created additional pressure on Diabetes and Endocrinology services. It has aggravated pre-existing diabetes in some people and has also triggered diabetes for some patients as a result of the virus or its treatment. This factor supports our proposals to improve the efficiency and effectiveness of the diabetes and endocrinology service by centralising the dedicated inpatient beds on the GRH site.

7.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel agreed that the move would strengthen links with vascular surgery, renal medicine and maternity services and that this would be advantageous for people with diabetes.
- The Panel was reassured that there will be sufficient specialist input available at CGH for the management of in-patients there with diabetes or other endocrine conditions.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

7.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

7.15.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.

- **98%** of all respondents either **strongly supported** or **supported** the ideas
- **100%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	26%	57%	36%	7%	93%
A community partner	4%	50%	50%	0%	100%
A member of the public	38%	44%	56%	0%	100%
An employee working in health or social care	28%	42%	58%	0%	100%
Prefer not to say	5%	40%	60%	0%	100%
Grand Total	**100%**	**47%**	**51%**	**2%**	**98%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 7.16.

7.15.2 *Qualitative Responses - Public and Patient themes*

Theme	Survey comment examples
Innovation	• I think it's good to centralise a specialty in one place however I do think that you need make more use of technology, e.g., virtual monitoring • Self-help, education and support for new patients and healthy eating should be part of any new service approach • Train other NHS staff (Drs, nurses, AHPs & dietitians) to enable triage process. These trained staff can refer on &/or discuss directly (phone/email) with specialist diabetes personnel to determine care plan.
Clinical considerations	• A protocol for treating Addisons Crisis and patients being “red flagged” for urgent treatment • More support needed for long-term diabetics. • I think life style is very important and self-control of healthy eating is a better option than reliance on medication. Healthy exercise is also vital. • The staff need to be trained and competent, to deal with patients who have complex needs.

Theme	Survey comment examples
Centres of Excellence	• This seems to be the most efficient way to organise services, but continued support to patients with diabetes or endocrine conditions located on other wards is essential. • The case made is good • The Centres of Excellence approach should bring patient benefits
Travel	• Having the team under one roof is a good thing, but the transport problem is still there. • The benefits are partially outweighed by transport for some people • I believe there should be inpatient beds available at both Gloucester and Cheltenham sites.
Patient experience	• Would just like any services focusing on patient care.

7.15.3 *Qualitative Responses - Staff themes*

Theme	Survey comment examples
Clinical considerations	• It has several linkages to acute specialties that it should remain at GRH. • Centralising service will improve outcomes, patient care and experience.
Integration	• It is important to integrate care for people with diabetes • Diabetes specialists/teams in the community to offer specialist care. • Patient education is really important especially in the community or primary care • I am concerned that reconfiguration discussions which are 'site centric' overlook the overwhelming need to move diabetes services into the community to point of near exclusivity.
Workforce	• There are not enough Diabetic Community Nurses to cover the whole county. • The Diabetes team is extremely small and therefore centralising services to GRH site makes sense
Car Parking	• Parking needs to be improved massively.

7.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
A protocol for treating Addisons Crisis
There are protocols available on the Trust's intranet for treating Addisonian crisis. The previous Trakcare system has an icon available to all patients with specific healthcare needs, of which steroid dependency is one of them. Whenever a patient is started on replacement steroids the icon will be allocated to them on Trakcare. There have been some issues pulling this through onto the new EPR system, but this is being addressed currently.

Feedback received and FFTF2 response
Diabetes specialists/teams in the community to offer specialist care
Confirm that community D&E outpatient clinics will not be impacted. Although this particular proposal focuses on inpatient care, The Hospital Trust does work in collaboration with Gloucestershire Health and Care to share information and projects being worked on in health care settings across Gloucestershire. ICS Diabetes and Endocrinology Integration Model Project aims to develop a single point of access to manage patients in the community who may not need to go into Acute Trust. Type 2 diabetic patients would be included within the scope of this project, with the objective being that the vast majority of these patients would be seen in a community clinic by default. In order to facilitate this, the ICS have recruited a community Diabetic consultant. CCG Virtual Ward Round Project - The virtual ward project is currently being scoped out by the ICS and focuses upon Diabetic and Endocrine patients who are discharged from the Hospital to reduce readmissions.
Patient education is really important especially in the community or primary care
The ICS run various patient education programs of people with newly diagnosed type 2 diabetes and for people who are starting on insulin. There are also a number of courses covering diet and lifestyle to assist in the prevention of the development of type 2 diabetes. In terms of type 1 diabetes, we do a lot of one-to-one work and also offer a number of options on learning to carbohydrate count, these are mainly online based.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 4% of patients will be negatively impacted, with 96% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.
Train other NHS staff (Drs, nurses, AHPs, dietitians) to enable triage process.
The future plan is to have two Diabetes link nurses for each ward and ED areas. In addition, there will be updated training every 2 months for healthcare professionals. There is currently and diabetes e-learning available online for staff, which is currently being considered to become mandatory training for all medical staff members. Furthermore, the service already RAG rates patients to determine which inpatients do need to be seen by the specialist team.

Key Points

- **This service change proposal delivers the case for change through an improved staffing model.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This proposal is currently implemented as a temporary service change.**

8 Non-interventional Cardiology

8.1 The 'current state' service model

The cardiology services currently operate at both Gloucestershire Royal (GRH) and Cheltenham General Hospitals (CGH) with 21 inpatient beds at CGH and 25 at GRH. The service runs outpatient clinics at CGH, GRH and several other community hospitals in the county.

Diagnosis may include the use of X-ray, MRI, ultrasound scans and CT scans. For some patients the service also undertakes interventional cardiology within the cardiac catheter labs to perform surgery. Procedures are undertaken as day cases or inpatients.

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

Patient Pathway

Non-interventional cardiac admissions include pathways such as Heart Failure, endocarditis, and cardioversions. These pathways are replicated on both acute hospital sites. A typical patient pathway would be:

- Patient presents to ED (GRH / CGH)
- Initial emergency diagnostics undertaken
- Routed to Same-Day-Emergency-Care / diagnosed with primary cardiac condition
- Patient admitted to cardiac ward
- Further specialist cardiac diagnostics undertaken
- Patients are then likely to follow one or more of the following paths
    - Non-interventional treatment such as IV antibiotics given
    - Patients may then be discharged if stabilised, or
    - If intervention is not deemed urgent, patients may be discharged home to attend follow up as an outpatient or be admitted for a planned surgical intervention.

8.2 Activity

The total number of admissions for cardiology (both interventional and non-interventional for the period Jan-Dec 2021 was 3,475.

8.3 Clinical Engagement

Clinical engagement has included regular discussions with clinical and operational leads in cardiology regarding development of options and case for change. The clinical and operational cardiac team developed a long list of options based on their developed Case for Change, then used the FFTF hurdle criteria to review this list and refine down to a medium list of options.

'Medical Triumvirate' senior leaders reviewed hurdle process whereby options are reduced from an initial long list to a medium list. Wider clinical engagement was achieved through monthly reporting to the Image Guided Interventional Surgery (IGIS) Programme Board, including clinical representation from Cardiology, Interventional Radiology and Vascular services.

The medium list was also shared for comment with clinical and operational representation for all services through presentation to the GHNHSFT Strategy & Transformation Delivery Group.

8.4 Case for change: the problem we are seeking to address

Before describing our ideas for FFTF2, it's helpful to summarise recent developments in cardiology services that were agreed as part of FFTF1.

These included the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an Image Guided Interventional Surgery (IGIS) hub at GRH and a spoke service for planned care at CGH; due to be completed in 2023/24. As part of these changes 13 inpatient beds will move from CGH to GRH.

The centralisation of interventional cardiology and the relocation of the cardiac catheter labs to GRH does present an opportunity to explore how we could potentially reorganise the remaining eight cardiology inpatient beds at CGH.

The problems we are seeking to address include;

- The challenges with patient pathways and identifying those patients requiring intervention at the point of admission. Also, for patients whose care pathway changes during their inpatient stay.
- Better use of the staff groups with significant shortages, such as radiographers, physiologists and specialist nurses.
- The need to improve Out of Hours Care for cardiac patients.

The patients that could be affected by these proposals are those not requiring cardiac intervention who would currently be admitted or transferred to the eight cardiology beds at CGH.

8.5 Clinical Evidence

The Cardiology GIRFT Programme National Specialty Report (Feb 2021) highlighted the need to review the ways cardiac services are delivered and included the following:

- Prevention, diagnosis and management of cardiovascular disease forms a key part of the NHS England and NHS Improvement (NHSE/I) Long Term Plan.
- The falling CVD mortality rate has been the biggest contributor to increased life expectancy for men and women within the UK. However, demographic shifts within our society mean that CVD-related mortality is increasing.
- To address this, we need to review the ways cardiac services are delivered and who is delivering them, to ensure both that patients are getting the care they need and that services are fit for the future.
- The best way to deliver equity of access to appropriate services and expertise, match demand to capacity and make the most efficient use of resources.
- Cardiology beds should be co-located and in hospitals with a cath or pacing lab there should be ring-fenced beds, trolleys or chairs.
- Multidisciplinary meetings are an essential part of cardiology treatment pathways and a core function of the heart team.

8.6 How was preferred option evaluated?

The Cardiology Service developed a long-list of options with support from the FFTF Programme Team. Hurdle criteria have been applied to the long-list of options[21]. Where any option has failed any of the criteria, it was been removed from the longlist. As described

[21] The long-list and hurdle assessment can be found in Appendix 10a

in section 5.2, the next step was the application of the FFTF desirable criteria.

		Centralise Non-Interventional Cardiology inpatient beds at GRH. Consult service at CGH.
Quality	**Scores**	Slightly to significantly better than status quo
	Comments	• Improved OOH care and ensures all cardiac patients are located on same site as interventional facilities. • Impact on those walking into CGH ED. • Inter-site transfers for cath labs cease • Should improve continuity of care through services and clinicians being on one site reducing need for moves
Access	**Scores**	Broadly similar to status quo
	Comments	• Patients will still present to their nearest ED. • Approx. 10% negative travel impact. • Improved utilisation of cath labs • Improved efficiency through centralisation could be used to create capacity.
Workforce	**Scores**	Significantly better than status quo
	Comments	• Single site allows improved staff cover and resilience. Only 1 x OOH consultant needed. • Single site provision allows for more efficient deployment of nursing staff. • Improved rota and cover arrangements. If rotas are more easily filled, then staff resilience will be improved. • Middle grade doctors will benefit from more access to senior colleagues. • Trainees will see a higher number of cases with standardised care.
Deliverability	**Scores**	Similar or slightly better than status quo
	Comments	• Implementation of non-interventional cardiology could be aligned with operationalising of interventional cardiology, part of IGIS FFTF Phase 1 proposals. • Clinical staff within the service are well engaged and supportive of the preferred solution. • Suitable location for the service identified at GRH.
Strategic Fit	**Scores**	Slightly to significantly better than status quo
	Comments	• Consolidating cardiology services are expected to achieve improved outcomes of care, reduced LoS and more timely and responsive intervention when required. • Improvement for inpatients and carers accessing specialist support, information and guidance from a strengthened team on site
Acceptability	**Scores**	Significantly better than status quo
	Comments	• 98% of respondents support the proposals. • Important to address the issues raised by the 2%. A change management programme of working with colleagues and professional partners along with a proactive communications campaign.

Based on the above assessment, the preferred option is to centralise Non-Interventional Cardiology inpatient beds at GRH and provide a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

8.7 How does this address the case for change?

Reason for change	How preferred option addresses this
The challenges with patient pathways and identifying those patients requiring intervention at the point of admission	Centralising all cardiology inpatient beds (interventional and non-interventional) at GRH would ensure patients were able to access the appropriate services once diagnosis was confirmed.
Improved out of hours care for patients	One consultant on call can attend to patients with greater efficiency when they are located on a single site.
Better use of the staff groups with significant shortages	Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers)

8.8 Benefits including clinical outcomes

Potential Benefits

- Looking ahead to the implementation of the FFTF1 IGIS model and the centralisation of interventional cardiology at GRH, the cardiology service believes it can provide a more efficient, more responsive and safer service by consolidating inpatient beds at GRH and providing a fully centralised cardiology inpatient service.
- Reduce length of stay for patients.
- Increased clinical presence for more ward rounds and consequently more efficient patient management. Length of stay reduction in transfer between sites, continuity of care with single consultant, increased efficiency of cath labs (delays caused from site transfers).
- Improved out of hours care for patients. One consultant on call can attend to patients with greater efficiency when they are located on a single site. Travelling cross sites can incur delays due to travel.
- Improved staff cover and improved staff resilience for sickness and absence
- Improved cross specialty working, i.e., how cardiology teams work with other acute specialties (service areas)
- Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
- Ensure that patients requiring regular Electrocardiogram (ECGs) receive this treatment in a timely way
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff; specifically nursing staff.
- Prevent the need for patient transfer which has cost implications. Transfer costs include both the ambulance cost but also for some patients the cost of a nurse

chaperone.) This is on the risk register. M2174CARD (score of 8) – risk to patient safety due to inability to treat patients whilst transferring between sites.

Potential drawbacks

- Friends or family travelling from the east of the county visiting a patient receiving non-interventional cardiology inpatient care at GRH would have to travel further.
- Approximately 10% of patients, families/carers[22] are negatively affected by centralising services on GRH.

8.9 Interdependencies

These include:

FFTF1 Implementation - As detailed in section 8.4 there are clear interdependencies with the centralisation of interventional cardiology, the relocation of the two cardiac catheter labs to GRH and the creation of an IGIS hub at GRH and a spoke service for planned care at CGH; due to be completed in September 2023.

Acute medical take – Impact of the centralisation of the acute medical take in September 2023.

Dept. Critical Care at GRH – the centralisation of cardiology will increase DCC demand at GRH.

8.10 Workforce

The cardiology service is staffed by 6 HCA's (3.55 WTE), 26 registered nurses (RN) band 5-7 (26.48 WTE) and 14 consultants (12 WTE and 2 part time P/T).

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

The staff benefits of the preferred option are listed above and include better training, workload efficiencies and help the service to make the best use of the staffing resource it currently has.

8.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact.

As part of FFTF1 we modelled the "blue light ambulance travel impact for interventional cardiology and we do not anticipate any requirement for non-interventional cardiology.

In respect of any emergency inter-site transfers, please see section 5.6.

8.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 10b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

8.13 Learning from Temporary Service Change Period

Cardiology services (interventional and non-interventional) have not been subject to any temporary service changes made in response to the pandemic.

[22] Details of the methodology can be found in section 11.5

8.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The panel agreed that the move of non-interventional cardiology in-patient services to the same site as the interventional service (i.e. at GRH) was advantageous.
- The Panel noted that routine echocardiograms performed by physiologists are not available at weekends at either GRH or CGH. They were reassured that when clinically necessary, echocardiograms can be performed by an on-call consultant cardiologist; however, recognising that the provision of echocardiograms is essential to an acute cardiology service and to other service such as critical care and stroke, the Panel recommends that, if possible, steps are taken to address this issue.

In response the clinical teams have indicated that we rarely need access to immediate echo for stroke patients but have good access weekdays and link with the cardiologists at the weekend if required.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

8.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

8.15.1 *Quantitative Survey responses*

The proposal we engaged on was to centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

- **99%** of all respondents excluding staff either **strongly supported** or **supported** the ideas
- **97%** of staff respondents either **strongly supported** or **supported** the ideas

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	14%	50%	50%	0%	100%
A community partner	4%	33%	67%	0%	100%
A member of the public	42%	49%	51%	0%	100%
An employee working in health or social care	37%	45%	52%	3%	97%
Prefer not to say	4%	33%	67%	0%	100%
Grand Total	**100%**	**47%**	**52%**	**1%**	**99%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented overleaf, with our response in section 8.16.

8.15.2 *Qualitative Responses - Public and Patient themes*

Theme	Survey comment examples
Innovation	• Use of technology to reduce referral times, e.g., patient/ GP/ specialist video calls and portable ultrasound and ECG equipment that can be used to provide diagnostic information to specialists
Clinical considerations	• How will patients with other medical issues who also have a need for non-interventional cardiology be treated in CGH? • It seems to make sense to consolidate cardiology beds in one site (GRH). Would be great for additional funding for MRI, CT, as well as services related to heart failure and genetic heart conditions. • Reduce length of stays. All different specialists under one roof, better for care and training, more likely to get correct specialist.
Centres of Excellence	• I can see the logic in moving the remaining non-interventional beds to be under the care of the centralised inpatient cardiology team. • Concentrating expertise in one hospital is important. • Objectively - absolutely right to optimise cardiac services in one place. Hard sell for past patients who have been treated successfully in Cheltenham, but this should be pushed forward.
Travel	• Transport over the county is appalling • Makes sense but it is the traveling that could be a problem for those without their own
Patient experience	• My first symptoms were over 65 years ago, and I am truly grateful for the NHS support I had since! I still enjoy life.

8.15.3 *Qualitative Responses - Staff themes*

Theme	Survey comment examples
Clinical considerations	• Best located where support services are • Agree cardiology inpatient provisions should be based at GRH • Centralising services on the GRH site will be of great benefit to ongoing cardiac care/services hopefully reduce waiting times for interventions, improving patient outcomes and LoS in the long term and decreasing the need for transfers out of county. • Better pathway to interventional investigations
Interdependencies	• Cardiology should be on the same site as Vascular Services • Cardiology should be based on the site with greatest cover from Vascular and Interventional Radiology • I am concerned that this good work in centralising specialist services will be overly reliant on Ambulance Service performance.
Travel	• Travel may cause a difficulty for some people; however, the benefits appear to outweigh the negatives.

8.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Co-location of all cardiology services (FFTF1 and FFTF2)
It is welcomed that both staff and the public see the benefits from centralising all cardiology inpatient services at GRH
Co-location of cardiology with vascular
It is welcomed that staff see the benefits from centralising all cardiology inpatient services at GRH which will be co-located with vascular services.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 10% of patients will be negatively impacted, with 90% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**

9 Respiratory

9.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change".

Our respiratory services provide a patient centred service for all ages of patients, presenting with respiratory related issues. The team consists of medical, nursing, therapy and support staff. The Consultant led Outpatient Clinics/Services are provided at both acute hospital sites plus seven locations in the community. These services are used for general respiratory conditions and also suspected cancer and sleep disorders. As part of the investigation patients may be referred for further screening. This could be arranged for the same day or as a separate appointment for another service for example an X-Ray, a CT scan, a blood test, lung function tests, a sleep study, an allergy skin prick test or a bronchoscopy, all of which will be undertaken as an Outpatients appointment.

Prior to the temporary COVID service changes (see below), specialist respiratory inpatient beds were provided on both hospital sites. At CGH they were located on Knightsbridge Ward (12 beds) and on Avening Ward (21 beds). At GRH they were located on Ward 8b (33 beds). A total of 66 beds. There were over 11,000 hospital admissions per year, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% to CGH (Feb 2019 to Jan 2020).

In June 2020, GHNHSFT implemented a number of temporary service changes as part of the Integrated Care System (ICS) response to the COVID Pandemic. The changes were implemented to reduce the number of emergency routes into hospital and to free-up additional capacity on the GRH site to create a 'red' emergency care COVID controlled site with patients managed through three emergency admission pathways: confirmed COVID, suspected COVID and confirmed non-COVID.

As part of these changes, GRH became the site for emergency admissions for patients in acute respiratory failure and a COVID Respiratory High Care (RHC) unit was created on one of the wards at GRH, where patients receive advanced respiratory support via non-invasive ventilation (NIV) or nasal high flow oxygen with full cardio-respiratory monitoring. This relieved the demand on the intensive care unit.

Under the temporary service changes, the improvements in efficiency and reduction in outliers ensure that the respiratory specialty inpatient beds, including High Care, can be located on Ward 8a and 8B (58 beds) at GRH. Currently, approximately 92% of patients are admitted to GRH and 8% admitted to CGH.

Current patient pathway

For patients attending ED a referral is made to the respiratory team for a respiratory assessment, either by an ED consultant or by the acute take physician. The patient is assessed and depending on the outcome, they are admitted to a respiratory bed, referred to another specialty or discharged.

The respiratory team provide a consultation service to other specialties (service areas) at CGH for patients who may require a specialist respiratory assessment or treatment.

Clinical protocols are in place to support the early recognition of and transfer of deteriorating patients at CGH and the management of patients in CGH needing advanced respiratory support.

9.2 Activity

From Feb 2019 to Jan 2020 there were 11,384 admissions, with an average length of stay of 5.1 days; 77% of the admissions were to GRH and 23% of these admissions were to CGH.

A comparison has been made of activity over a three-month period (July – Sept 2021) against the FFTF baseline year 2019/20, with the same time period in 2021. During this period there were 2210 admissions in 2019/20 compared to 2421 admissions in 2021, showing a 10% increase in admissions.

In 2021 approximately 92% of patients were admitted to GRH and 8% were admitted to CGH, which reflects the temporary centralisation of respiratory specialty beds at GRH. Also, during this period 146 patients were cared for within COVID respiratory high care beds.

9.3 Clinical Engagement

The clinical team developed a long list of options and used the FFTF hurdle criteria to review this list and develop a medium list of options. The medium list, together with the case for change was presented to the Medical Division Board, which was approved. The Trust has also presented the case for change and the medium list of options to the Respiratory Clinical Programme Group (CPG). The CPG has also supported the case for change and the medium list of options.

9.4 Case for change: the problem we are seeking to address

The proposals are concerned with centralisation of respiratory inpatient beds and the provision of the respiratory high care service taking into consideration a number of factors, including:

- Workforce challenges;
- Benefits of a Respiratory High Care Unit (RHC)[23];
- Improvements to multi-disciplinary team working, and;
- Interdependencies related to the centralisation of the acute medical take to GRH in Sept 2023 (FFTF1).

Workforce challenges

- Make more efficient and effective use of the specialist team
- Need to cover gaps in establishment, medical staff rotas and staff absences.
- Need to improve staff recruitment and retention
- Need to improve junior doctor training and improved training for nursing and therapy staff
- To provide resource support towards the development of a Respiratory High Care unit

[23] Also known as Respiratory Support Units (RSU)

Respiratory High Care (RHC)

- A Respiratory High Care Unit is a dedicated area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a standard ward environment.
- Currently there isn't a dedicated area for patients requiring non-invasive ventilation (NIV) on the Respiratory wards and there are no central monitoring facilities. This makes it difficult to co-ordinate and safely manage the care for patients receiving NIV.
- The service does not have the necessary support from Advanced Care Practitioners and physiotherapists to be able to deliver high quality care. The lack of facilities and dedicated skilled resource means that the service is limited in its ability offer NIV to patients who would benefit from this service.
- Evidence has shown that patients requiring NIV can be managed within a Respiratory High Care facility, avoiding the need for admission to DCC[24]
- RHC delivers Improved clinical outcomes, specifically improved mortality rates.

Improved multi-disciplinary team working

- Desire to improved multi-disciplinary team working
- Support the implementation of new ACP roles

Support the Centralised Acute Medical Take

- Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit
- There is a need to ensure that the respiratory service has the on-site staff and bed capacity to support the acute medical take.

Compliance with National Recommendations

- Nationally the British Thoracic Society, the Intensive Care Society and the Getting It Right First Time (GIRFT) programme recommend the development and implementation of RHC/ RSU

9.5 Clinical Evidence

The new national report for respiratory medicine published in Sept 2021, by the Getting It Right First Time (GIRFT) programme, outlined how more patients' lives could be saved if all acute trusts could establish a dedicated NIV unit. The report highlighted a gap in provision of NIV. GIRFT recommends a series of actions to help all trusts work towards a dedicated NIV service to help improve outcomes for patients. These include measures to identify the right patients for treatment and starting more treatment at the right time. These units emerged as a key response to the pandemic, delivering improved outcomes for patients and allowing respiratory support for patients outside of intensive care, freeing critical care capacity for those patients who needed invasive ventilation. GIRFT aligns with the British Thoracic Society (BTS) in recommending RSUs in all NHS hospitals.

[24] The intensive care at GHNHSFT is known as Dept. of Critical Care (DCC)

The British Thoracic Society and Intensive Care Society[25] provides guidance on the development and implementation of Respiratory Support Units, setting out the following recommendations:

- Acute NIV should be offered to all patients who meet evidence-based criteria. Hospitals must ensure there is adequate capacity to provide NIV to all eligible patients.
- Acute NIV should only be carried out in specified clinical areas designated for the delivery of acute NIV.
- All staff who prescribe, initiate or make changes to acute NIV treatment should have evidence of training and maintenance of competencies appropriate for their role.

9.6 How was the preferred option evaluated?

Hurdle criteria have been applied across all options[26]. Where any option has failed any of the criteria, it has been removed from the longlist. Whilst the medium-term trajectory of this, and potential future, pandemics is uncertain, the capability to establish a COVID controlled respiratory ward at short notice, is a key part of our response, particularly as we learn more about how the longer-term pattern of these diseases in our communities emerge. The lessons learned regarding the benefits of high care for other (non-COVID) respiratory patients in our hospitals is another factor in developing this important service.

Due to the specialist staffing, equipment and infection control measures already installed at GRH, there is no realistic CGH location for high care in the short to medium term.

As described in section 5.2, the next step was the application of the FFTF desirable criteria.

The solutions appraisal exercise was designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in this case was ***reverting back*** to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.

The Trust is currently collaborating with the West of England Academic Health Science Network (AHSN) on implementing an NIV care bundle with ongoing data monitoring, audit and evaluation. Data monitoring would include:

- Numbers of patients receiving RHC on the ward
- Mortality rates in comparison with other Trusts providing RHC
- Early discharges
- Length of stay
- Number of admissions to DCC compared to current position
- Avoidance of readmissions

The outputs will be reviewed as part of the monthly service line review process within the Medical Division.

[25] *British Thoracic Society and Intensive Care Society. Respiratory Support Units: Guidance on development and implementation - June 2021, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021*

[26] The long-list and hurdle assessment can be found in Appendix 11a

Respiratory

Revert the Respiratory Inpatient Beds from a centralised model at GRH (with High Care) to a split site model at GRH and CGH (without High Care).		
Quality	**Scores**	Similar to significantly worse than status quo
	Comments	• When Acute take at GRH more patients would require transfer if revert back. • Most patients will be directed to correct site pre arrival but some 'walk in patients' to CGH may require transfer. • Time to start NIV is important so a reduction in transfer will optimise start time. • Average of 7mins increase in "blue light" does not have clinical impact.
Access	**Scores**	Similar to status quo
	Comments	• Little effect on patient travel- maybe more on family • Same staffing hours but centralisation gives slightly more clinical time. • Respiratory disease often associated with deprivation therefore proposal to collocate at GRH has a positive impact. • Distribution of beds better matched to caseload. • Increased resilience from centralisation to offer Resp. High care
Workforce	**Scores**	Slightly to significantly worse than status quo
	Comments	• Team building positive in last 2 years during move. • Overall time allocated Consultant ward consultation remains the same but beneficial for nursing staff and other members of the team. • Significant impact on nursing team when cross site changes are made. • Centralisation means trainees have an opportunity to see a greater number of conditions plus high care. • Recruitment is easier as roles more attractive. Retention of staff felt to be a major factor
Deliverability	**Scores**	Significantly worse than status quo
	Comments	• If move back significant interruption to other services. • This would affect staff groups, specialist nurses & therapists. • If move back will be without Respiratory High Care. • Dependencies with Acute Take and possibly other services, e.g., cardiology.
Strategic Fit	**Scores**	Significantly worse than status quo
	Comments	• Current configuration in line with clinical strategy • Respiratory high care is nationally recognised as a standard of care and reversing model would prevent delivery of respiratory high care facilities
Acceptability	**Scores**	Significantly worse than status quo
	Comments	• 96% of respondents support the proposals.

Based on the above assessment, the preferred option it to maintain the Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital with a consult service at CGH.

There will continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.

9.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Workforce Challenges	Centralisation allows more efficient staffing of the wards, making it easier to cover gaps in establishment, medical staff rotas and staff absences With the specialist staff in one place, it is easier to co-ordinate care, provide training and improve staff recruitment and retention. Centralisation provides the medical and nursing resource to support the development of a Respiratory High Care unit
Respiratory High Care	Our proposed option would enable us to develop a dedicated enhanced Respiratory High Care area, within one of the respiratory wards with central monitoring facilities. Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.
Improved multi-disciplinary team working	Centralisation supports improved multi-disciplinary team working as evidenced by processes for joint working e.g. ward/board rounds, MDT meetings, joint care plans etc Centralisation also supports the implementation of new ACP roles
Support the Centralised Acute Medical Take to GRH	When Cheltenham acute medical take moves to Gloucester there should be less respiratory patients coming through. The risk of the patient in Cheltenham who becomes sick with a respiratory complaint will be lower and a patient on a surgical ward becoming unwell could be seen. Acute respiratory patients represent a significant proportion of the acute medical take, including many of the sickest patients who often require immediate care on a specialist unit.
Compliance with National Recommendations	Other than a centralised respiratory service at GRH, there is no realistic alternative location for Respiratory High Care in the short to medium term.

9.8 Benefits including clinical outcomes

Potential Benefits

- The provision of a respiratory high care unit will enable the service to comply with National Quality Standards for acute non-invasive ventilation (NIV) in adults[27] and compliance with recommendations of both the British Thoracic Society and Intensive Care Society and GIRFT for respiratory high care units[28].
- The provision of a respiratory high care unit will improve capacity to deliver NIV care in a ward setting. Experience during COVID showed that an 11 bed RHC unit increased capacity to provide NIV in a ward area by 50%, compared to current provision.
- Provide more timely care. Experience during COVID showed that patients could be admitted direct from ED to the RHC Unit.
- Improve clinical outcomes:
    - Reduce mortality rates. Patients with acute respiratory failure requiring NIV have a 25% inpatient mortality, with national audit showing significantly worse outcomes in patients receiving NIV outside designated high care areas.
    - Improve recovery – reducing the need for oxygen at home
- Decrease Length of Stay through additional prescribing and specialist input throughout the Respiratory unit.
- Reduce re-admission rates, through the provision of timely care.
- Reduction in admissions of respiratory patients to DCC and the ability to step down Respiratory patients in an appropriate timeframe. Admissions are seasonal, at its peak it is anticipated that the provision of a RHC Unit would avoid 7 admissions to DCC a month
- Having the specialty respiratory beds in one place makes it easier to staff the wards and makes more efficient use of the specialist team. With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention.
- Improved cross specialty working, i.e., how respiratory teams work with other acute specialties (service areas).

Potential drawbacks

- The centralisation of specialist respiratory beds at GRH will impact some patient and carer travel times
- The overall impact is <10% of respiratory patients[29], families and carers are negatively affected by centralising at GRH
- Additional investment will be required to deliver the new high care service on a permanent basis, but evidence shows that this service increases capacity to provide NIV on the ward, improves the quality of care and patient outcomes, including reducing mortality and reducing the number of respiratory admissions to intensive care.

[27] *Davies M, Allen M, Bentley A, et al. British Thoracic Society Quality Standards for acute non-invasive ventilation in adults. BMJ Open Resp Res 2018;5:e000283. doi:10.1136/ bmjresp-2018-000283*

[28] *Guidance on development and implementation - June 2021, ISSN 2040-2023, British Thoracic Society Reports, Vol 12, Issue 3, June 2021*

[29] Details of the methodology can be found in section 11.5

9.9 Interdependencies

There is a key dependency with the acute medical take. The preferred option would support the planned centralisation of the acute medical take. Respiratory patients form a significant proportion of the acute medical take and are some of the highest acuity patients within the medical take, who require prompt transfer and treatment on specialist respiratory ward areas.

Details of the interdependencies between respiratory high care and DCC can be found in section 5.7.4.

9.10 Workforce

The only staffing changes that are being considered relate to the development of the Respiratory High Care service and include 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.

The workforce benefits of co-location are detailed in the sections above.

9.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for Respiratory are as follows:

- The respiratory emergency patients were diverted to GRH in the model; the C2 mean increases in Gloucestershire CCG by 32 seconds.
- The performance impacts are generally larger than the HASU impacts, though are small in the context of the overall performance.
- The average utilisation of ambulances across SWAST increases by 0.1 percentage points to 68.6%. The increase in travel time to hospital is 6m 26s on average across the 1.5% of transported patients in Gloucestershire CCG who are affected.
- The total time from time of call to handover at hospital increases by 5m19s on average for respiratory patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- An increase of 28 ambulance hours per week is required to mitigate the performance degradation.

9.11.1 *2019/20 Arrival to Handover Modelling*

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, respiratory emergency modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In respiratory emergency, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.

- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

9.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 11b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

9.13 Learning from Temporary Service Change Period

These respiratory proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

Of particular importance was the development of our COVID respiratory high care service. There is a need to develop a respiratory high care service to improve the quality of service for the local population of Gloucestershire; including patient outcomes, continuity of care, patient experience and reductions in mortality.

9.14 South West Clinical Senate Review

The clinical panel made the following comments:

- The Panel believed that the proposals would deliver clear benefits for respiratory patients.
- The panel believed that the development of a Respiratory High Care Unit (RHCU) is an important advance that would have benefits for patients and is likely to have a positive impact on workforce recruitment and development. However, the panel did not think the development of this unit would have the proposed impact on future critical care bed requirement as many patients are currently receiving respiratory support on the respiratory wards.
- The Panel agreed that the proposals resulted in good training opportunities for respiratory registrars working at CGH during the daytime.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

9.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

9.15.1 *Quantitative Survey responses*

The proposal we engaged on was to continue to centralise Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.

- **97%** of all respondents either **strongly supported** or **supported** the idea
- **100%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	64%	0%	0%	100%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	43%	41%	51%	5%	3%	92%
An employee working in health or social care	34%	48%	52%	0%	0%	100%
Prefer not to say	6%	40%	60%	0%	0%	100%
Grand Total	**100%**	**44%**	**53%**	**2%**	**1%**	**97%**

Survey respondents were also asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 9.16.

9.15.2 *Qualitative Responses - Public and Patient themes*

Theme	Survey comment examples
Innovation	• More opportunities for self-referral and annual pulmonary rehab
Clinical considerations	• Need to ensure that patients on these wards with other health conditions receive good support from other specialties. • If the last 2.5 years has shown this to work and be beneficial, that's a pretty compelling 'inadvertent pilot'!! • Review by same practitioners maintain continuity of care. This gives the patient confidence in their care.
Ward environment	• On the whole this idea should be supported however the wards in Gloucester Hospital are poorly ventilated and understaffed.
Integration	• Lack of community support is a huge problem • Putting respiratory professionals in GP clinics/hubs rather than only in GRH • Community involvement may be needed, and it is important to introduce them as soon as possible, to maintain quality care.
Travel	• Makes good sense and has been 'trialled' through the pandemic, again we need to acknowledge limited resources, and the distance is manageable but could be costly for some.

9.15.3 *Qualitative Responses - Staff themes*

Theme	Survey comment examples
Clinical considerations	• Anyone with a diagnosis of acute respiratory illness having access to relevant teams to avoid A&E attendance, perhaps contact through the direct admission pathway to avoid the emergency department. • Patient transfers from CGH. • Respiratory is a service that has worked well being centralised to GRH site • It seems to make sense to consolidate beds in one site especially with more consultant emergency cover should the patient become acutely unwell
High Care	• Respiratory high care service is a needed service to be able to meet the requirements of acutely unwell respiratory patients. • Evidence from COVID suggests a higher level of respiratory care needed.
Workforce	• The proposal is exciting, there needs to be consideration of the workforce resource required outside of medics and nursing. • The Respiratory service at the Trust is exceptionally well lead and proactive in its outlook and approach.
Integration	• There is further work to be done with improving integration of services across the ICS with further investment for managing respiratory conditions and access to services such as pulmonary rehabilitation and care/support in the community. • Curious as to why some respiratory services couldn't be offered at community level.

9.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Respiratory High Care
The business case includes on average 11 respiratory high care monitored beds – demand is highly variable. Extra beds are to have monitors in the side rooms for times of high demand of infection control needs. Additional resources required to develop this service are 2 x Advanced Clinical Practitioners and 1.5 x band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.
Patients who come in for surgery may develop other problems that need respiratory help
This would be covered by the consultant based at Cheltenham, very sick patients could be looked after in intensive care.
Patients needing transfer
At the point that the ED team think that the patient needs to be admitted they would put them on the Acute take list, arrangements would then be made to transfer the patient (via a Trust inter-site ambulance) to Gloucester. The patient would be taken directly to the Acute Medical Unit, avoiding the ED.

Feedback received and FFTF2 response
Community support
Cheltenham outpatient clinics will not be changed. We are also developing an Acute Respiratory Infection Virtual Ward. This model will be aimed at patients who would otherwise have been admitted to hospital on a <5 Length of Stay (LoS) bed stays and have a News2 score of <4. This model also supports patients being discharged from hospital to the care of this ward who would otherwise have had to remain in hospital longer.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 9% of patients will be negatively impacted, with 91% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits, including the significant patient outcomes resulting from the establishment of a Respiratory High Care Unit.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **The centralisation of Respiratory in-patient beds is currently implemented as a temporary service change.**

10 Stroke

10.1 The 'current state' service model

It should be noted that the "current" service model is a result of temporary service changes and reflects proposals for the future configuration of services as opposed to the pre-COVID configuration which is the "no change" model.

The specialist stroke pathway in Gloucestershire is delivered jointly by Gloucestershire Hospitals NHS FT (GHNHSFT) and Gloucestershire Health and Care NHS FT (GHCFT). The stroke service consists of medical, nursing, therapy and support staff and cares for patients of all ages that present with stroke and/ or Transient Ischaemic Attack (TIA).

The GHNHSFT stroke service manages the largest number of stroke patients in the South West. It is a well-established service with well-developed links to the regional tertiary stroke centre at North Bristol Trust (NBT).

The Gloucestershire stroke pathway comprises the following:

Service	Provider	Pre-COVID location	Current Location
Hyper Acute Stroke Unit (HASU)	GHNHSFT	GRH	CGH[30]
Acute stroke Unit (ASU)	GHNHSFT	GRH	CGH[31]
Community Stroke Rehabilitation unit	GHCFT	The Vale Community Hospital	
Early Supported Discharge (ESD)	GHCFT	Domiciliary / Patient's Home	

Currently (Feb 2023), HASU has 10 beds on the Acute Care Unit and the ASU is located on Woodmancote Ward with 32 beds. Outpatient services are located at CGH and include new and follow up clinics and a transient ischaemic attack clinic. The Stroke service have a funded establishment of six consultants. Details of future bed requirements are provided in section 5.7.

The FFTF2 changes only relate to the location of the HASU and the ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway listed above.

Current patient pathway

There is an agreed protocol with South West Ambulance Services Foundation Trust (SWASFT) to take all stroke/query stroke patients direct to CGH.

- SWASFT/GP call via CINAPSIS
- The patient is accepted by the stroke team
- The patient arrives at CGH and is taken directly for a CT scan (no contact with the Emergency Department at CGH)
- The patient is swabbed for COVID. (If a patient requires admission and is negative the patient is admitted to a bed on ACUC. If positive the patient is admitted to Knightsbridge ward.)

[30] Relocated in February 2022 (temporary until March 2023). Split site model Jun 2020 to Jan 2022.

[31] Relocated in June 2020 (temporary until March 2023)

- Depending on their condition, following their stay on HASU, patients are either transferred to the ASU (~50%) to continue their inpatient treatment and care, transferred to another service provider or able to return home with on-going community support where needed.

If patients with stroke symptoms 'walk in' at the CGH Emergency Department, the stroke team are alerted, the patient is assessed and if appropriate, they are admitted.

If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment.

There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site.

Prior to the relocation of the HASU to CGH the Trust discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

10.2 Activity

The pathway schematic (Appendix 12a) details the flow and numbers of patients for the period Jun 20- May 21. In summary:

- ~ 1000 strokes including stroke admissions and existing inpatients experiencing a stroke
- ~50% of stroke admissions are transferred to ASU
- A significant proportion of stroke admissions (~30%) are discharged to usual place of residence from HASU

10.3 Clinical Engagement

A Task and Finish group, as a sub-group of the Circulatory CPG, was established to undertake a diagnostic review of current service configuration and with the aim of developing a service model and configuration for the stroke services in Gloucestershire, which will maintain and enhance service performance as measured by the SSNAP[32] indicators.

The scope of this review included the optimal number of beds, the longer-term preferred staffing models for each element of the pathway (including opportunities and benefits of enabling staff to work across the whole pathway) and options[33] for improving the non-bedded element (Community Rehabilitation etc.).

Membership of this group included clinical and management representatives from GHNHSFT and GHCFT, CCG commissioning leads, Stroke Association and lay representation.

[32] Sentinel Stroke National Audit Programme

[33] This is subject to a separate Business Case process and outside the scope of FFTF2

10.4 Case for change: the problem we are seeking to address

The FFTF2 proposals are concerned with location of the HASU and ASU taking into consideration a number of factors, including:

- Benefits of co-location including workforce
- Removal of stroke from the ED pathway improving outcomes and mitigating ED demand
- Site bed capacity constraints
- Ward environment available at each site

Workforce

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool. Strenuous efforts have also been made to backfill these posts, including locum/off framework agency staff. Despite these efforts it has proved difficult to cover these vacancies.

In addition, a combination of planned and unplanned staff changes means the number of stroke medical and nursing staff has reduced. This position made it difficult to provide safe and sustainable staffing levels on stroke wards under the post-COVID split site configuration at GRH and CGH, and to continue to provide outpatient services on both sites.

Given the above position the Trust identified the stroke staffing levels as an intolerable risk (number ID 3706) and, following detailed assessment of the options to reconfigure the service to make the best use of available staff, it determined that centralising stroke services onto one site would help mitigate this risk; the Trust moved HASU to CGH in Feb 2022.

This change has enabled staff covering all stroke areas (stroke doctors, nurses and therapists) to be on same site, so more able to cross cover each other.

ASU Ward Environment

Operating the ASU at CGH has highlighted a number of staff and patient benefits. Feedback from staff and patients is that Woodmancote is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.

Removal of stroke from the ED pathway

GRH and CGH Emergency Departments (EDs) are facing increasing demand due to delayed presentations from the pandemic, continued COVID demand, difficulties in patients accessing other services, difficulties in discharging patients who are medically fit, all of which affects to overall patient flow from the ED and delays in ambulance handovers. This can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis[34] and admission to a dedicated stroke ward within 4 hours. The timely administration of tPA/ thrombolysis saves lives and because tPA restores blood flow by dissolving the clots in a blood vessel, it may limit the damage from a stroke and protect

[34] The medicine itself is called alteplase, or recombinant tissue plasminogen activator (rt-PA). The process of giving this medicine is known as thrombolysis.

against quality of life impacts, like mobility loss or speech difficulties. More benefits can be found in section 10.8).

In its pre-Pandemic configuration (with both HASU and ASU at GRH) the stroke service was rated C (on a scale of A to E), and initially, in its temporary configuration the service was rated B. However, the split site model and system pressures during winter 21/22 resulted in a rating fall to D.

The creation of a direct admit pathway, avoiding the need for patients to be seen in ED has improved the Trust's performance against national SSNAP targets on the time taken to receive a CT scan, to be assessed, to receive thrombolysis and be admitted to a stroke ward. Following the relocation of HASU to CGH the Trust SSNAP scores have improved (to either C or B in the quarters since Mar 2022).

In addition, relocating the HASU to CGH and revising the admission pathway has reduced pressure in GRH ED and GRH cardiology ward/medical bed base. The direct patient pathway to stroke team, that avoids ED, has reduced pressure in GRH and CGH ED.

10.5 Clinical Evidence

There has been strong evidence for many years that treatment at specialised stroke units, offering rapid access to the range of appropriate assessments and multidisciplinary expertise and intervention, is associated with lower mortality and lower rates of post-hospital disability[35].

Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT), a more protected bed capacity and so better access to specialist stroke unit.

As stated in section 10.1 the FFTF2 changes only relate to the location of the HASU and the Acute Stroke Unit ASU provided by the Hospitals Trust and do not include any change to the core elements of the Gloucestershire stroke pathway, which are aligned with best practice[36], that is:

- **Hyper-acute care** typically covers the first 72 hours after admission. Every patient with acute stroke should gain rapid access to a stroke unit (<4 hours) and receive an early multidisciplinary assessment.
- **Acute stroke car**e immediately follows the hyper-acute phase, usually 72 hours after admission. Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
- **Inpatient rehabilitation** is an essential bridge for many stroke survivors between acute stroke care and post-discharge integrated community rehabilitation. Its key outcomes overlap with those for acute stroke care, community rehabilitation and life after stroke.
- **Early Supported Discharge** facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting.

[35] Stroke: GIRFT Programme National Specialty Report (April 2022)

[36] National Stroke Service Model (May 2021)

10.6 How was preferred option evaluated?

The T&F Group applied hurdle criteria to the long-list (of 256 possible permutations)[37]. This process was undertaken prior to the decision to relocate HASU to CGH (Feb 2022) and before the decision to separate the non-bedded developments into a separate business case process outside of FFTF2. Taking these factors into account, particularly the learning over the past two years that it is more effective to manage and deliver a quality service if both units are on the same site, the medium-list became #3.

As described in section 5.2, the next step was the application of the FFTF desirable criteria. Our solutions appraisal exercise is designed to evaluate proposed changes compared with the status quo. Given that the changes outlined above are already in place, the proposed change evaluated in the case of stroke was ***reverting back*** to the original configurations, i.e., reversing the current temporary service change.

The scorecard from the solutions appraisal process is presented overleaf.

[37] The long-list and original hurdle assessment can be found in Appendix 12a

Stroke

		Revert Hyper-Acute Stroke Unit and Acute Stroke Unit from CGH and back to GRH
Quality	**Scores**	Worse than status quo
	Comments	• Key benefit of current model is direct admitted pathway. • SSNAP from Feb access to CT and HASU beds has improved. • Woodmancote purpose built as an acute unit. • CGH gives more opportunity to provide the number of beds required. • Some feedback from vascular but view not essential to have co-location. • No significant "Blue Light" impact
Access	**Scores**	Broadly similar to status quo
	Comments	• Cinapsis significantly improved • Overall public transport options for services moving to CGH generally worse. • Access to HASU is better on CGH site as well as Woodmancote as less bed pressures and ability to reduce LOS
Workforce	**Scores**	Similar or slightly worse than status quo
	Comments	• Move positively received by staff. • Issue moving Woodmancote back for rehab colleagues, thrive in a rehab environment. • Better space for training • Woodmancote better environment to develop skills and deliver care
Deliverability	**Scores**	Worse than status quo
	Comments	• Should not underestimate the space needed, which would be a challenge to provide on the GRH site. • Better access to CT and MRI at CGH.
Strategic Fit	**Scores**	Similar than status quo
	Comments	• Purist planned and emergency site split - slightly worse. • Innovative model not accepted "norm" but other sites in England
Acceptability	**Scores**	Similar than status quo
	Comments	• Comments from vascular. Concerns re pathway, but this would not materially change. • 82% of respondents support the proposals

Based on the above assessment, the preferred option it to maintain the Hyper Acute Stroke Unit (HASU) and Acute stroke ward (ASU) at Cheltenham General Hospital.

There will continue to be a choice of outpatient appointments at CGH and virtually when appropriate.

10.7 How does this address the case for change?

Reason for change	How preferred option addresses this
Improved rehabilitation ward environment	Woodmancote at CGH is much better suited to support acute stroke care and rehabilitation than the previous Tower Block ward at GRH, as it includes wide spaced bays that are open and light, bathroom facilities include overhead ceiling hoists, an environment that is designed to stimulate physical interaction and cognitive improvement.
Removal of stroke from the ED pathway	Our current pathway (and proposals) is following NICE guidance (NG128, QS2 and CG 162) and the removal of stroke from the ED pathway is enabling direct to CT, earlier Alteplase (we are starting bolus in CT.
Site bed capacity constraints	The relocation of both HASU and ASU to CGH has created an opportunity for a more protected stroke bed capacity than was achieved on our emergency site (GRH)
Workforce	The co-location of HASU and ASU are essential to mitigating our workforce requirements and risks. The proposal delivers this.

10.8 Benefits including clinical outcomes

Potential Benefits

- Direct admit stroke pathway (avoiding ED) which improves performance against four of ten SSNAP domains, i.e., Domain 1 -time to scan, Domain 2 – admission to a stroke Unit, Domain 3 proportion of patients receiving thrombolysis and timescale and Domain 4 – specialist assessment and timescale.

Overall thrombolysis/ tPA effectiveness:

- 1 in 3 get better
- 1 in 10 get significantly better incl complete recovery
- 1 in 33 get worse including bleeding and/or death
- Every 15 minute delay in re-perfusing an ischaemic stroke equates to 1 extra year of disability

- Both inpatient units are on the same site - which supports a seamless service and means that patients can access the right specialist staff at the right time
- The co-location of HASU and ASU provides improved staff cover and improved staff resilience for sickness and absence
- The ASU would continue to use the specialist Woodmancote Ward and would not need to share space with HASU. This environment is more spacious, it has hoists and provides an area for therapy services. It is also a better and quieter environment for patients receiving rehabilitation care. The quality of this environment is better than the original space available at GRH

- When compared to a split site option it reduces the need to transfer patients receiving inpatient stroke care[38]
- There would not be the same challenges on bed availability as there would be on the GRH site.
- Reduced pressure in GRH ED and GRH cardiology ward/medical bed base
- Better training of stroke ward juniors
- TIA clinic could be run from Ambulatory Emergency Care Unit (AEC) at CGH – enabling faster access to specialist opinion, ability to train acute medical juniors in stroke.
- Reduced pressure on GRH CT/MRI.

Potential drawbacks

- There will be travel impact for some patients previously attending GRH who will now attend CGH. The overall impact is 15% of HASU and 17% of ASU stroke patients / families/ carers are negatively affected by centralising at CGH[39]
- There are a number of non-stroke conditions that can present with similar clinical features to stroke and TIA (these patients are known as stroke mimics). These may be taken to CGH and then, once identified, are either managed by the stroke team at CGH or may be required to be transferred to GRH.
- Likewise, there may be patients that develop a stroke whilst an inpatient at GRH and may need to be transferred stroke unit. However, this position would be similar if the stroke service was to revert to being centralised at GRH.
- Whilst the clinical evidence for consolidating stroke services onto a single site (now CGH) shows improved patient outcomes, clinical protocols are in place for any suspected stroke patient presenting at GRH, including advice and support and safe transfer from GRH to CGH.

10.9 Interdependencies with other services

There are a number of interdependencies of operating the HASU at CGH (our planned site), these including medical cover at CGH once the Acute Medical Take (ACUC) moves to GRH (September 2023). Full details of rotas are provided in Appendix 6.

10.10 Workforce

The Stroke service have a funded establishment of 6 consultants.

There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

[38] There would still be occasions where a patient may 'walk in' at the GRH Emergency Department and would need to be transferred to CGH or an inpatient at GRH has a stroke, while under the care of another service area (specialty) and, based on their clinical needs, it is decided to transfer them to CGH.

[39] Details of the methodology can be found in section 11.5

10.11 "Blue light" ambulance travel impact

As with FFTF1, the FFTF programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in Gloucestershire CCG are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

10.11.1 *2019/20 Arrival to Handover Modelling*

- SWAST has experienced increased handover delays in 2021/22 compared to previous years.
- The base position, HASU modelling scenarios were re-run with 2019/20 handover delays to quantify the effect of longer handover times on response performance.
- In HASU, the impacts on performance with 2019/20 handover delays are of a similar magnitude to that with 2021 handover delays. With 2019/20 handover delays the mean response time impacts are generally smaller, but the 90th percentile impacts are generally larger.
- The C1 impacts are smaller, potentially as due to the lower strain placed on resources by reduced handover delays, the highest acuity category is protected.

In respect of any emergency inter-site transfers, please see section 5.6.

10.12 Standard Operating Procedures (SOPs)

The current SOP is attached as Appendix 12b. This describes in more detail the pathway process outlined earlier. This SOP will be updated when the acute take centralises at GRH.

10.13 Learning from Temporary Service Change Period

These stroke proposals have been influenced as a result of temporary service changes made in response to the pandemic, and this provided the opportunity to test and trial service configurations before deciding formally to consider them as permanent change proposals.

10.14 South West Clinical Senate Review

The clinical panel made the following comments:

- Whilst most stroke services are co-located with the acute medical take, the Panel believed that the proposals would deliver clear benefits for stroke patients but that there are also some possible disbenefits including for those presenting to GRH who will need to be transferred to CGH for management and rehabilitation and may experience delays in their early management.
- Integration of the ASU and HASU on the same site at CGH in purpose-built accommodation is advantageous for both patients and staff.
- "Direct to CT" pathways will save valuable time in assessing and managing people with a stroke brought to hospital by ambulance.
- It would be preferable for stroke mimic patients to be cared for at GRH under other acute medicine pathways, instead of in the Stroke Unit at CGH, but this may not always be possible, and bed and workforce planning must allow for the continuing management of stroke mimics at CGH.
- The Panel observed that the imaging support at CGH is currently unable to identify late presenting patients who may be suitable for thrombectomy using CT Perfusion Imaging in line with NICE Guidance NG128 and the national optimal stroke imaging pathway. The Panel recommended that this is addressed as soon as possible.

In respect of the point raised above, the clinical teams have indicated the following:

- We are aware of the benefits of CT perfusion scanning and are working with our radiology department to look at how to progress this within GHNHST. This will require training of radiographers and radiologists, which does not have an immediate solution, but we know this is an aim.

For completeness our responses to the Senate Desk-top review report are included in Appendix 17.

10.15 Engagement feedback

As described in section 4 we have undertaken an extensive public and staff engagement programme.

10.15.1 *Quantitative Survey responses*

The proposal we engaged on is that both the Hyper Acute Stroke Unit and Acute Stroke Unit remain permanently at CGH and the way that patients currently access the service remains the same. The learning over the past two years is that it's easier to manage and deliver a quality service if both units are on the same site (CGH).

- **84%** of all respondents excluding staff either **strongly supported** or **supported** the idea
- **73%** of staff respondents either **strongly supported** or **supported** the idea

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	46%	9%	9%	82%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	44%	51%	47%	0%	2%	98%
An employee working in health or social care	35%	36%	37%	0%	27%	73%
Prefer not to say	5%	20%	20%	0%	60%	40%
Grand Total	**100%**	**43%**	**41%**	**1%**	**15%**	**84%**

It should be noted that the ideas for stroke received the highest proportion of opposition from survey respondents compared to other services, particularly from staff concerned with the location of stroke at the non-emergency site. Concerns were raised especially regarding co-location with vascular surgery and cardiology. All survey comments were reviewed by the Stroke team and a response is provided in section 10.16. Meetings between the two services have also been undertaken.

All survey respondents were asked to provide us with the rationale for their response and what information they would like us to consider. A summary of the key themes and some example comments (from staff and the public) are presented below, with our response in section 10.16.

10.15.2 *Qualitative Responses - Public and Patient themes*

Theme	Survey comment examples
Interdependencies	• Getting a stroke patient to one of these units within the critical 4 hours is another matter given the current demand for ambulances.
Clinical considerations	• I'm very unsure about this. No mention made of thrombectomy • I am concerned that, with the often time critical nature of strokes, the move of in-patient stroke to CGH might lengthen the time before a patient received a necessary thrombolytic agent. • The issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Why would you have Stroke based at Cheltenham General when cardiac, interventional radiology and vascular services are all at Gloucestershire Royal Hospital • Happy that CGH has control of stroke admissions. I agree with potential benefits.
Benefits	• Excellent - good analysis of potential drawback • Streamline to get the best optimal service. The better and sooner we treat stroke, the way better the outcomes for patients and their long-term outlook.
Ward environment	• It makes sense to have both the HASU and ASU on the same site, but also that they are separated so as to have the ASU in the quieter area.

Theme	Survey comment examples
	• Vital to have prompt effective assessment and treatment. Good to have a therapy areas on Woodmancote Ward.
Inter-site transfers	• There will still be transfers required, but there would be anyway if it was all located at GRH. However, as ever the issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Same site for both makes sense and if transport between the 2 hospitals if needed is in place, that should cover the unusual cases

10.15.3 *Qualitative Responses - Staff themes*

Theme	Survey comment examples
Clinical considerations	• The purpose-built ward at CGH is suitable • I share the concern about receiving the correct treatment, diagnosis and transfers to Cheltenham. • The new model for HASU works well having limited beds and a focus on patients being moved on quickly
Interdependencies	• Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site. • Acute stroke is an emergency service, and it should be based at a site where there is 24 hour ED • What happens to overnight Strokes when ACUC moves to GRH, and the medical cover goes with it? • Removing the service from the main ED and delaying crucial intervention such as thrombolysis.
Workforce	• It has hugely helped with staffing and team moral being on the same site. • I point out that, especially for understaffed therapy teams, HASU and ASU being on the same site saves huge amounts of resources as the therapists can help out on each ward depending on staffing and patient demands. • I would also say that the service should have more funding for therapists and assistants and would benefit from an activities coordinator, social work support and complex discharge coordinator
Ward environment	• The current HASU ward is not fit for purpose • Larger clinical area for HASU - more room for beginning rehabilitation of patients • Woodmancote is more modern, lighter and purpose built for Stroke rehabilitation. • Woodmancote is well suited to the therapy needs of patients considering the track hoists and large therapy room and Cheltenham hospital is a good environment for these patients with nice outdoor areas that can be accessed.

Theme	Survey comment examples
Health inequalities	• Stroke services should be at biggest acute hospital in the city where socioeconomic circumstances make stroke most common

10.16 Addressing themes from engagement feedback

Feedback received and FFTF2 response
Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site.
There is currently no interventional radiology input from Gloucester or Cheltenham. The interventional radiology for strokes is carried out at Southmead and there is no intention that that will change. If, and when, GHNHSFT starts providing thrombectomy for strokes, we will revisit our service configurations, but currently and the for the next few years, this is not an issue. The vascular issue is around access to carotid dopplers and carotid endarterectomy for the high TIAs. Surgery is not performed on the same day and best practice is within seven days. The vascular unit at GRH includes patients from Swindon which is acceptable. Cardiology input is for telemetry and tapes and echoes. We will continue to have cardiac investigations on both sites. Furthermore, echoes are never immediate to help guide next steps of treatment. It's not emergency care. We rarely share stroke patients with cardiology. We may occasionally ask for advice on rhythm disturbance, but we have not had a patient that suddenly had a heart attack and needed resuscitating.
Medical cover at CGH
Out of hours there is 24/7 medical registrar cover at CGH. This registrar provides cover for the acute take as well as supporting the stroke service. Once the acute take centralises at GRH the responsibilities of this post will reduce. The medical registrar works closely with the specialist nurses and the Advanced Care Response Team. There is a Consultant Specialist regional on call rota for thrombolysis/thrombectomy queries. At weekends there is a Stroke Consultant on site at GRH from 8am – 12.00.
Strokes at GRH
If a patient with stroke symptoms ‘walks in’ at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment. There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site. There is now an agreed protocol for managing COVID positive stroke patients in CGH.
Ambulance travel times
As with FFTF1, the FFTF2 programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the “blue light” ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows:

- The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG.
- Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on average, only 1.2% of transported patients in NHS Gloucestershire are affected by the change.
- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

Ward environment

As part of proposed moves for Cardiology in May 23, the HASU will be able to relocate into the Cardiology ward at CGH, which will provide 21 beds. This ward looks out on to a courtyard garden providing better space for recovery. It will also provide better space for therapy services. Cheltenham has better car parking access for wheelchair users.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 15% of patients will be negatively impacted, with 85% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Inter-site transfers

The Trust currently has a contract with an independent company to provide patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites.

As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

Key Points

- **This service change proposal delivers the case for change.**
- **This service change proposal delivers a range of patient and staff benefits and supports improvements in SSNAP performance.**
- **This service change proposal is supported by the Clinical Senate**
- **This service change proposal is supported by respondents to our engagement**
- **This service change proposal is currently implemented as a temporary service change.**

11 Integrated Impact Assessment (IIA)

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate and supporting decision makers to meet their Public Sector Equality Duty (see section 13.3), and their duty to reduce inequalities.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The assessment uses techniques such as evidenced based research, engagement and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the assessment is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change. The Fit for the Future (FFTF) programme undertakes the following process to develop its IIA.

1. Undertake a baseline IIA for each service based on the proposals, clinical evidence and potential outcomes prior to the engagement process and include recommendations based on the evidence review to inform an action plan.
2. Update the baseline IIA following public involvement to take account of feedback from the public, patients, staff and stakeholders. The IIA report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles[40].

A full IIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The FFTF IIA uses data and analysis provided by the Office of National Statistics (ONS) to help us understand impacts on those affected by potential change. These IIA's use data from the 2011 Census as this is the most recent Census data that has been robustly analysed by the ONS, who provide a statistical commentary which we have used to help us with our assessments of impact. The IIA's also contain data from GHFT detailing admissions to hospital by protected characteristic and location which helps us analyse impacts of change.

The most recent census also took place in 2021 and the ONS is currently in the process of releasing data, analysis and commentary, however, this is not available for this DMBC as the ONS release schedule is currently planned for:

- Early 2023 - Phase 2: Multivariant data releases and statistical commentary
- Spring 2023 – Phase 3: Alternative population base analysis (workplace etc) and statistical commentary
- Summer 2023 – Phase 4: Comparable data released and statistical commentary

As soon as more data is available it will be used in future IIA's.

[40] [40] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

The FFTF IIA is made up of 3 chapters:

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

The proposals presented in the FFTF2 engagement for all groups were found to be either neutral impact, significant positive impact/moderate adverse impact, or significant positive impact.

Our approach to the engagement targeted all groups, ensuring proactive engagement amongst older and disabled residents more likely to be service users and ensuring opportunities for people to have their say were provided in both urban and rural venues through the extensive use of the NHS Information Bus and Get Involved in Gloucestershire (GiG) engagement website.

11.1 IIA Summary

As stated above full IIAs for each service is provided in the relevant appendices, however, the impact assessment for services consolidating on either the CGH or GRH site is often similar including:

- Centralisation of services can improve patient outcomes, continuity of care, length of stay, patient experience and reduces mortality particularly beneficial to patients with protected characteristics including those with long term conditions or co-morbidities which are prevalent in patients with disabilities and those over 65.
- Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services to GRH might have a greater positive impact on these communities
- On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from Type 2 Diabetes (6.8%) there is a potential that patients who access the service from Gloucester will be positively impacted by a movement of services to GRH
- The re-location of services from GRH to CGH will impact some patient and carer travel times either positively or negatively (see individual service sections for service impacts)
- There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely based on a person's sex.
- There is currently limited data to determine any impact of the changes for women during pregnancy.
- There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.
- According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+
- There is currently limited data to ascertain any impact of the changes for those who are from any particular religious background.
- There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation.

- Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes.
- Consolidation of the inpatient bed base should provide shorter lengths of stay, faster diagnostics and minimised waiting times which will help carers who have to attend hospital regularly.
- Services centralising at GRH will be located nearer to the highest proportion of homeless people in Gloucestershire. Homeless people are more likely to have long term conditions and multiple conditions which means consolidating and co-locating services will provide support for more complex needs such as these.
- Mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. Relocation of services may therefore be beneficial to this group.
- GHNHSFT admission data demonstrates that more people attend GRH than CGH with mental health related issues. Relocating services to GRH may therefore be beneficial to this cohort.
- The consolidation of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations
- Feedback from staff and patients suggests public transport and parking can be a challenge at both sites.
- Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access.

11.2 Equality Impact assessment

Equality impact assessment (EIA) is a tool which identifies and assesses impacts on a range of affected groups of people with characteristics protected under the Equality Act 2010, namely: age; gender, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race and ethnicity; religion and belief; and sexual orientation.

The aim of an EIA is to establish the differential impact of a policy, such as in this case the development of centres of excellence and the proposed relocation or centralisation of services within Gloucestershire, on these groups. It also considers the potential measures which could reduce any negative impacts, especially in relation to health outcomes and the experiences of patients, carers, communities and the workforce. It also seeks to identify opportunities to better promote equality and good relations.

A full EIA for each service is provided in the relevant appendices (13a-e), which includes all data and evidence-based review. The impacts for each EIA domain are presented below; the key indicates the nature of the impact. This key is used throughout this section.

Key	Description
Significant Positive Impact	The positive impact is significant despite small adverse impacts
Significant Positive Impact Moderate Adverse Impact	The positive impacts outweigh the adverse impacts, however the adverse impacts have been identified and recommendations made to mitigate against these
Significant Adverse Impact	The adverse impact is significant and despite positive impacts it is not clear that the adverse impacts are outweighed by the positive impacts
Neutral Impact (no significant change)	No significant change identified for this cohort

Equality Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
Protected Charictaristics	Age	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Disability	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Pregnancy	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Marital Status	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Ethnicity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Religion	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender reassignment	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.3 Health Inequalities Impact Assessment

The Health Inequalities Impact Assessment identifies and assesses health inequalities and the impact of the proposed changes for the local community. The aims of a health inequalities impact assessment include identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

Unlike the protected characteristics listed in the Equality Act 2010, there are no specific groups identified in Section 14T of the NHS Act 2006 in relation to the duty to reduce health inequalities. However, research has identified that a range of groups and communities are at greater risk of poorer access to health care and poorer health outcomes[41]. Groups other than those that have protected characteristics as defined in the Equality Act 2010 who face health inequalities include Looked after and accommodated children and young people, carers (paid/unpaid & family members), homeless people or those who experience

[41] https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf

homelessness, people with addictions and substance misuse problems, on low incomes, living in deprived areas or remote locations, and those with enduring mental ill health.

A full Health Inequalities Impact Assessment (HIIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIIA domain are presented below; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	**Stroke**	**Benign Gynaecology**	**Diabetes & Endocrinology**	**Non-Interventional Cardiology**	**Respiratory**
Health Inequalities	**Deprivation**	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Looked After Children (LAC)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)
	Carers and unpaid carers	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact
	Homelessness	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact
	Substance Abuse	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Mental Health	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	People Living in rural and remote areas	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Neutral Impact (No Significant Change)	Significant Positive Impact

11.4 Health Impact Assessment

The Health Impact Assessment (HIA) identifies and assesses health outcomes, service impacts and workforce impact of the proposed changes for the local community. The aims of a health impact assessment include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

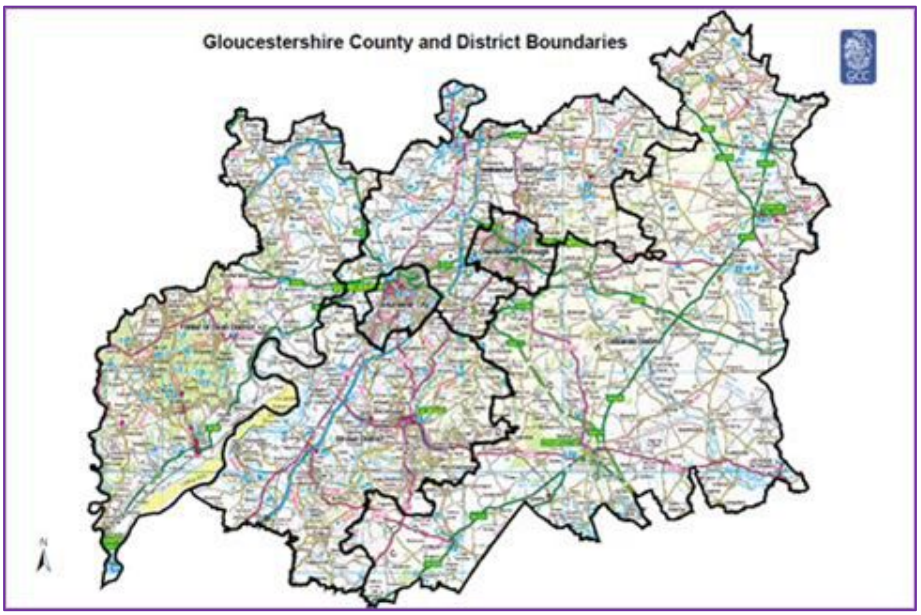
A full Health Impact Assessment (HIA) for each service is provided in the relevant appendices, which includes all data and evidence-based review. The impacts for each HIA domain are presented overleaf; the key indicates the nature of the impact; see key description used above.

Health Inequalities Impact Assessment – Summary of Impact by Service Proposal

	Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
	Service	**Stroke**	**Benign Gynaecology**	**Diabetes & Endocrinology**	**Non-Interventional Cardiology**	**Respiratory**
Health Impact	**Cardiovascular Disease**	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Diabetes Mellitus	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Falls among the elderly	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Overweight and Obesity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

11.5 Patient and Carer Travel

All of the proposed changes involve services being centralised (or consolidated) on one or other of GHNHSFT two main hospital sites, Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), which are 8 miles apart.



Locality Populations	
Cheltenham	117,090
Gloucester	129,285
Tewkesbury	92,599
Cotswolds	89,022
Stroud	119,019
Forest of Dean	86,543

We fully recognise and appreciate that behind every number is a patient and family/carer and that the day to day impact on them will vary dependent on a range of factors including access to car travel, public transport availability and accessibility and differential impact related to protected characteristics.

We have undertaken detailed analysis using anonymised activity for the FFTF2 services to assess the impact of our proposals on patients. Using the postcodes in our baseline activity we worked with the NHS South, Central and West Commissioning Support Unit (SCW CSU) to create spatial maps for each service proposal. The analysis was completed for:

- Travel by car (peak)
- Travel by car (off peak)
- Travel by public transport

As the data was anonymised and we therefore do not have access to the specific mode of transport used by patients who currently access services, we have used the following methodology to calculate the impact for each model:

Step 1. For all modes of travel (assuming all patients were to access using this mode), calculate the numbers of patients for each service, for each of the following categories

a. Positive impact (decrease 20+ minutes)
b. Neutral impact (+/- 20 minutes)
c. Negative impact (increase 20+ minutes)

Step 2. For each service identify the locality within Gloucestershire where the largest number of negatively impacted patients reside.

Step 3. Using ONS car ownership data for the relevant locality, calculate the potential number of patients for each service who could be users of public transport (This is likely to overstate the use of public transport as many non-car owners will use other means to get to hospital).

Step 4. For each service proposal assess if time of day (peak or off-peak) can be estimated e.g., if emergency (distributed across 24 hrs) or Day-case (2 cohorts a.m. peak and p.m. off-peak).

Step 5. Using the data from Step 1 calculate the number of patients for each proposal that will be travelling by car (peak and off-peak) and by public transport.

Step 6. Using the data from Step 1 and 5 calculate the number of patients for each proposal who are negatively or positively affected and deduct from the total to find those where the impact is neutral.

The details of the annual travel impact (for peak / off-peak car and for public transport) is provided for each service in the respective service sections above with a more detailed breakdown in the service IIAs (Appendices 13a-e); a summary of impacts is tabled below:

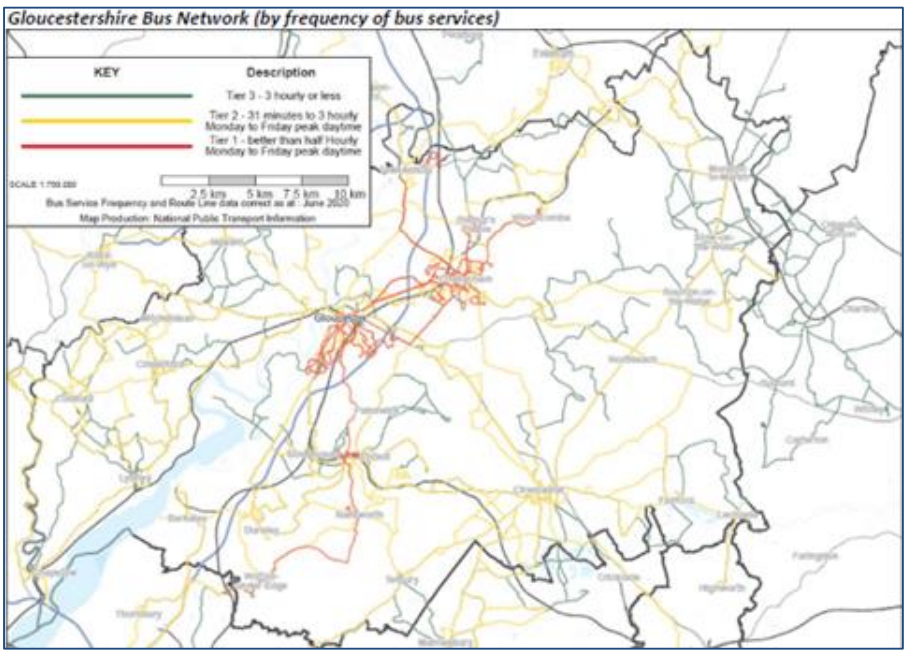
Service	Positive Impact (Decrease 20+ mins)	Neutral Impact (+/- 20mins)	Negative Impact (Increase 20+ mins)
Stroke			
-Hyper-Acute Stroke Unit (all patients)	9.7%	75.2%	15.1%
-Acute Stroke Unit (50% patients[42])	11.0%	72.1%	16.9%
Respiratory	2.0%	89.5%	8.5%
Diabetes and Endocrinology	4.9%	90.9%	4.2%
Non-interventional Cardiology	15.3%	74.7%	10%
Benign Gynaecology	8.6%	73.7%	17.8%

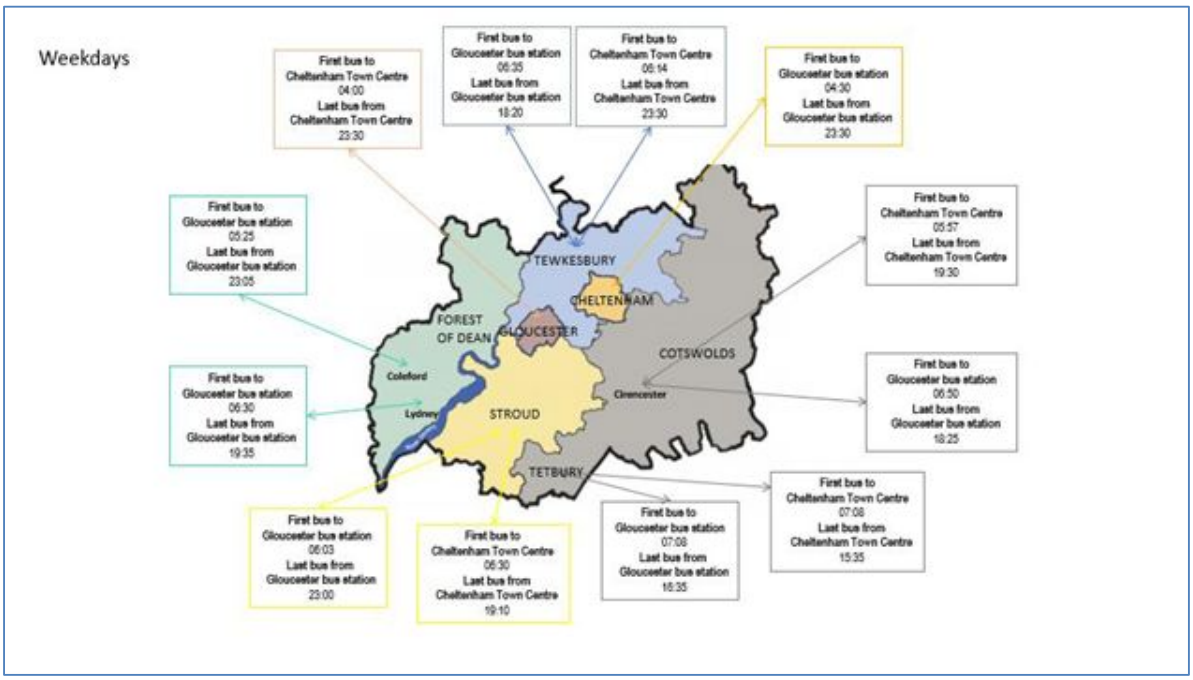
[42] The other 50% are discharged

11.6 Public transport services to GRH and CGH

Gloucestershire County Council (GCC) leads the Local Transport Plan which has public transport as one of its key themes. Although public transport has been identified as an issue there a range of services in place and proposals to improve access summarised below:

- GCC spend approx. £2.5 million a year on subsidised bus routes across the county. This remains a significant investment in public transport especially as in recent years some Councils have dramatically scaled back their funding.
- The Local Transport Plan is currently being refreshed up until 2041 which will set out strategic ambition for bus travel this sets out a commitment to making GP surgeries accessible with 45 minutes.
- The average journey time by train between Cheltenham Spa and Gloucester is 10 minutes. On an average weekday, there are 60 trains travelling between Cheltenham Spa and Gloucester.
- GCC provides £0.5 million per year in annual grants to support community transport providers, as this is an important provider of transport for vulnerable people. Dial-A-Ride is a bookable door-to-door transport service for those people who do not have their own transport and are unable to use public transport. The following community and Voluntary transport providers operate in Gloucestershire:
    - Connexions – county wide
    - Lydney Dial-A-Ride
    - Cotswold Friends
    - Newent Dial-A-Ride (Shepard House).
- Non-Emergency Patient Service exists for people who are eligible. These services provide free transport to and from hospital.
- GCC is progressing the Thinktravel Total Transport portal which will bring community, voluntary and public transport together under one platform, making accessible transport available to a wider audience who may not previously have considered these options as a travel choice.
- GHNHSFT works closely with a range of partners on transport planning services including GCC.
- GCC currently operates three Park & Ride facilities.
- The 99 bus service connects GRH, Gloucester Bus station, Arle Court Park and Ride, Cheltenham Town Centre and CGH.
- The bus network does have key routes linking Gloucester, Cheltenham and key towns, with services running on a regular basis during peak hours (see maps overleaf).





Weekday bus services (first and last) to Gloucester and Cheltenham

Further information is available in the following appendices:

- Appendix 14a Travel Impact travel analysis includes spatial maps and impact activity (by locality) for each mode of travel for each FFTF2 service proposal.
- Appendix 14b public travel info includes information on bus, train, dial-a-ride services available for each locality to access CGH and GRH.

11.7 Car Parking

On the GRH site there are a total of 11 car parks providing 1,854 car parking spaces, of which 532 are public, 1208 staff and 87 spaces available for blue badge holders (DDA). On

the CGH site there are a total of 11 car parks providing 741 car parking spaces, of which 192 public, 437 staff and 40 Oncology patient car parking spaces with 56 spaces for blue badge holders.

Prior to COVID GHNHSFT initiated a full review of staff travel and car parking in line with NHS car parking management guidance to identify best practice in car park management and sustainable transport; including:

- Working with patients and staff to make sure that users can get to the site as safely and conveniently as possible;
- Solutions should also be economically viable;
- Travel plan should reduce environmental impact of staff commuting to work;
- Charges should be reasonable for the area;
- Concessions should be available for certain groups of users;
- Other concession, for example for volunteers or staff who car share should be considered locally; and
- Priority for staff parking should be based on need.

The review was paused at the start of the pandemic and has recently been re-started.

The public and staff have the option of using the 99 bus that operates between the two hospital sites. It runs Monday to Friday from 06:20 (first bus) to 20:05 (last departure[43]), every half an hour and takes 30 minutes. It is free to GHNHSFT staff on production of an ID badge. The bus also stops at other stops between the hospitals with a fee of £1.00 payable at Gloucester Road, Cheltenham, Cheltenham Road and Longlevens. The bus service also collects passengers from the Arle Court Park and Ride in Cheltenham. The cost for this is £1.00 on production of ID badge and the cost for parking your car there is free. Staff impacted by changes may choose to use this service if their base changes from one site to another, but consideration needs to be given to the increase in their daily journey time as a result.

11.8 Carbon Impact

We have estimated the carbon impact using the following methodology:

- Using our travel impact analysis to determine number of patients positively and negatively impacted.
- Using travel time as a proxy for travel distance calculated the net impact (difference between positively and negatively affected)
- Using the 8 mile distance between GRH and CGH calculated the carbon impact

An assessment of the travel impacts on carbon footprint of the proposed changes can be found in Appendix 14c; the overall impact is +1.35 metric tonnes of CO^2.

We recognise this analysis does not report any other environmental impacts but as the level of activity and therefore resource use is the same as the baseline, travel is the single largest change.

[43] Up until March 2023 when the current extended service trial ends (19:05 is the non-trial last departure).

Key Points

- **Equality Impact Assessments (for groups with protected characteristics) have been completed for all service change proposals.**
- **Health Inequalities Assessments (for groups and communities that are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Health Impact Assessments (for groups and communities that have specific health needs and are at greater risk of poorer access to health care and poorer health outcomes) have been completed for all service change proposals.**
- **Impact is predominantly positive or neutral with no significant adverse impacts.**
- **Patient and carer travel impact modelling has been undertaken.**

12 Economic and Financial Analysis

12.1 Introduction

The economic and financial analysis has been developed by the Fit for the Future Programme team working with GHNHSFT clinical divisions, reporting to the GHNHSFT Director of Finance, and in collaboration with the Gloucestershire Integrated Care System Resources Steering Group (RSG) which comprises Directors of Finance from ICB, GHNHSFT, and GHCFT. Prior to the decision to stand-down the NHSE Stage 2 process, the programme also engaged with NHSE Finance colleagues.

The programme team included GHNHSFT Finance team, information analysts, a Senior HR Business Partner for Workforce Transformation, as well as the FFTF Programme Director and Programme Managers.

12.2 Methodology

The methodology used for FFTF1 was repeated for FFTF2 and was based on the following principles:

- Identification of the relevant clinical divisions / service areas for solutions in scope
- Identification of the appropriate baseline for activity, workforce and finance
- Identification of shifts of activity for each of the proposed solutions
- “Bottom up” impact assessment for each service proposal to identify changes in workforce or other resource requirements
- Robust “Confirm and Challenge” process to ensure any staffing or resource requirements were essential
- Identification of financial impact (income and expenditure, both recurrent and non-recurrent) of proposed changes
- Combine proposed changes with baseline to determine finance for each service area
- Review of Downside Risk.

As stated in section 3.6, four of the five FFTF2 service change proposals are currently already in place under Temporary Service Change arrangements, some since June 2020 and one (stroke HASU) since Feb 2022. The additional resource requirements are significantly less than those identified in FFTF1 (see section 12.7) and are presented in the sub-sections below:

12.2.1 *Growth*

Our assessment of the impact of population growth uses 2018 subnational population projections from the Office of National Statistics (ONS). The management of growth demand is a consistent and ongoing objective within the ICS to ensure that hospital appointments and admissions are appropriate as well as the year-on-year efficiencies within GHNHSFT to deliver productivity improvements.

Whilst the ONS projections are recognised as the usual source for growth assumptions, it should be noted that they were published in 2018 and pre-date the Coronavirus (COVID-19) pandemic. Our proposals are to deliver our case for change over the medium to long-term and we have therefore, in agreement with NHSE&I, excluded impact of COVID-19 from our baseline data, staffing models, resource requirements and finances.

Given the multi-factorial nature of COVID-19 effects and uncertainty as to their impacts, the DMBC has not attempted to inflate resource demand (e.g. bed numbers) based on an unmitigated position. If these proposals are approved and the programme shifts to implementation, decisions will take account of the position at the time, and the developing pandemic recovery paradigm.

12.3 Workforce

Any additional workforce requirements were presented in the individual service sections (6 to 10), and are summarised in the table below:

Service	Additional Workforce
Benign Gynaecology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Diabetes and Endocrinology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.
Non-interventional Cardiology	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals
Respiratory	The only staffing changes that are being considered relate to the development of the Respiratory High Care service
Stroke	There are no plans/ requirements to change the clinical or operational staffing as a result of these proposals.

12.3.1 *Respiratory High Care service*

Centralising respiratory beds at Gloucestershire Royal Hospital, provides the flexibility and capacity to support the development of a respiratory high care unit. With additional investment in providing 2 x Advanced Clinical Practitioners and 1.5 x Band 7 physiotherapists, the Respiratory service can provide an 11 bedded high care unit. The medical and nursing support can be provided within existing establishments.

12.4 Financial Impact

As stated above the only anticipated additional resources for the delivery of FFTF2 relate to the establishment of a Respiratory High Care unit, which requires a revenue investment of £274,000 and a capital investment of £21,000

Workforce

The recurrent revenue cost of the additional FTE includes pay, staff non-pay and on-costs:

Role	FTE	£ Revenue)
ACP Grade 8A	2	£148,210
Band 7 Physio	1.5	£82,575
Total	**3.5**	**£230,785**

Equipment and Set-up Costs

The equipment and set-up costs are:

Item	£ (Revenue)	£ (Capital)
Monitoring Equipment - £17,000 Monitoring Installation - £4,000		21,000
IT Project Management (6mths)	18,000	
5-year Maintenance Contract	22,540	
Equipment depreciation (per year for 10 years)	£1,700	
PDC cost of capital @3.5%	£565	
Total	**£42,805**	**£21,000**

The ICB is currently following up funding opportunities through Additional Capacity Investment with NHSE.

12.5 Phasing

Subject to DMBC resolution approval and recruitment, the phasing profile of the costs identified above would be as follows for 2023/24 year and then £59,391 per quarter going forward:

Respiratory High Care	FTE	Total	2023/2024 Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
Revenue						
ACP Grade 8A	**2**	£148,210		£37,053	£37,053	£37,053
Band 7 Physio	**1.5**	£82,575		£20,644	£20,644	£20,644
IT Project Management (6mths)		£18,000	£12,000	£6,000		
5-year Maintenance Contract		22,540	£1,127	£1,127	£1,127	£1,127
Depreciation		£1,700	£425	£425	£425	£425
Cost of capital		£565	£141	£141	£141	£142
Total (Revenue)	**3.5**	**£273,590**	**£13,693**	**£65,390**	**£59,390**	**£59,391**
Capital						
Monitoring Equipment & Installation		£21,000	£21,000			
Total (Capital)		**£21,000**	**£21,000**			

12.6 Downside risks

There is one implementation risk (section 15.6), that may result in finanical risk if unmitigated.

Implementation Risk	Comment	£
DCC Capacity at GRH if planned mitigations are insufficient to managed demand	Additional staffing cost (Appendix 8) This risk is managed by the Cross Division Task and Finish group (section 15.3.1)	£403,356

There were a number of Downside Risks associated with FFTF1 and these have been assessed in respect of FFTF2 services:

FFTF1 Downside Risk	FFTF2 Update
Inability to achieve repatriated income	There are no assumptions in FFTF2 for repatriated income.
Impact of Inter-site Ambulance Transfers	These have been refreshed for FFTF2 services and are within the funds approved in the FFTF1 DMBC
SWASFT Conveyances to GWH	These have been monitored and have not increased as a result of FFTF changes.
Activity shift to GWH	These have been monitored and have not increased as a result of FFTF changes.

12.7 FFTF 1 Finance Update

This DMBC is concerned only with the proposals for service change within Phase 2 of the FFTF Programme; these are:

- Benign Gynaecology *[44]
- Diabetes and Endocrinology *
- Non-interventional Cardiology
- Respiratory *
- Stroke *

The DMBC for FFTF1 was approved in March 2021 and none of the services in Phase 1, their costs or benefits are part of the approval resolutions contained within this DMBC (section 14).

As stated at the start of this section, the FFTF Programme has worked closely with RSG and was requested to include updates/refresh on FFTF1 benefits and costs. These have been presented at:

- ICB Board (Jan 23);

[44] *Currently subject to Temporary Service Change (for details see individual service sections)

- Resources Steering Group (Jan 23);
- ICS Strategic Executives (Feb 23);
- GHNHSFT Finance & Resources Committee (Feb 23), and;
- GHNHSFT Board briefing session (Feb 23).

A copy of the information shared can be found in Appendix 4b, and the original FFTF1 DMBC can be found at Fit for the Future | Get Involved In Gloucestershire (glos.nhs.uk).

A summary of the refresh can be found in the table below:

Service Area	Type	Original FYE (Mar 2021)	Refresh FYE (Feb 2023)
Emergency General Surgery	**Investment**	£137,000	£81,872
	NCRB[45]	£314,382	£379,797
Planned General Surgery	**Investment**	£112,000	£140,612
	NCRB	£216,731	£216,731
Vascular Surgery	**Investment**	£0	£0
	NCRB	£0	£44,640
IGIS	**Income**	£463,600	£518,660
	Investment	£559,135	£723,072
	CRB[46]	£27,000	£27,000
	NCRB	£142,147	£142,147
Acute Care Response Team	**Investment**	£397,000	£522,169
Acute Medical Take	**Income**	-£250,000	£0
	Investment	£349,456	£277,000
	CRB	£187,606	£187,606
	NCRB	£144,147	£144,147
Total	**Investment**	£1,804,591	£1,744,725
	Benefits CRB	£678,206	£733,266
	Benefits NCRB	£817,407	£927,462
	Net excl. NCRB	-£1,126,385	-£1,011,459
	Net incl. NCRB	-£308,978	-£83,997

The refreshed benefit position reduces Phase 1 net investment by £100,000 to £1M. This is further reduced to £84k when Non Cash Releasing Benefits (NCRB) are included.

Key Points

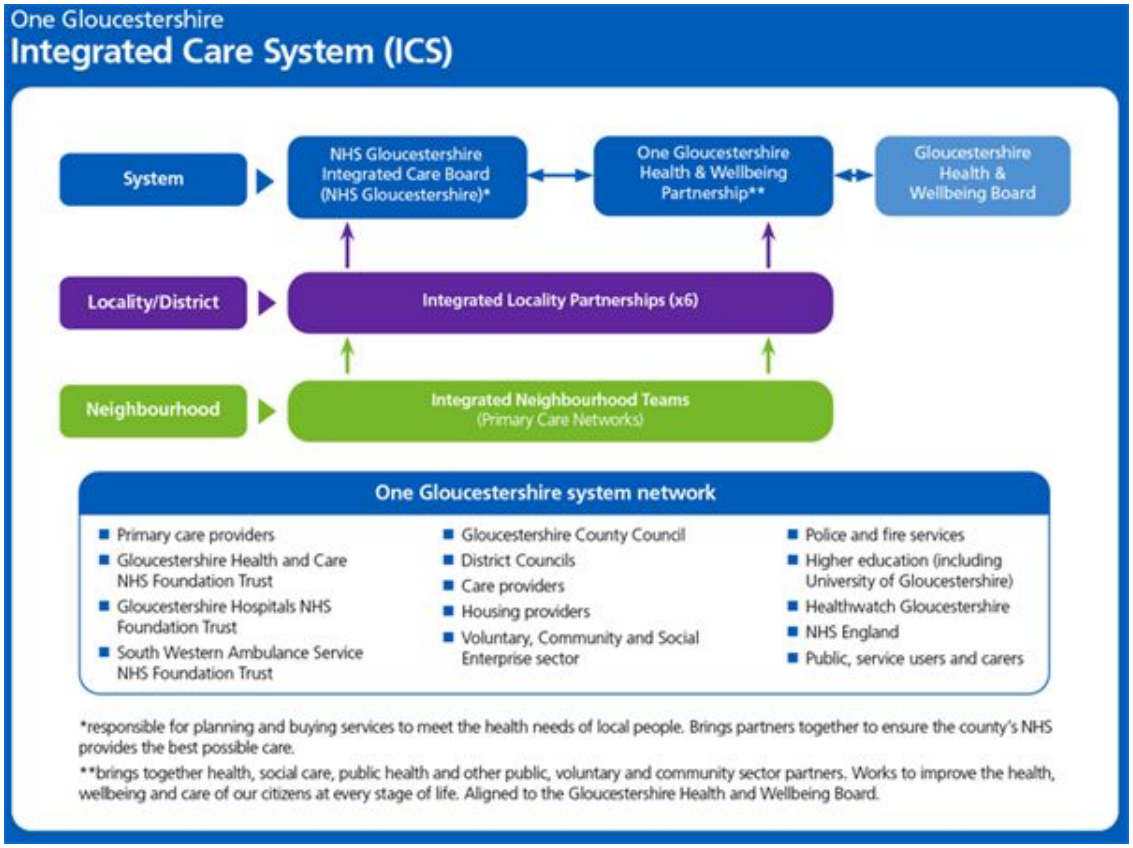
- **Four of the five FFTF2 service change proposals are currently already in place under Temporary Service Change arrangements.**
- **The additional resource requirements (<£300,00), are significantly less than those identified in FFTF1 and relate only to Respiratory High Care (RHC) Unit.**
- **Funding is being sourced to support the establishment of RHC Unit.**
- **For context, update information is provided on FFTF1 finances.**

[45] Non-Cash Releasing Benefits

[46] Cash Releasing Benefits

13 Governance and Decision making

A short introduction to One Gloucestershire Integrated Care System is provided in section 3 (and schematic presented below). We have a strong commitment from all of our system partners to move forwards with this new way of working and believe it will be pivotal to support us to deliver against our challenging performance, financial and delivery objectives more quickly, as embodied by the scale of our Fit for the Future Phase One (FFTF1) implementation and our Fit for the Future Phase Two (FFTF2) proposals for change set out in this document.



13.1 Internal Assurance

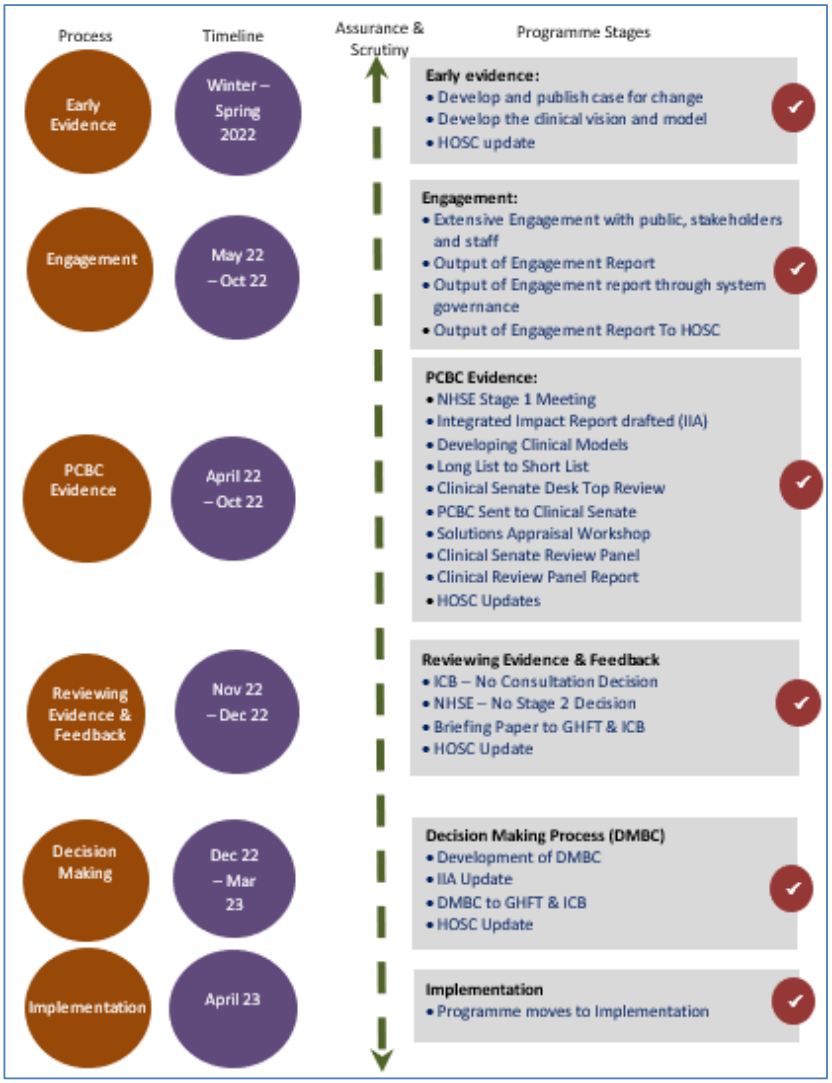
As presented in section 3.1.1 FFTF is a priority programme within our ICS Integrated Delivery Plan, that we will be seeking to deliver as partners across the health and social care system in Gloucestershire. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the year ahead.

The FFTF programme is embedded into both system and GHNHSFT governance structures. Regular reports have been taken to the NHS Gloucestershire ICB and ICB Strategy Executives GHNHSFT Trust Board and the ICS Resource Steering Group (RSG), as well as system and Board sub-committees.

The programme management arrangements are overseen through the programme Senior Responsible Officers (held jointly by both ICB and GHNHSFT Directors), the ICS Programme Development Group (PDG) including oversight of the Programme Director, the Programme Managers Group, FFTF Communications and Engagement and activity and financial

modelling. Investment is provided by the system to ensure that there are central programme resources in place to ensure delivery of programme objectives.

This DMBC is the result of years of evidence development, assurance and review of proposals to deliver an option that addresses our case for change and delivers our clinical model. The process is summarised below

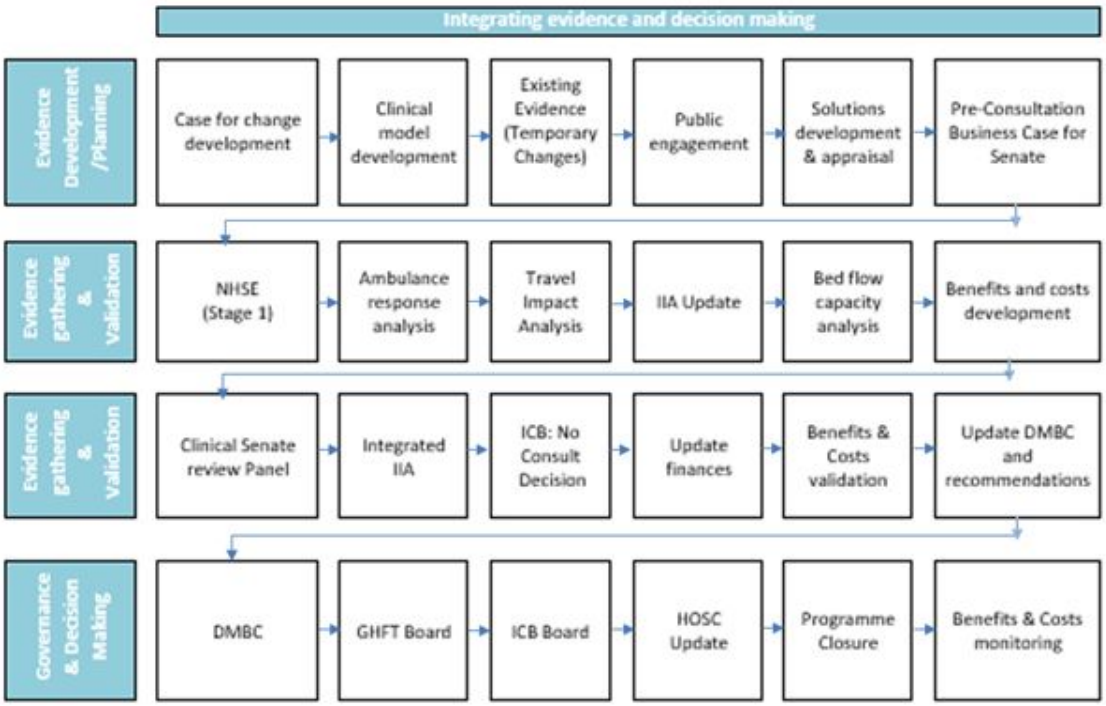


13.1.1 *Process for decision-making*

As set out in the national guidance on service change in the NHS the ICB's statutory responsibilities includes their duty to lead involvement on any planned service change in their local systems. In this case, NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).

The decision-makers in this regard will be the Board of Gloucestershire Hospitals NHS Foundation Trust and the of Board NHS Gloucestershire ICB.

The process of evidence gathering, validation and decision-making is provided overleaf:



13.2 External Assurance

13.2.1 *South West Clinical Senate review*

Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5. The service specific comments can be found in the individual service sections and titled *South West Clinical Senate Review* and our responses to the Desk-top review can be found in Appendix 17.

13.2.2 *NHS England assurance process*

NHS England has been continuously involved in the Fit for the Future Programme and assured FFTF1 at our Stage 2 review in September 2020 and the FFTF2 proposals completed their Stage 1 assessment in March 2022. As detailed in section 2, following discussions with the SW Regional NHSE team and the decision by the ICB Board that there should be no further public involvement in Phase 2 of the FFTF programme, NHSE were content and confirmed that a Stage 2 assurance process was not required; therefore the FFTF2 proposals would not be subject to the government's four tests and NHSE's test for proposed bed closures (where appropriate) i.e. the "5 Tests".

Notwithstanding the above, the FFTF Senior Responsible Officers believe it would provide additional assurance for decision-makers on the robustness of these FFTF2 proposals for an assessment against the "5 Tests" to be included in the DMBC; details are provided in the sub-sections below. Furthermore, the FFTF Programme has used the NHSE Stage 2 Key Lines of Enquiry (KLOE) as a reference document.

13.2.3 *Test #1: Strong public and patient engagement.*

The FFTF Programme has a strong track record in public engagement and involvement, and Section 4 details our FFTF2 engagement including both our activities and the feedback received. FFTF2 engagement built on the extensive engagement and consultation activities

of FFTF Phase 1, which clearly identified that there is high recognition of Centres of Excellence approach amongst those responding to our surveys.

The comprehensive Output of Engagement Report can be found in Appendix 1 and was reviewed by NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHSE and our local HOSC.

13.2.4 *Test #2: Consistency with current and prospective need for patient choice.*

Our solutions appraisal criteria for preferred options always includes a specific assessment of the impact on patient choice i.e. "*What is the likelihood of this option meeting the requirements of the NHS Constitution and The NHS Choice Framework*".

When considering the impact on patient choice it should be noted that:

- None of the proposed solutions/models will withdraw the number of specialties provided by GHNHSFT.
- There would continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate.
- For FFTF2 services the potential changes relate to the centralisation of services either on the Gloucester or Cheltenham sites (previous centralisation has resulted in improved outcomes for patients).
- Four of the five FFTF2 service proposals relate to emergency pathways (not elective) where, in accordance with the NHS Choice Framework, patients may not have a choice.
- Whilst the number of sites where patients can choose to have their operation may change, the two hospital sites are only 8 miles apart and we believe that when the impact of the changes is assessed the improved patient outcomes will outweigh the reduction in choice regarding inpatient locations.

13.2.5 *Test #3: Clear, clinical evidence base.*

Details of the current service, proposed changes, clinical evidence and impacts can be found in the individual service sections. Details of the independent clinical review undertaken by the South West Clinical Senate are provided in section 5.1 and the full report of the Clinical Review Panel (CRP) can be found in Appendix 5.

Overall, the Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

13.2.6 *Test #4: Support for proposals from clinical commissioners.*

Prior to July 2022, the NHS Gloucestershire CCG undertook a lead role in the FFTF Programme working closely with ICS partners and this role is now the responsibility of the NHS Gloucestershire ICB. In respect of Test#4, the FFTF Programme provides regular updates to ICS, GHNHSFT internal governance forums and the proposals contained within this DMBC will be required to be approved by the NHS Gloucestershire ICB.

Details of our FFTF2 engagement with all of our neighbouring ICBs and Health Boards can be found in section 4.5.1. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) were finalised.

13.2.7 *Test #5: Bed modelling*

There are no planned reductions in beds available at GHNHSFT as a result of any of the Fit for the Future proposed changes. Full details of our bed demand and capacity modelling can be found in section 5.7.

13.3 Public sector equality duty (PSED)

The Equality Act 2010 requires the ICB, in the exercise of its functions, to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to advance equality of opportunity, decision-makers should have due regard in particular to the need to:

- Remove or minimise the disadvantage suffered by persons who share relevant protected characteristics;
- Take steps to meet the needs of those who share such characteristics, and;
- Encourage participation of those who share such characteristics.

The requirements of the Equality Act 2010 also mean that the ICB should ensure that service design and communications should be appropriate and accessible to meet the needs of diverse communities

The requirements of the Public Sector Equality Duties are integral to the Fit for the Future approach. To inform the programme there has been extensive engagement and communications activity seeking to gather the views of seldom heard groups.

Furthermore, our solutions appraisal criteria included a specific assessment of the impact of solutions on accessibility to services and the Public Sector Equality Duty; namely "*What is the likelihood of this option having a positive impact on equality and health inequalities*?"

13.4 Information Governance (IG) issues and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) has been drafted on the basis that the current phase of the FFTF Programme is focusing on a DMBC, and there should be no change to any patient pathways and patient data flows. At no time will any patient identifiable data be held by the programme. The data that will be held by the programme during the next phase are as follows –

- Project Management documentation
- Programme Governance documentation
- Involvement documentation and feedback

The current DPIA is presented in Appendix 15 and will be adapted for each the phase of the programme, including implementation.

It should be noted that all the proposals that form part of this DMBC are not intended to change the provider of the services nor are there changes to clinical systems or record-keeping specific to the FFTF Programme; any changes would be subject to a separate DPIA process.

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

Key Points

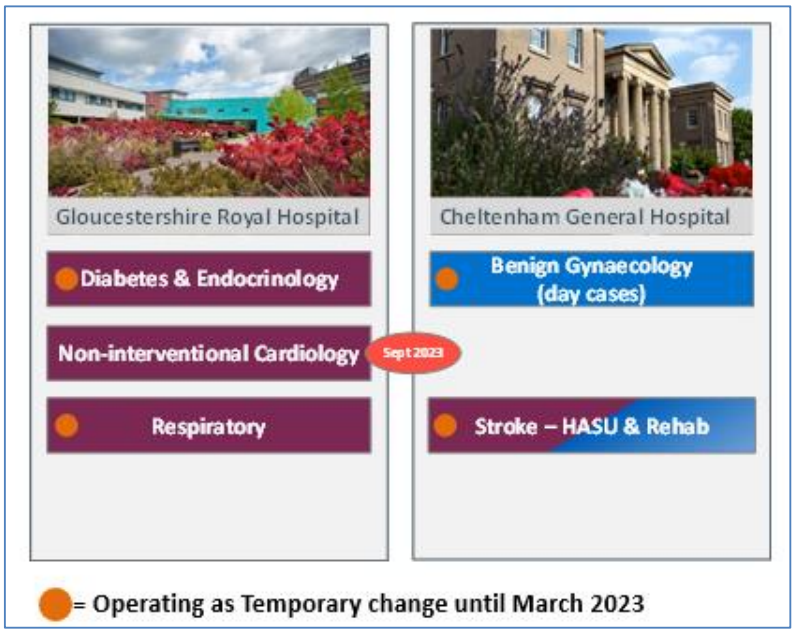
- **The FFTF programme is embedded into both system and GHNHSFT governance structures.**
- **NHS Gloucestershire ICB leads on behalf of the One Gloucestershire Integrated Care System (ICS).**
- **FFTF2 proposals have been subject to independent clinical review by the South West Clinical Senate**

14 Recommendation

14.1 Resolutions to be agreed

It is the Programme's recommendation to the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the NHS Gloucestershire Integrated Care Board (GICB) that the following resolutions should be considered for agreement and approval, considering all the evidence that has been made available, on the basis that they represent the most appropriate option to address the case for change.

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[47] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.



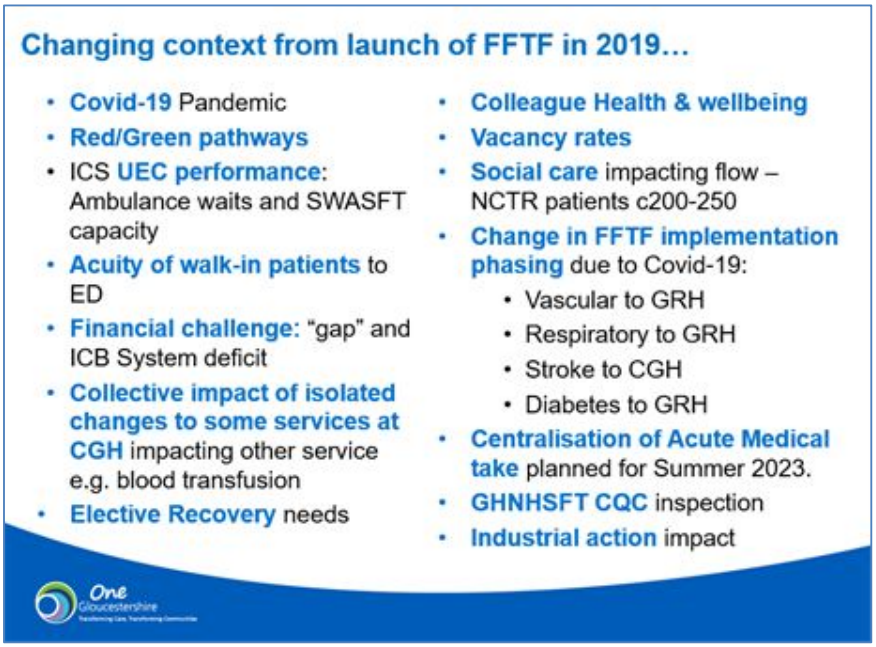
[47] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

15 Implementation

15.1 Introduction

Our *Fit for the Future Programme,* which incorporates *Centres of Excellence,* is a large scale, long-term change programme which is being delivered through a number of phases over a number of years. Furthermore, the implementation of services within FFTF1 and FFTF2 have and will not be implemented sequentially as, in some cases, we needed to align with the implementation of the GHNHSFTs strategic site development (SSD) programme. This has had to be combined with the phased implementation of FFTF1, in some cases accelerated by the need to respond to the early stages of the COVID pandemic and the development of our FFTF2 programme, which includes a number of services that are subject to temporary service change, having also relocated in response to COVID and other pressures.

The implementation context/ landscape has also changed since the start of the FFTF Programme, which has added additional pressures and challenges that need to be considered and managed by the implementation teams; these are well understood by anyone working in the NHS for the last 36 months and are summarised below:



15.2 Implementation Phasing

The factors listed above have created a level of complexity that needs to be carefully presented to ensure all those involved in assessing these proposals are assured. For completeness we have included both FFTF1 and FFT2 services and these are summarised below:

- **FFTF Phase 1 services – formally implemented following decision-making**: these were services that were in place in March 2021, such as the Trauma and Orthopaedics, Gastroenterology, Emergency General Surgery and Vascular Surgery.
- **FFTF Phase 1 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed, for

example, estates work, recruitment and training, procurement and installation of equipment. This includes IGIS and Acute Medicine.

- **FFTF Phase 2 services - Temporary service changes formally implemented following decision-making**: these are services that are currently in place (March 2023), including Stroke, Benign Gynaecology, Diabetes and Endocrinology and Respiratory.
- **FFTF Phase 2 services - Implemented following completion of other enabling workstreams:** these are services that require enabling work to be completed and include Non-Interventional Cardiology.

The table below presents a summary of each service and its actual or indicative implementation status.

FFTF Phase	FFTF service	Actual implementation date	Formal or planned implementation date
FFTF1	Trauma at GRH and Orthopaedics at CGH	October 2017	March 2022
FFTF1	Gastroenterology at CGH	November 2018	March 2022
FFTF1	Emergency General Surgery at GRH	April 2020	March 2022
FFTF1	Vascular Surgery at GRH	June 2020	March 2022
FFTF2	ASU at CGH [1] HASU at CGH [1]	June 2020 February 2022	March 2023[2]
FFTF2	Respiratory at GRH [1]	June 2020	March 2023[2]
FFTF2	Benign Gynaecology at CGH [1]	June 2020	March 2023[2]
FFTF2	Diabetes & Endocrinology at GRH [1]	September 2021	March 2023[2]
FFTF1	Acute Medicine (Acute Medical Take) at GRH	-	September 2023
FFTF1	Image Guided Interventional Surgery 'Hub' at GRH and a 'Spoke' at CGH (including interventional Cardiology)	-	September 2023
FFTF2	Non – Interventional Cardiology at GRH	-	September 2023[2]
FFTF1	Elective General Surgery at GRH and CGH	-	October 2023

[1] Subject to Temporary Service Change (for details see individual service sections).
[2] Subject to approval.

15.3 Governance arrangements for implementation

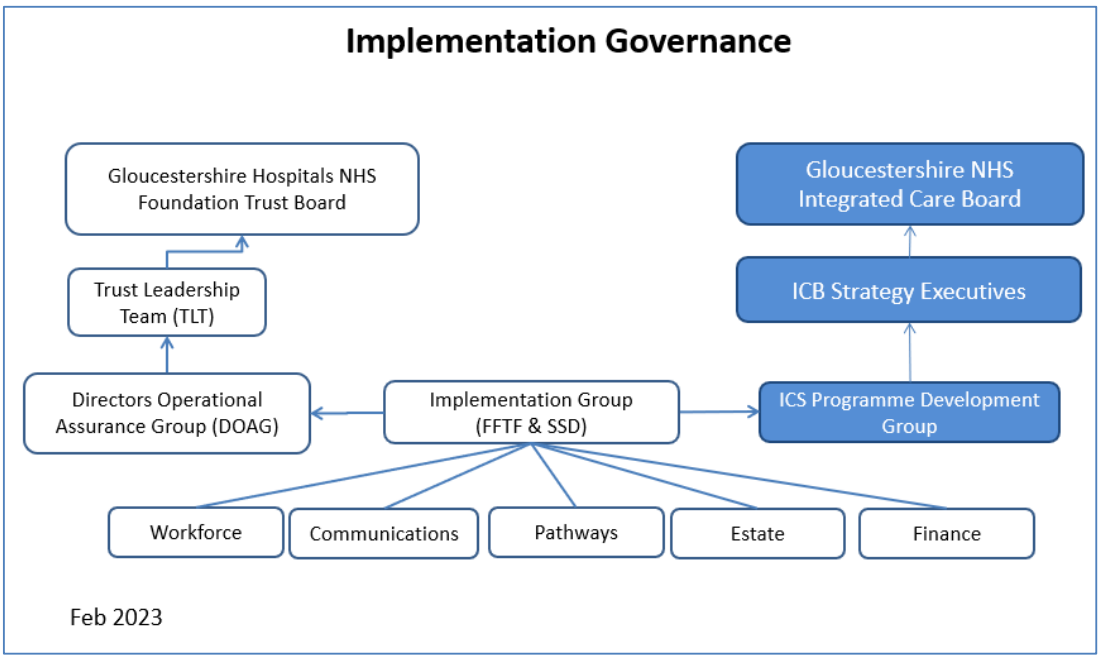
Formal governance arrangements are required to steer and govern the process of service reconfiguration and development of the FFTF programme; to deliver this we have a dedicated FFTF Implementation Group, that is implementing FFTF1 and will be responsible for implementing FFTF2.

In order to oversee the implementation of Phase 1 FFTF GHNHSFT established a working sub-group of the Directors Operational Assurance Group (DOAG). This subgroup was titled

'Phase 1 Implementation Group[48]', it meets monthly, is chaired by the Deputy COO, with representation from Deputy Divisional Directors of Operations and is tasked with overseeing the implementation of GSSD (Gloucestershire Strategic Site Development) and Phase 1 FFTF; including any interactions between the programmes or with wider strategies and changes being implemented in the Trust. The Phase 1 Implementation Group reports monthly to DOAG; DOAG has a direct reporting line to TLT (Trust Leadership Team) and then Main Board.

A number of workstreams will lead on both the planning and development required to support FFTF2 changes to service provision, as well as the transactional processes of change. Governance arrangements will have clear links within the wider Gloucestershire ICS and individual organisational governance structures to ensure that implementation plans across all areas are aligned.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting risk are maintained.



15.3.1 *Cross Division Task and Finish Group*

As part of the implementation planning, particularly focused on the centralisation of the Acute Take in September 2023, GHNHSFT have established the Cross Division Task and Finish group, chaired by the Medical Director. The group's objectives include:

- To consider the FFTF service moves and agree what clinical and support services and processes need to be in place, to ensure the delivery of sustainable services at CGH and GRH.
- To develop *go/no-go* criteria for the centralisation of the acute take to GRH.
- To produce a paper for DOAG setting out recommendations including go/no-go criteria, to confirm the date for centralisation of the acute take.

[48] Subject to DMBC approval the group will be re-named FFTF Implementation Group and cover FFTF 1 & 2.

- Area of scope include:
    - Engagement and communications
    - Patient pathways/operational policies/SOPs[49]
    - Clinical standards/protocols
    - Medical Cover arrangements
    - Medical Training
    - Clinical Support Services
    - Inter site ambulance transfers
    - SWASFT protocols
    - Acuity of Emergency Department walk-in patients
- As detailed in section 5.7.4 the group have agreed DCC metrics to monitor the impact of the current mitigations to assess the confidence that the demand at GRH DCC can be met.

15.4 Communication and engagement plan

One Gloucestershire partners will formally publish the Fit for the Future 2 Decision Making Business Case (DMBC) ahead of the GHNHSFT Board meeting 9th March 2023 and the NHS Gloucestershire Integrated Care Board meeting on 29th March 2023.

The aim of the communications and engagement plan (Appendix 16) is to ensure staff, community partners, the public and media receive information on the outcome of the decision-making process and next steps in a timely and appropriate way.

There are a number of communication and engagement objectives, including:

- To provide clear, consistent and accurate information
- To support the NHS to communicate the outcome and the changes
- To ensure relevant audiences receive the information in the right order e.g. staff first
- To ensure effective media and social media arrangements are in place.

The communications and engagement plan includes a number of key stakeholders that need to be engaged and supported as decisions are made and communicated.

The communication plan will consider the South West Clinical Senate Panel recommendation that the ICB should develop a communications strategy that informs patients about the location of specialist medical services such as cardiology and stroke and encourages patients to present to the most appropriate hospital.

The communication plan will also include the request by the HOSC that updates be brought to future meetings of the committee regarding the implementation of Fit for the Future 2 service changes.

[49] Standard Operating Procedures

15.5 Benefits Realisation

Details of the benefits are provided in Appendix 4a and 4b[50], including benefits realised for FFTF2 services already in place through temporary service change. Benefits will be continuously developed and monitored as part of the implementation programme; a summary is provided below:

	Benefits
Improved patient outcomes	• Ensuring safe and consistent staffing levels • Reduction in surgical cancellations. • Better coordination of inpatient work • Provide regular daily visits to admission wards on both sites • Improved rehabilitation ward environment • Removal of stroke from the ED pathway • Improve the quality of care provided for respiratory patients • Improved out of hours care for patients • Reduction of mortality due to Respiratory High Care
Improved patient experience	• The provision of a protected dedicated day case unit • Improved rehabilitation ward environment • Improve bed capacity constraints • Improved Patient experience • Prevent the need for patient transfer
Improved staff experience	• Easier to staff the wards • Better use of the staff groups with significant shortages • Improved staff cover and improved staff resilience for sickness and absence. • Provide enhanced training for junior and middle grade doctors with regular access to the full clinical team
Improved staff recruitment and retention	• Improved training • With the specialist staff in one place, it is also easier to co-ordinate care, provide training and improve staff recruitment and retention
Improved efficiency and effectiveness (cash releasing and growth avoidance/non-cash releasing)	• More efficient use of the specialist team • Inpatient bed number reduction. • Reduce length of stay for patients. • Prevent the need for patient transfer

The FFTF Implementation Group will work with the clinical divisions to ensure the identified benefits are delivered. The ICS Programme Development Group will link these benefits with the wider system in support of the delivery of our Operational Plan.

[50] Appendix 4b also includes FFTF1 benefits realisation to date.

15.6 Implementation Risks

The FFTF programme risk register hold risks associated with the DMBC assurance process only[51]. Implementation risks are part of the risk management function of the FFTF Implementation Group post decision-making. When assessing implementation risk, it should be noted that four of the five FFTF2 services are already in place through temporary service changes.

The risks regarding DCC are held on Divisional and, where appropriate, GHNHSFT Risk Registers.

The high level risks specifically associated with FFTF2 implementation but excluding GHNHSFT service Business as Usual (BAU) risks, are listed below.

FFTF service	Implementation Risks
Stroke Currently located at CGH as Temporary Service Change	• Completion of FFTF1 & 2 implementation to allow ward moves at CGH
Respiratory Currently located at GRH as Temporary Service Change	• Funding for Respiratory High Care (RHC) Unit • Impact on DCC capacity at GRH if RHC Unit not implemented
Diabetes & Endocrinology Currently located at GRH as Temporary Service Change	• None identified
Benign Gynaecology Currently located at CGH as Temporary Service Change	• Benefits accruing from Chedworth Day Surgery Unit if delays in completion of construction
Non – Interventional Cardiology	• Bed reduction resulting from planned benefits is not realised leading to bed pressures and outliers on other wards • Alignment of FFTF2 implementation with FFTF1 IGIS enabling works • DCC capacity at GRH

[51] Available on request

15.7 Outline programme implementation plan

As summarised in the introduction to this section, the implementation of the recommendations contained within this DMBC will be completed in stages over the next 12 months (on the basis that resolutions are approved in March 2023).

15.7.1 *FFTF2 -Formally implemented following decision making*

- **Resolution #1**: To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital.
- **Resolution #2**: To centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.
- **Resolution #4a**: To centralise Respiratory Inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.
- **Resolution #4b**: To establish a Respiratory High Care unit at Gloucestershire Royal Hospital.
- **Resolution #5**: To locate the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital.

15.7.2 *FFTF2 - Implemented following completion of enabling workstreams*

- **Resolution #3**: To centralise Non-Interventional Cardiology inpatient beds[52] at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

Implementation is dependent on a number of enabling workstreams, including:

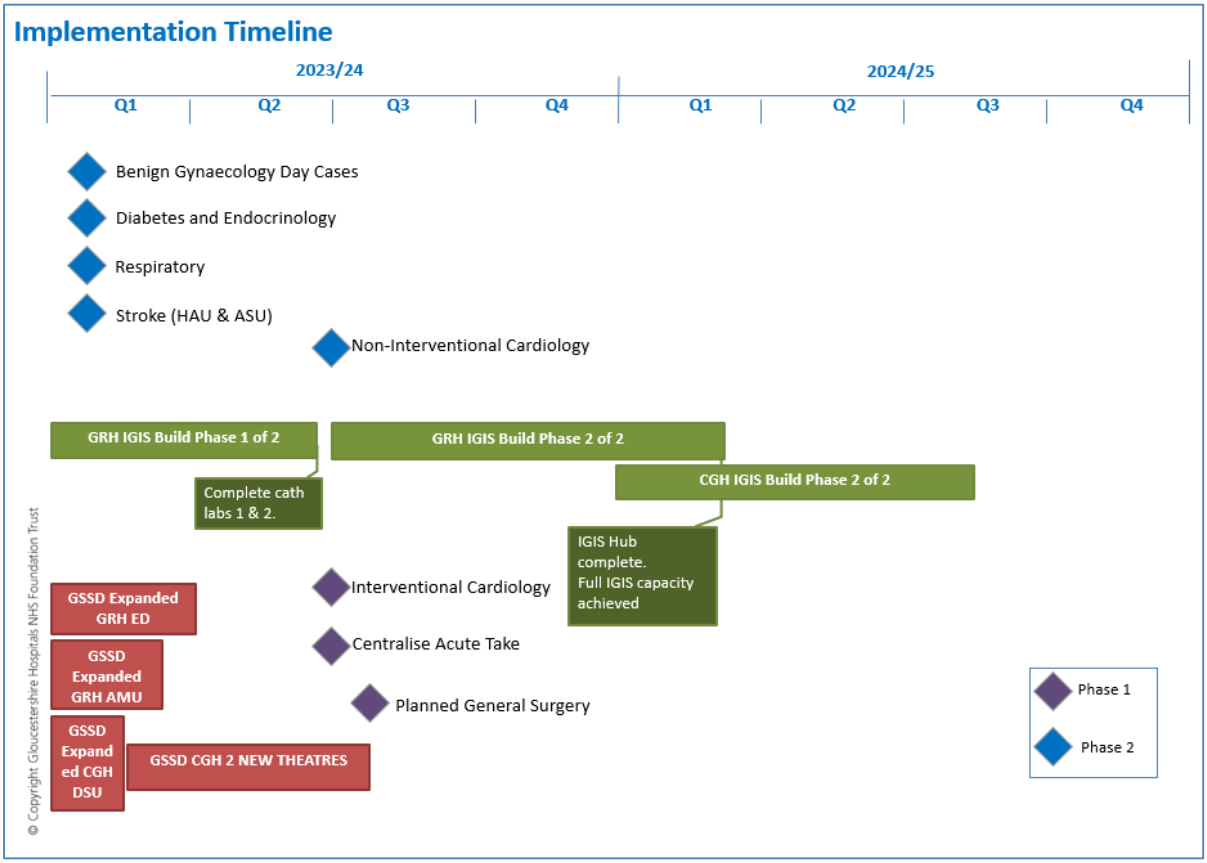
- Changes to the Trust estate – delivered through the Trust Strategic Site Development Programme;
- Workforce – recruitment and training to support new models of care;
- Procurement and installation of new equipment – new Cardiac Cath Labs, additional Interventional Radiology equipment; and,

15.7.3 *Implementation timetable*

A Gantt chart outlining the high-level implementation milestones described above can be found overleaf.

[52] Centralisation of Interventional Cardiology Inpatient Beds at GRH was approved as part of FFTF1.

Implementation



Key Points

- **Four of the five FFTF2 proposals are currently implemented as temporary service changes.**
- **One of the five FFTF2 proposals requires completion of enabling work prior to implementation.**
- **The dedicated FFTF Implementation Group, implementing FFTF1, will be responsible for implementing FFTF2.**

16 Appendices

Appendix 1: FFTF2 Output of Engagement Report

See separate document

Appendix 2: Gloucestershire Joint Health and Wellbeing Strategy 2019-2030

See separate document

Appendix 3: Gloucestershire Joint Strategic Needs Assessment (2017)

See separate document

Appendix 4a: FFTF2 Benefits Realisation

See separate document

Appendix 4b: FFTF1 & 2 Benefits and Costs

See separate document

Appendix 5: South West Clinical Senate Review Panel Report

See separate document

Appendix 6: Out-of-Hours Doctor Rotas

See separate document

Appendix 7: Bed Modelling Paper v1.5

See separate document

Appendix 8: DCC Capacity v4

See separate document

Appendix 9 Diabetes & Endocrinology Supporting Documentation

See separate document

Appendix 10a Non-interventional Cardiology Supporting Documentation

Appendix 10b Non-interventional Cardiology Opinion SOP

See separate documents

Appendix 11a Respiratory Supporting Documentation

Appendix 11b Respiratory SOP

See separate documents

Appendix 12a Stroke Supporting Documentation

Appendix 12b Stroke Pathway SOP

See separate documents

Appendix 13a: Benign Gynaecology IIA

Appendix 13b: Diabetes & Endocrinology IIA

Appendix 13c Non-interventional Cardiology: IIA

Appendix 13d: Respiratory IIA

Appendix 13e: Stroke IIA

See separate documents

Appendix 14a: Travel Impact Analysis

Appendix 14b: Public Travel Information

Appendix 14c: Carbon Footprint

See separate documents

Appendix 15: Data Protection Impact Assessment (DPIA)

See separate document

Appendix 16: DMBC Communications Plan v3

See separate document

Appendix 17: South West Clinical Senate -Desk-top review and responses

See separate document

Appendix 18: Glossary

See overleaf

Appendix 18: Glossary

Acute Medical Take	The Acute Medicine team coordinates initial medical care for patients referred to them by a GP or the Emergency Departments and decides on whether they need a hospital stay (also referred to as 'the acute medical take')
A&E	Accident and Emergency department (also known as Emergency Department (ED)
Acute Care Response Team (ACRT)	The ACRT includes technicians, nurse practitioners and advanced nurse practitioners who cover 24/7 both Cheltenham and Gloucester and respond to referrals for unwell and deteriorating patients across all adult wards and departments.
Acute Medical Unit (AMU)	Provides rapid assessment, diagnosis and treatment of patients with urgent medical and surgical conditions.
Acute Stroke Unit (ASU)	Acute stroke care services provide continuous specialist input, with daily multidisciplinary care and continued access to stroke trained consultant care, physiological monitoring and urgent imaging as required.
Addison's crisis	A life-threatening situation that results in low blood pressure, low blood levels of sugar and high blood levels of potassium
Benign Gynaecology	The medical speciality (area) dealing with the health of the female reproductive system and benign means non-cancerous.
British Geriatric Society:	The professional body of specialists in the healthcare of older people in the United Kingdom
British Thoracic Society (BTS)	A registered charity that aims to improve standards of care for people who have respiratory diseases and to support and develop those who provide that care
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CGH	Cheltenham General Hospital
CINAPSIS	A referral system that makes it easy for clinicians to communicate between healthcare organisations
Comprehensive Geriatric Assessment (CGA)	A multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances
Community Stroke Rehabilitation unit	Inpatient ward which is dedicated to patients who would benefit from specialist stroke rehabilitation following acute medical treatment
COTE	Care of the Elderly
COVID/ Coronavirus	COVID is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
CT Scan	A procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body
CPAP	Continuous positive airway pressure (CPAP) therapy is a common treatment for obstructive sleep apnoea.

Department of Critical Care (DCC)	A special ward in Gloucester that cares for people who are critically ill, in an unstable condition, or need close monitoring after surgery
Diabetes and Endocrinology (D&E)	Diabetes is a serious condition where a person's blood glucose (sugar) levels are too high as a result of their body being unable to produce enough insulin or being unable to produce any insulin at all. Endocrine conditions are where a person's endocrine system (that produces the body's hormones) does not work correctly, causing hormonal imbalances in the body.
Diabetic KetoAcidosis (DKA)	A serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones
Decision-Making Business Case (DMBC)	Prepared following consultation, to support in making a final decision on service change. It will consider all the responses to the consultation
DOAG	GHNHSFT Directors Operational Assurance Group
Early Supported Discharge (ESD)	Facilitates early transfer of care to a community setting, where rehabilitation continues at the same intensity and with the same expertise as in the inpatient setting
ED	Emergency Department
EGS	Emergency General Surgery
EPR	Electronic Patient Record
Frailty Assessment Service/Frailty Assessment Unit (FAS/FAU)	Works with community services to provide specialist assessment and support for older people who attend the Emergency Department with signs of frailty
Clinical Programme Groups (CPGs)	Supports the delivery of the whole pathway transformation across key clinical programme areas in Gloucestershire.
Gloucestershire Clinical Commissioning Group GCCG/CCG	CCGs are the GP-led bodies responsible for planning and investing in many local health and care services, including the majority of hospital care and stroke services.
Gloucestershire Health & Care NHS Foundation Trust (GHCFT)	Formed in 2019 by the merger of 2gether Trust and Gloucestershire Care Services to provide joined up physical health, mental health and learning disability services
Gloucestershire County Council (GCC)	Responsible for a large number of services, including education, health and transport.
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)	Provides a wide range of specialist acute services
Gloucestershire Strategic Site Development (GSSD) (SSD)	A £39.5M Programme to improve acute care facilities at Gloucester Royal and day surgery and theatre capacity at Cheltenham General
GI	Gastrointestinal (a planned gastrointestinal service is sometimes referred to as upper GI and a planned colorectal service is sometimes referred to as lower GI).
GIRFT	A national programme designed to improve the treatment and care of patients through in-depth reviews of services.

GRH	Gloucestershire Royal Hospital
GAU	Gynaecology Assessment Unit
Hyper acute stroke unit (HASU)	Provides the initial investigation, treatment and care immediately following a stroke
Health overview and scrutiny committee HOSC	A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and, if necessary, challenging health plans.
Homeward Assessment Team (HAT)	A multi-disciplinary team who assesses and supports people to leave hospital after treatment
Hot and Cold Split	Emergency Care (Hot) and Planned Care (Cold)
IPC	Infection Prevention and Control
Image Guided Interventional Surgery (IGIS)	Surgical procedures where the surgeon uses tracked instruments in conjunction with live images to guide the procedure
Integrated Impact Assessment (IIA)	The purpose of the Integrated Impact Assessment is to explore the potential positive and negative consequences of the proposals. It includes a Health Impact Assessment (HIA), Travel and Access Impact Assessment, Equality Impact Assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and Sustainability Impact Assessment.
Integrated Locality Partnerships (ILPs)	Partnerships made up of senior leaders of health and social care providers and local government.
Intensive Care Society	Representative body and Charity for all intensive care professionals and patients across the UK
Inpatient (IP)	A person who stays one or more nights in a hospital in order to receive medical care or treatment
Joint Strategic Needs Assessment (JSNA)	Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
Joint Health and Wellbeing Strategy (JHWS)	The Local Authority and Clinical Commissioning Group (CCG) work together to understand the health and wellbeing needs of their local community and agree joint priorities for addressing these needs to improve health and wellbeing outcomes and reduce inequalities.
Length of Stay (LoS)	The amount of time someone has to stay in hospital for care, treatment, and recovery.
MOFD	Medically Optimised for Discharge, an intensive therapy ward working with patients to focus on improving their capacity in order to facilitate timely discharge.
MFFD/NMCTR	Medically fit for discharge/not meeting the criteria to reside

NaDIA	National Diabetes Inpatient Audit provides a comprehensive view of diabetes care in England and Wales
Non-invasive ventilation (NIV)	The use of breathing support administered through a face mask, nasal mask, or a helmet
NHS Long Term Plan (LTP)	Sets out priorities for the NHS over the next ten years
NHSE	NHS Improvement became part of NHS England in July 2022
NHS South, Central and West Commissioning Support Unit (SCW CSU)	An NHS organisation providing support and transformation services to health and care systems
Operational Research in Health (ORH)	A management consultancy that uses advanced Operational Research techniques to support resource planning in the public sector.
One Gloucestershire Integrated Care System (ICS)	The working name given to the partnership between the county's NHS and care organisations to work in partnership in improving health and care, to help keep people healthy, support active communities and ensure high quality, joined-up care when needed in Gloucestershire
Office of National Statistics (ONS)	The UK's largest independent producer of official statistics and the recognised national statistical institute of the UK
Pre-Consultation Business Case (PCBC)	The document which presents the business case for any changes to services on which the CCGs agree to consult. It shows that CCGs have properly considered the options, undertaken pre-consultation engagement, submitted to the required scrutiny, and met the four tests and three conditions required by the Secretary of State.
PCI	Primary Percutaneous Coronary Intervention. A coronary angioplasty is a procedure used to widen blocked or narrowed coronary arteries
Primary Care Network (PCN)	Groups of GP practices working closely together - along with other healthcare staff and organisations - providing integrated services to the local population
Royal College of Surgeons of England (RCS)	An independent professional body and registered charity that promotes and advances standards of surgical care for patients
Respiratory High Care (RHC) or Support Unit (RSU)	An area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a routine ward environment
Same Day Emergency Care (SDEC) (SDEC)	This unit provides same day assessments and treatment; without being admitted into hospital overnight
SAU	Surgical Assessment Unit
South West Clinical Senate	Established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders

South West Ambulance Service Foundation Trust (SWASFT)	Provides a wide range of emergency and urgent care services across South West England
SSNAP	Sentinel Stroke National Audit Programme - An audit tool for collecting patient data
Task & Finish Group (T&F)	A time limited group set up as an action sub-group of a larger committee or meeting with the aim of a delivering a specified objective
TrakCare	The electronic patient management system used across NHS
Transient ischemic attack (TIA)	A temporary period of symptoms similar to those of a stroke. A TIA usually lasts only a few minutes and doesn't cause permanent damage
TLT	GHNHSFT Trust Leadership Team
The King's Fund	An English health charity that shapes health and social care policy and practice and provides NHS leadership development
UAU	Urology Assessment Unit
VAU	Vascular Assessment Unit
VCSE	Voluntary Care Sector Enterprise

One Gloucestershire
Transforming Care, Transforming Communities

Fit for the Future #2

Decision-Making Business Case

Integrated Care Board

29/03/23

@One_Glos
www.onegloucestershire.net

Session Purpose

The Board are requested to:

- **Approve** Decision Making Business Case (DMBC)
- **Approve** the DMBC resolutions
- **Approve** the programme proceeding to implementation

One Gloucestershire
Transforming Care, Transforming Communities

FFTF Gateways

- **Gateway #1**: 30/03/22, NHSE Stage 1 review– COMPLETED
- **Gateway #2**: South West Clinical Senate Panel – 10/08/22, confirmation proposals are clinically viable – COMPLETED
- **Gateway #3**: ICB Board – 29/11/22, no further public involvement in Phase 2 - COMPLETED
- **Gateway #4**: NHSE Assurance – 11/22, No requirement for Stage 2 – COMPLETED
- **Gateway #5**: GHFT Trust Board- 09/03/23 , Approval of Decision Making Business Case and resolutions - COMPLETED

One Gloucestershire
Transforming Care, Transforming Communities

Conscientious consideration

- The Decision-Making Business Case (DMBC) sets out the proposals for service change
- ICB members to apply ‘conscientious consideration’ to the issues raised by our stakeholders and public responders.

Context: FFTF Programme

Phase 1: Approved March 2021

Gloucestershire Royal Hospital

- Summer 2023 — Acute Medical Take
- Emergency General Surgery (I)
- Trauma (I)
- Phased from Sept 23 — Image Guided Interventional Surgery (IGIS) Hub
- Vascular Surgery (I)

Cheltenham General Hospital

- Gastroenterology (I)
- Orthopaedics (I)
- Image Guided Interventional Surgery (IGIS) Spoke

Phase 2: Scope of this DMBC

Gloucestershire Royal Hospital

- Diabetes & Endocrinology
- Non-interventional Cardiology — Sept 2023
- Respiratory

Cheltenham General Hospital

- Benign Gynaecology (day cases)
- Stroke – HASU & Rehab

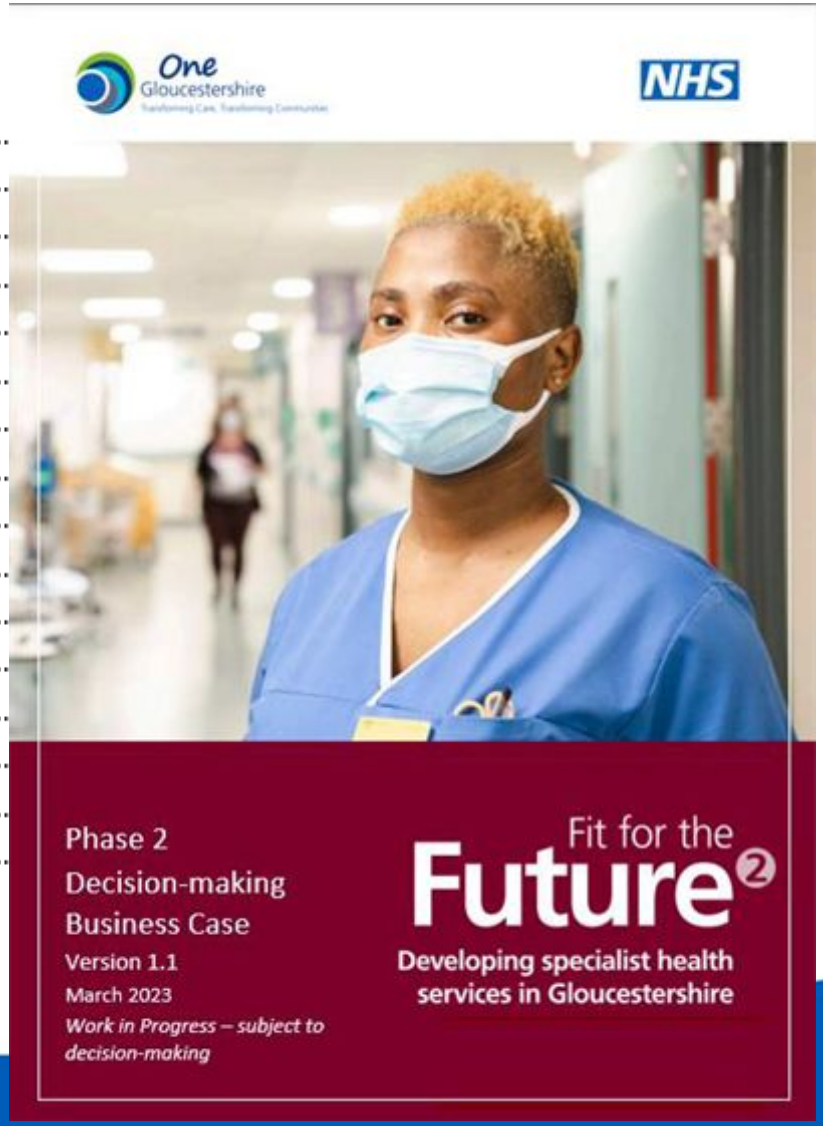
(I) = Implemented

= Operating as Temporary change until March 2023

One Gloucestershire
Transforming Care, Transforming Communities

Phase 2: Decision Making Business Case (DMBC)

Contents



One Gloucestershire
Transforming Care, Transforming Communities

Section 4: Public, Patient & Staff Engagement

- **50+ engagement events**
- **3,000 Engagement booklets** distributed
- **6 Facebook Live** events
- Over **1,800 face-to-face conversations** with public and staff
- **200+ surveys** completed
- NHS **Information Bus Tour**
- Internal **GHFT communication** campaign
- **Presentations** to Primary Care Networks, Integrated Locality Partnerships, Clinical Programme Groups, Health Overview & Scrutiny Committee and local councillors.
- **Outcome of Engagement report** received by ICB in September 22.

FFTF Phase		Support	Oppose
Phase 2 *engagement* **N=100**	Stroke to CGH	**84%**	16%
	Benign Gynaecology to CGH	**92%**	8%
	Respiratory to GRH	**97%**	3%
	Diabetes to GRH	**98%**	2%
	Cardiology to GRH	**99%**	1%

One Gloucestershire
Transforming Care, Transforming Communities

Sections 6 to 10: Service Proposals

Gloucestershire Royal Hospital

- Diabetes & Endocrinology
- Non-interventional Cardiology
- Respiratory

Sept 2023

Cheltenham General Hospital

- Benign Gynaecology (day cases)
- Stroke – HASU & Rehab

● = Operating as Temporary change until March 2023

Provided for each service:

- The "current state" service model
- Clinical engagement
- Case for change
- Clinical evidence
- Our preferred option for "future state" and the work done to assess
- Benefits
- Interdependencies
- Workforce
- Learning from temporary service change period (where applicable)
- South West Clinical Senate review
- Engagement feedback
- Addressing themes from engagement.

One Gloucestershire
Transforming Care, Transforming Communities

Section 11:Integrated Impact Assessment (IIA)

Equality Impact Assessment:

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary					
Protected Charictaristics	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
	Age	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Disability	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact
	Pregnancy	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Marital Status	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Ethnicity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Sexual Orientation	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Religion	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Gender reassignment	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Health inequalities impact assessment:

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary						
Health Inequalities	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
	Deprivation	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Looked After Children (LAC)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)
	Carers and unpaid carers	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact
	Homelessness	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact Moderate Adverse Impact
	Substance Abuse	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Mental Health	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	People Living in rural and remote areas	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Neutral Impact (No Significant Change)	Significant Positive Impact

Health impact assessment:

Fit For the Future Phase 2 Integrated Impact Assessment - Overall Impacts Summary						
Health Impact	Service	Stroke	Benign Gynaecology	Diabetes & Endocrinology	Non-Interventional Cardiology	Respiratory
	Cardiovascular Disease	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Diabetes Mellitus	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact
	Neurological Conditions	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Falls among the elderly	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Neutral Impact (No Significant Change)	Significant Positive Impact	Significant Positive Impact
	Overweight and Obesity	Neutral Impact (No Significant Change)	Significant Positive Impact Moderate Adverse Impact	Significant Positive Impact	Significant Positive Impact	Significant Positive Impact

Impact is predominantly positive or neutral with no significant adverse impacts.

One Gloucestershire
Transforming Care, Transforming Communities

Section 12: Economic & Financial Analysis

Proposal: Create an 11 bed Respiratory High Care (RHC) Unit, providing advanced respiratory support, including non-invasive ventilation (NIV) for patients within the respiratory bed base at GRH.

Cost: £274k Revenue (FYE) & £21k Capital.

Context:

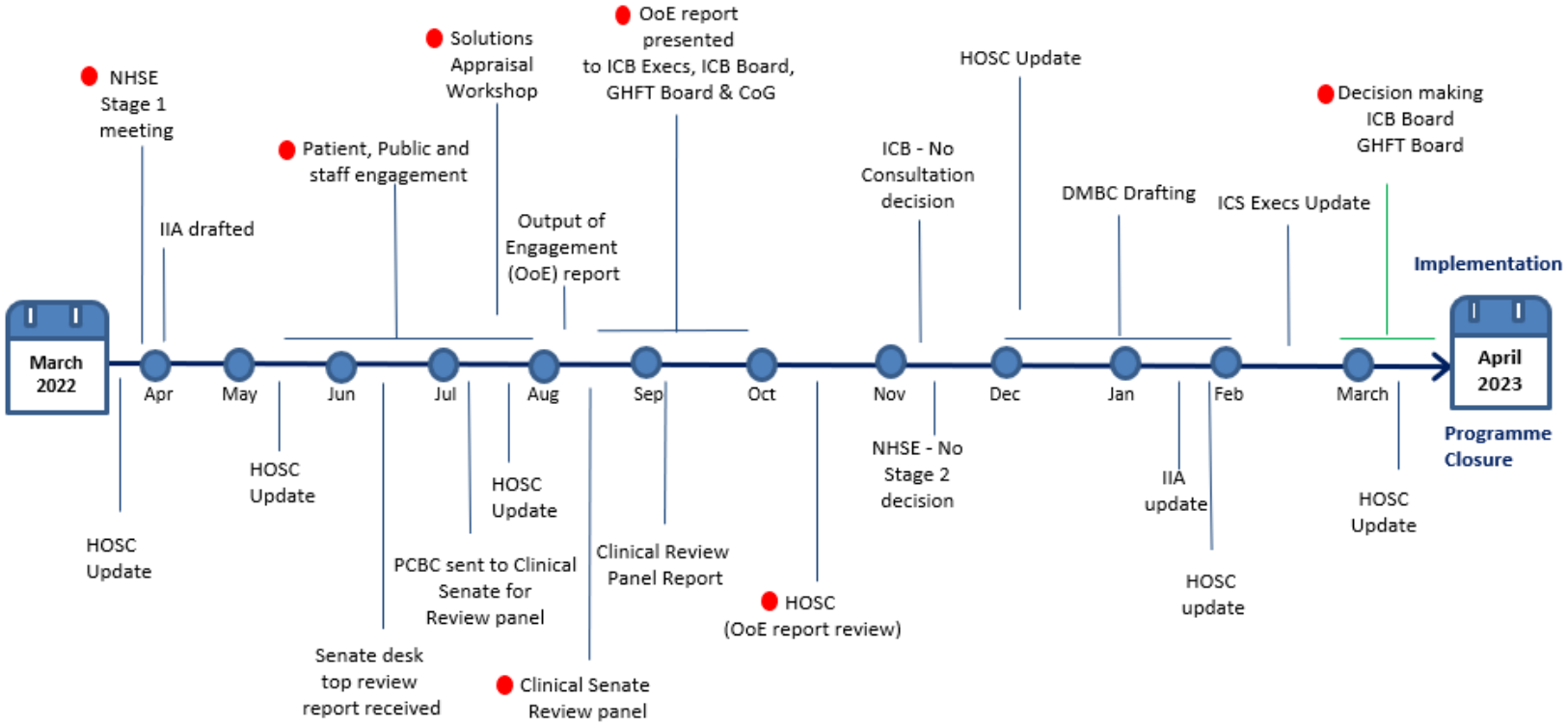
- ***National Best Practice***:
  - **GIRFT** –recommends establishing a dedicated non-invasive ventilation (NIV) service to improve outcomes of care
  - **British Thoracic Society and Intensive Care Society** recommends the establishment of Respiratory Support Units.
- ***COVID experience*** - Established RHC during COVID and managed around 270 patients with acute respiratory failure during this period, avoiding admission to DCC
- ***Staff costs*** - Medical and nursing staff costs included within current budget

Benefits:

- Aligns with national best practice guidance
- Improves patient outcomes – inc. reducing mortality and improve recovery
- Reduces GRH DCC bed demand (range of 1 to 7 beds with greater impact over Winter), **a key enabler for centralisation of Acute Medical Take.**

One Gloucestershire
Transforming Care, Transforming Communities

Section 13: Governance & Decision Making



Pre March 2022
Case for change developed
Clinical model and solution development

Section 13: Governance & Decision Making

Following feedback from:

- **Public & colleague engagement**
- **Gloucestershire Health Overview & Scrutiny Committee (HOSC)**
- **South West Clinical Senate**
- **NHS England**
- **GHFT Trust Board**

On 30th November, **NHS Gloucestershire Integrated Care Board (ICB)** approved the recommendation that *no further public involvement is required on the proposals within FFTF Phase 2 and the programme should proceed to Decision Making Business Case (DMBC) stage.*

One Gloucestershire
Transforming Care, Transforming Communities

Section 14: Recommendation

Resolution #1: To locate the majority of **Benign Gynaecology** Day Cases at **Cheltenham General Hospital (CGH)**.

Resolution #2: To centralise the dedicated **Diabetes and Endocrinology Inpatient beds** at **Gloucestershire Royal Hospital (GRH)** and provide a **Diabetes and Endocrinology Consult service** at **CGH**.

Resolution #3: To centralise **Non-Interventional Cardiology inpatient beds** at **GRH** and provide a **Cardiology Consult service** at **CGH**.

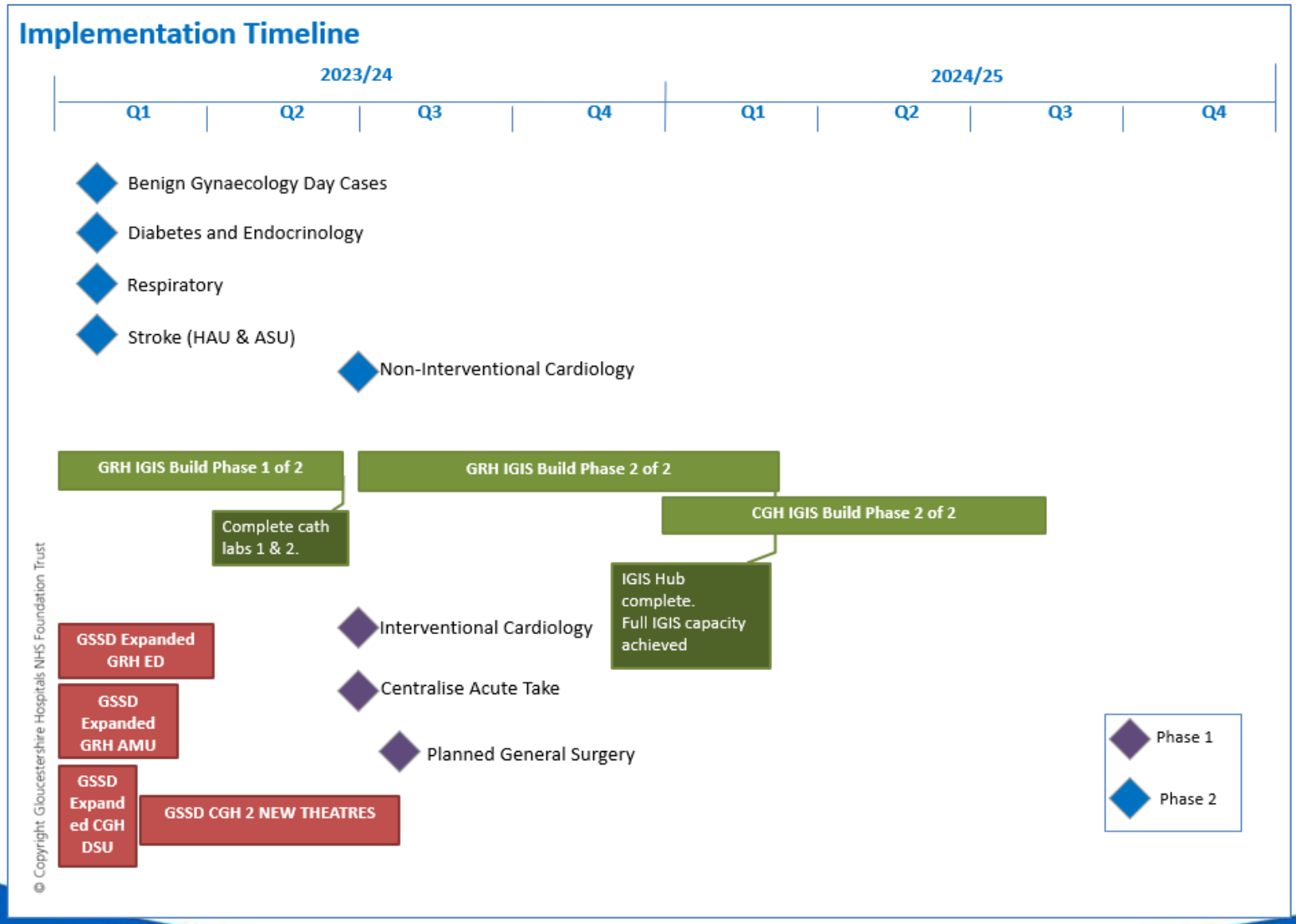
Resolution #4a: To centralise **Respiratory Inpatient beds** at **GRH** and provide a **Respiratory Consult service** at **CGH**.

Resolution #4b: To establish a **Respiratory High Care unit** at **GRH**.

Resolution #5: To locate the **Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU)** at **CGH**.

One Gloucestershire
Transforming Care, Transforming Communities

Section 15: Implementation



One Gloucestershire
Transforming Care, Transforming Communities

Agenda Item 11

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**ICB Progress Report – Public Sector Equality Duty and our response to the Equality Delivery System**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
			EDS22 Task and Finish Group	16/03/23			
Executive Summary	Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework designed to assist organisations in assessing their performance and identifying future improvement actions. The PSED includes a requirement that the ICB will publish equality information about both the communities we serve and the staff we employ. It also requires ICBs to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The report sets out or response to these requirements and evidences the process we have undertaken to review our performance against the EDS framework and the eleven outcome areas spread across three Domains: • *Commissioned or provided services* • *Workforce health and well-being* • *Inclusive leadership.* We are required to undertake a self-assessment of our performance and independently verify our position with stakeholders and staff. As a result of this process, we have also identified a range of improvement actions which are described in the report and will form a programme of work for the coming year.						

<table>
<tr><td>Key Issues to note</td><td colspan="4">Due to the Covid pandemic this is the first time for several years that we have utilised the EDS framework.

We have worked collaboratively with GHFT and GHC on Domain 1 and the outcome areas relating to Commissioned and Provided services

Whilst we have identified some good practice, the overall scoring reflects our position as a newly formed organisation and our desire to deliver further improvements over the next 12 months.

We have developed 3 equality objectives that are designed to reflect the areas of improvement identified and to ensure alignment with Operational Plan priorities.</td></tr>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The Equality and Human Rights Commission (EHRC) wrote to ICBs on 16th February setting out the requirements relating to the PSED and the deadline for the publication of equality information (31st March 2023).

This process is also part of the System Oversight Framework for ICBs and NHS provider organisations and so failure to comply with these requirements would mean that we are potentially unable to show are commitment to addressing equality of access and experience across the services we provide and commission and how we treat our staff.

Risk rating 3x 2 – Low</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">There are no conflicts of interest identified through this process.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>X</td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">There are no additional costs associated with carrying out this annual assessment.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">It is statutory obligation for public sector to evidence how they are meeting the Public Sector Equality Duty.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">The outputs of this process highlight the potential gaps in service provision and experience for both patients and staff and areas where improvements can be made to address health inequalities</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">As above.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">Not applicable.</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">We have utilised information from patient and staff surveys as part of the evidence base to inform our response and the recently established Working with People & Communities Advisory Group (WPACG) have worked with us to review the information and to independently assess our performance</td></tr>
</table>

Recommendation	The Board is requested to: Note the up to date position of Gloucestershire's population against the 9 protected characteristics. i) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group and the ICB's Joint Staff Consultative Committee. ii) Note and approve the improvement actions set out in Section 6. iii) Approve the ICB's equality objectives set out in Section 7. iv) Note that information about the profile of our local population and the ICB's equality objectives will be published on our website on 31st March 2023.		
Authors	**Tracey Cox** **Christina Gradkowski** **Caroline Smith**	**Role Title**	**Director People, Culture & Engagement** **Associate Director of Corporate Affairs** **Senior Manager, Engagement & Inclusion**
Sponsoring Director (if not author)	**Tracey Cox, Director People, Culture & Engagement**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
EHRC	The Equality and Human Rights Commission
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
PSED	Public Sector Equality Duty
VCSE	Voluntary, Community and Social Enterprise
WPACG	Working with People & Communities Advisory Group

ICB Progress Report – Public Sector Equality Duty and the Equality Delivery System

Contents

1 Purpose of the Document

Integrated Care Boards have a vital role in tackling inequalities in access to and outcomes from health and social care services. Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework and toolkit that is designed to assist organisations in assessing their performance and identifying future improvement actions. This paper reports on our progress against both the PSED and the revised EDS toolkit issued in 2022.

2 Public Sector Equality Duty & Equality Delivery System Toolkit

2.1 PSED Duty

The PSED is designed to support ICBs and other bodies to think about equality across our work programme, to identify the major challenges and to agree the actions we will take to tackle them.

The PSED consists of a general duty and specific duties. The general duty requires ICBs to think about how they can prevent discrimination, advance equality and foster good relations. This applies to the services that are provided and commissioned and to the employment of staff. The PSED requires a thorough consideration of the needs of people with each protected characteristics and is therefore different to the focus of the health inequalities duty which includes a focus on geographical inequalities and other non-protected characteristic inequalities.

The specific duty requires the ICB to be transparent about our work on equality and to show how we are meeting the requirements of the general duty. Each year we must publish equality information that demonstrates how we are thinking about equality across the services we provide and commission and the employment of staff.

ICBs should also have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The Equality and Human Rights Commission (EHRC) wrote to ICBs on 16th February setting out these requirements and the deadline for the publication of equality information (31st March 2023).

2.2 Equality Delivery System Toolkit

The NHS Equality Delivery System 2022 is an accountable improvement tool for NHS Organisations in England. Updated EDS Technical Guidance was published August 2022. This is the third version, commissioned by NHS England and supported by the Equality Diversity Council and is a simplified version of EDS2. The EDS comprises eleven outcomes spread across three Domains:

- Commissioned or provided services
- Workforce health and well-being
- Inclusive leadership.

Outcomes are evaluated, scored, and rated using available evidence and are designed to provide assurance or point to the need for improvement.

EDS ratings and Score Guidance are in place to assess each outcome area with the overall assessment approach based on the following: -

Undeveloped activity – organisations score 0 for each outcome	Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score 1 for each outcome	Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score 2 for each outcome	Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score 3 for each outcome	Those who score 33, adding all outcome scores in all domains, are rated Excelling

Completion of the EDS, and the creation of interventions and action plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach, the five Health Inequalities Priorities set out in the 22/23 Operational Planning Guidance. NHS organisations are also being encouraged to start to adopt a system approach to application of the EDS framework where possible.

3 Overview of Gloucestershire's Equality Information

The 2021 Census data information is now available providing us with more accurate and up to date information about the profile of our local population. The infographic at Appendix 1 shows our position across the nine protected characteristics.

4 Our Approach to EDS22 for 2022/23

Across Gloucestershire we have agreed that we will collaborate on a review of *Commissioned and Provided* services for the 2022/23 review and each organisation would review its own progress on *Workforce health and wellbeing and Inclusive Leadership.*

We have collated evidence to support a review of the requirements against the 3 Domains and 11 outcome areas and have engaged with both staff networks and the recently established *Working with People & Communities Advisory Group (WPACG) to* review the information and to independently assess our performance. The membership of the WPAGAG is available at Appendix 2.

The next section shows our evidence and assessment against the framework. Whilst we have identified some good practice, the scoring reflects our position as a newly formed organisation and our desire to deliver further improvements over the next 12 months.

5 Overview of Outcomes

5.1 Domain 1: Commissioned or Provided services

This year we have agreed across Gloucestershire to review our performance for Cancer Services and Translation & Interpretation Services. For each service area we were required to test four outcomes:

- 1A: Patients (service users) have required levels of access to the service
- 1B: Individual patients (service user's) health needs are met
- 1C: When patients (service users) use the service, they are free from harm
- 1D: Patients (service users) report positive experiences of the service

What we did
We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The evidence has been discussed with the ICB Working with People and Communities Advisory Group, who gave valuable insight into our self-assessment and made recommendations regarding ratings for each of the four outcomes
What we found
Outcome 1A: Patients (service users) have required levels of access to the service **Cancer services:** Whilst there is good provision of cancer services across primary care, acute and community services, the quality of our data does not allow us to undertake robust analysis/demonstrate required across protected characteristics. • There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Currently ethnicity analysis in particular is challenging due to the incompleteness of data ("unknown" or "not recorded" are more common than the majority of non-white ethnicities recorded). • There is a focus on improving access to care and reducing backlogs in waiting times (COVID19 recovery). • The Gloucestershire ICS Cancer Programme oversees much of the work to increase early diagnosis rates and ensure identification of, and reduction in, inequalities.

Translation and Interpretation (T&I) Services: Each NHS organisation in One Gloucestershire commissions Translation & Interpretation (T&I) Services, which are available to patients' attending appointments in Primary Care, Acute and Community Services.

- We monitor numbers of requests for T&I services, but struggle to compare this to the numbers of people accessing health care services who are not fluent in speaking and/or understanding English.
- Our work with Gloucestershire Deaf Association has provided a better understanding of the number of British Sign Language users accessing health care in the county**.**
- In line with the Accessible Information Standard (2016), we prepare written information in alternative formats including Easy Read and large print, but we do not understand the level of compliance across our system.

Outcome 1B: Individual patients (service user's) health needs are met

Cancer Services: System-wide work to deliver the Cancer Operational Planning guidance 2022/23 has contributed to local action, examples include:

- Targeted focus on inequalities in prostate cancer aimed at increasing engagement in men over 45 from a black ethnic background.
- Targeted Lung Health Checks pilot Inner City Primary Care Network (PCN), Gloucester, an area of high deprivation and high lung cancer incidence.
- PCN cancer information packs produced to support delivery of cancer early diagnosis Direct Enhanced Service.
- Macmillan Next Steps: use of personalised planning (MYCAW wellbeing tool)
- Hospital based support:
  - Learning Disability Specialist nursing team to support patients coming in for surgery or treatment; and
  - Admiral nurse for inpatients with dementia diagnosis.
- Scoping of place-based approach to engagement, with system partners: Hub at Home, ICS Collaborative Awareness Campaigns Project: testing difference engagement approaches in areas identified as having later diagnosis of cancer and/or low screening uptake.
- Additional PCN initiatives, e.g.:
  - to improve uptake of screening amongst patients with poor language skills, disability, learning disability; and
  - provide an improved, joined-up, out-of-hospital service for patients, with support from Cancer and Palliative Care Specialist Nurse.

Translation and Interpretation (T&I) Services: Access to the T&I services available across One Gloucestershire services 24/7, 365 days.

- Policies and procedures in place to ensure staff are able to access T&I support.
- Training provided: Managing Memory services, Dementia induction delivered and more plans to upskill all providers around Learning Disability services.

- Reasonable adjustments made e.g. longer appointments, mobility, support for hearing and sight impairments

Outcome 1C: When patients (service users) use the service, they are free from harm

Cancer Services: Gloucestershire residents are able to access reasonably high quality, safe healthcare. The Care Quality Commission has rated both main providers as 'Good'. In Primary Care settings, residents can also access good quality GP services, most of which are rated as either 'Good' or 'Outstanding'.

- System Safety Group established to oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level.
- Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy.
- Embedded through Professional Registration, Staff training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour.

Translation & Interpretation Services:

- Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients.
- DATIX reporting reviewed and actioned.
- Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement.
- One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety.

Outcome 1D: Patients (service users) report positive experiences of the service

Cancer Services: Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities. Patient experience information gathered through engagement is reported back to service leads and system partners.

- Patient Experience data is gathered, monitored and acted upon:
  - National cancer survey – high levels of satisfaction reported, although limited analysis by protected characteristics possible.
  - Patient experience data gathered via Friends and Family Test (FFT)
  - Programme evaluation/wellbeing measures gathered via Macmillan Next Steps

However, data regarding protected characteristics is often not requested or disclosed when information is gathered through PALS, FFT and survey work and it is therefore,

not possible to identify inequity in the experience of patients with protected characteristics.

Translation & Interpretation Services: Routine mechanisms for capturing patient experience (e.g. FFT) are unlikely to identify specific issues with T&I service.

- Feedback forms and case studies collated. However, patient/service user feedback is often gathered on an *ad hoc* basis. Opportunity to improve this through current re-procurement of T&I services.
- Negative feedback from Clinical Teams is collated by Contract leads and discussed at regular contract meetings, but this is predominately about the process/difficulties associated with securing the interpreter or specific language, rather than patient experience of the service.
- We hear anecdotally that some patients still do not have independent interpretation for their health care appointments, or that interpreters attending did not speak the required dialect.
- Recent reports: Gloucester City Commission to Review Race Relations, January 2022 and #BlackLivesMatter – Gloucestershire Mental Health Services, December 2021 highlight some people's poor experience of access to interpreters, with both reports recommending that more *"needs to be done to ensure there is a level playing field in access to healthcare*".

Our assessment rating:

Outcome 1A – Developing activity = Score 1

Outcome 1B – Achieving activity = Score 2

Outcome 1C – Achieving activity = Score 2

Outcome 1D – Achieving activity = Score 1

Overall Rating for Domain 1: Commissioned or Provided services is Developing Activity (score 6 out of possible 12)

Improvement Actions: -

In addition to the ongoing work focusing on health inequalities in Cancer services (led by the Cancer CPG), the ICS should:

- continue to develop links between Electronic Patient Records and DATIX Cloud;
- explore the collection of protected characteristic data in relation to PALS, complaints and incident reporting;
- review compliance with the Accessible Information Standard and ensure
  - additional training and support for staff
  - sharing of information across the system via the Joining up your Information (JUYI) system; and

- establish a system-wide working group to review uptake of translation and interpretation services, including improving mechanisms for gathering patient experience of translation and interpretation services.

5.2 Domain 2: Workforce health and wellbeing (ICB employed staff)

The 4 outcomes areas for review of our approach in this area are as follows:

- 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source
- 2D: Staff recommend the organisation as a place to work and receive treatment

What we did

We reviewed the data and statistics we have on our workforce profile including a breakdown of staff according to gender, ethnicity, age and disability. We reviewed the range of health and wellbeing initiatives and projects that the ICB has supported over the past year to assess how staff are supported to manage their health conditions such as obesity, diabetes, asthma, COPD and mental health conditions.

The staff survey results for 2021 were assessed as well as more recently the staff survey results relating to 2022. The range of activities and resources produced was listed on a spreadsheet as evidence and shared with the ICB Joint Staff Side Consultative Committee.

What we found

Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions

The ICB has supported a range of health and wellbeing projects and initiatives including:

- Staff health checks (MOTs) available to all ICB staff and widely promoted via the staff bulletin, wellbeing day and weekly emails. The health checks include an assessment of blood pressure, cholesterol, HbA1c (diabetes check) BMI, and a discussion with healthy lifestyle coach. Approximately 100 health checks have been carried out over the past 5 months.
- Staff Wellbeing Day organised in November 2022 providing free sessions on nutrition, exercise – pilates and cardiovascular exercise, Diabetes stall and resources for staff, health checks (MOTs), mental health and wellbeing
- Health & Wellbeing policies have been developed including the Drugs and Alcohol Policy and Menopause Policy with a range of resources available.
- Specific publicity and training provided to managers to understand the Flexible Working Policy.

- During the Covid pandemic and the immediate aftermath, Staff Risk Assessment forms were required to be completed. Managers were provided with guidance that if staff members were from an ethnic minority background and / or long term conditions that put them at greater risk of Covid then reasonable adjustments should apply, including ensuring that staff could work at home during this period and would not be required to attend the office.
- Wellbeing Newsletters were produced on a range of topics including Stress, Mental Health, MSK, diet and exercise and financial wellbeing amongst many other topics.
- Healthy Eating is a topic covered in a variety of newsletters over the last 2 years. Diet and Nutrition is highlighted in articles on Cancer, Diabetes, weight management.
- The 'Healthy Eating, Smart Meeting' guidance has been developed as a statement of intent and is available on the staff intranet.
- The ICB has trained 15 staff as Mental Health First Aiders.
- There is a new ICB Appraisal process which includes a discussion during the appraisal of staff health and wellbeing and signposting to resources
- Publicity about pension seminars to staff – specifically targeted at the older workforce in preparation for retirement have been included in staff bulletins and shared with JSCC members.
- The ICB specifically employs a Health and Wellbeing Consultant to work 2 days a week to develop and promote wellbeing policies, resources and communications.

Staff Survey Results 2022

- 85% of staff are satisfied with opportunities for flexible working patterns.
- 88% of staff can approach immediate manager to talk openly about flexible working 88%.
- 83% of staff confirm that the organisation takes positive action on health and well-being
- 93% of staff reported that the organisation made reasonable adjustment(s) to enable them to carry out their work.

Key theme in the staff survey affecting the wellbeing of staff is **B*urnout***

- How often, if at all, do you find your work emotionally exhausting? 24% same as 2021
- How often, if at all, do you feel burnt out because of your work? 20.1%, a slight increase on 2021
- During the last 12 months have you felt unwell because of work-related stress? 33%
- In the last three months have you ever come to work despite not feeling well enough to perform your duties? 42.7%

Gloucestershire Healthy Workplace Award

A local award which recognises employers' commitment to the health and wellbeing of its employees. The ICB has been awarded the Healthy Workplace Award Level 1 in 2021 and the Advanced Award in 2022.

Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

- The ICB has updated its policies on Harassment and Bullying.
- Managers training on Harassment and Bullying was provided in 2022 by the CSU HR Team.
- ICB has a Whistleblowing and Freedom to Speak Up Policy.
- ***The ICB offers Restorative supervision*** for clinical staff at the ICB either group or 1:1 available from Professional Nurse Advocate's (PNA).
- The ICB has accreditation as a Disability Confident Employer until 2025.
- A compassionate leadership workshop was held with senior managers in March 2023 and a compassionate leadership intranet page has been produced with a range of resources for staff.

Staff Survey 2022

WRES data

- The percentage of Gloucestershire ICB (GICB) staff from an ethnic minority background that had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months was 0.0%, compared to 9.3% of GICB white staff. The ICB average for staff from an ethnic minority background was 8.3% and for white staff it was 7.9%.
- The percentage of Gloucestershire ICB (GICB) staff from an ethnic minority background that had experienced harassment, bullying or abuse from staff in the last 12 months was 17.6% compared to 10.9% of GICB white staff. The ICB average for staff from an ethnic minority background was 20% and for white staff it was 15.5%.

WDES data

- The percentage of Gloucestershire ICB (GICB) staff with a Long-Term Condition (LTC) experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months was 11.7%, compared to GICB staff without a LTC which was 7.8%. The ICB average for staff who have a LTC was 10.7%, compared to 7.3% without a LTC.
- The percentage of Gloucestershire ICB (GICB) staff with a Long-Term Condition (LTC) experiencing harassment, bullying or abuse from managers in the last 12 months was 8.3% compared to staff without a LTC 5.6%. The ICB average for staff with a LTC was 15.2% and for staff without a LTC it was 7.6%
- The percentage of GICB staff with a LTC experiencing harassment, bullying or abuse from other colleagues in the last 12 months was 15% compared to those GICB staff without a LTC it was 5.1%. The ICB average for staff with a LTC it was 15.5% and for staff without a LTC it was 8.7%.

- The percentage of GICB staff with a LTC saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it 31.3% compared to GICB staff without a LTC which was 44.4%. The ICB average for staff with a LTC was 40.9% and for staff with a LTC it was 42.2%.

Outcome 2C. Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source

The ICB has a range of resources and procedures in place to support staff as follows:

- Flexible working policy to help staff achieve a work-life balance.
- Leave and Other Leave policies.
- The ICB has a Harassment and Bullying Policy in place
- In the autumn 2021 Harassment and Bullying Managers training was provided to staff
- Additional Leave procedures and process whereby staff can purchase additional leave for 2023-24 are in place with 57 staff having exercised this choice.
- Newsletters and communications around managing stress and encouraging a work-life balance.
- Wellbeing days for staff to help them manage stress and promote wellbeing.
- The ICB provides a range of employee support to health staff manage their health conditions including the Occupational Health Service – working well; the Employee Assistance Programme provided by Care First and the Gloucestershire Wellbeing Line. All three resources listed above are independent and provide advice and support to staff experiencing bullying and harassment, any physical violence and stress be that at work at home or both. Resources are promoted via the Corporate Induction, Health and Wellbeing intranet pages, ConsultHR portal, weekly Staff Bulletin.

Staff Survey

- 76.6% of staff feel safe to *speak up about anything that concerns me in this organisation*, equivalent to the 'Best'.

Outcome 2D: Staff recommend the organisation as a place to work and receive treatment

58% of Glos ICB staff reported If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation, this is above the national average 53% but has significantly decreased from 2021 with 71% of ICB staff reporting favourably on this question. However, 80.6% of Gloucestershire ICB staff reported that the care of patients / service users is my organisation's top priority equivalent to the 'Best'.

		2019	2020	2021	2022
Glos ICB	-	**62.5%**	**68.8%**	**71.0%**	**58.0%**
Best	-	88.6%	85.7%	88.5%	65.3%

Average	-	61.5%	66.0%	61.8%	53.6%
Worst	-	28.6%	30.9%	37.7%	35.7%

It is evident that Gloucestershire ICB has positive scores in relation to recommending the ICB as a place to work compared to the national average however there has been a dip in scores between 2021 and 2022.

		2019	2020	2021	2022
Glos ICB	-	75.9%	**81.4%**	**82.7%**	**80.6%**
Best	-	95.7%	95.5%	94.5%	80.6%
Average	-	65.1%	71.0%	67.4%	62.1%
Worst	-	29.8%	42.9%	45.4%	39.6%

Our assessment rating:

Outcome 2A – Achieving activity = Score 2
Outcome 2B – Developing activity = Score 1
Outcome 2C – Developing activity = Score 1
Outcome 2D – Developing activity = Score 1

Overall Rating for Domain 2: Workforce health and wellbeing (ICB employed staff) Score 5 out of possible 12.

Improvement Actions: -

- Further work will be undertaken on wellbeing initiatives that are targeted to protected characteristics.
- There is more work to be undertaken to understand Burnout of staff and effect on the health and wellbeing of staff and additionally how this relates to those members of staff with protected characteristics.
- Continued awareness raising on harassment and bullying including ensuring that staff are aware of the ICB policies including the Freedom to Speak Up policy which is currently under review.
- Continue to promote compassionate leadership as part of the ICB's values and culture.
- To raise awareness further of the range of staff support resources through the Staff Bulletin, Team meetings, Staff Meeting, JSCC meetings and ensure that resources are fully accessible on the new ICB intranet.

5.3 Domain 3: Inclusive Leadership

The 3 outcomes areas for review of Inclusive Leadership are as follows:

- 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
- 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
- 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

What we did
Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. 1. Surveyed all ICB Board members and asked for an overview of activities undertaken to support Inequalities & the Equality, Diversity and Inclusion (EDI) agenda in the past year. 2. Collated an evidence file. 3. Reported on key system initiatives in place and provided an overview of these to the Working with People and Communities Advisory Group in December 2022. Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed. We undertook a desk top review of a number of meetings which have taken place since January 2022 to see how frequently the Board Members were discussing inequalities and issues relating to equality, diversity and inclusion. Meetings reviewed: • CCG Governing Body (Public) • Integrated Care Board Meetings (Public) • ICS Strategic Executive (Closed) Outcome 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients. We reviewed how well the ICB is using relevant tools such as the following: • Workforce Race Equality Standards (WRES) • Workforce Disability Standards (WDES) • Impact Assessments • Gender Pay Gap Reporting • Accessible Information Standards • Equality Delivery System 2022

- Patient and Carer Race Equality Framework (Mental health)

What we found

For Outcome 3A:

- Equality and health inequalities are regularly discussed as part of specific items at ICB Board meetings (also see 3B below).
- All ICB Board members and Executives provided evidence of attendance and involvement in EDI activities.
- Attendance from across the system from a range of Executives and Senior leaders at a number of community events across Gloucestershire.
- Addressing health inequalities has been identified as key part of our draft Integrated Care Partnership Strategy.
- The ICB could show its continued commitment to this agenda e.g. through participation in the NHS Employers Diversity in Health and Care Partners programme with EDI and Human Resources (HR) leads from across the system participating (a national support programme running over a 6-month period).

For Outcome 3B:

The ICB could demonstrate it had taken a regular focus on equality and health inequalities through the range of reports and information that had been presented to its main Committee meetings. Since 1st July 2022 with the onset of the ICB, report templates now included specific information to be included on EDI/Inequalities information. However, there is not necessarily a consistent approach to how well these sections were completed.

For Outcome 3C: -

- All these tools are used by the ICB to monitor progress and to determine action plans.
- The People Committee on 6 October 2022 completed a detailed review of Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) performance across Gloucestershire, and our comparative performance across the South West and nationally and reviewed current actions.
- The ICB carries out an annual review of the gender pay gap amongst its staff.

Our assessment rating:

Given the ICB is a relatively new statutory body, and we are continuing to develop our approach, both ICB assessors and WP&ACAG members proposed the following ratings:

Outcome 3A – Developing activity = Score 1

Outcome 3B – Developing activity = Score 1

Outcome 3C – Developing activity = Score 1 **Overall Rating for Domain 3: *Inclusive Leadership (Activity Score 3 out of possible 9)***
Future Improvement Actions: -
• Dedicated EDI development session for Board members planned in first half of 2023. • ICS-wide Reciprocal Mentoring Scheme mobilised in 2023 for (Executives and Band 9 senior managers to be matched with mentors from staff under-represented groups. • Adherence and improvement of equality and health inequalities data as part of ICB reports. • All ICB staff are being supported with Inclusive Leadership training focusing on from March 2023.

6 Our Overall Assessment & Rating

Organisations are required to provide an overall rating, created by adding all outcome scores together. Our position is:

Domain 1 Commissioned & provided services = 6
Domain 2 Staff health and wellbeing = 5
Domain 3 Inclusive Leadership = 3
This gives an overall score of 14. Those who score between 8 and 21, adding all outcome scores in all domains, are rated as Developing.

7 Equality Objectives

In line with the Public Sector Equality Duty requirements we are required to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. In recognition of the issue identified through the EDS22 process and drawing upon existing priorities for the ICB we are proposing the following 3 equality objectives for the ICB:

7.1 To develop the quality and range of equality and health inequalities data as part of our clinical programmes of work to improve our understanding of the impact of inequalities and the opportunities to take improvement actions.

7.2 To deliver our programme of work in the Core 20 Plus5 clinical priority areas.

7.3 To work with system partners across One Gloucestershire on the implementation of the Equality Delivery System to share information, learning and good practice.

8 Future Issues to Consider

Later this year the Equality and Human Rights Council, working collaboratively with NHS England and the Care Quality Commission will monitor how every ICB is meeting its PSED obligations and will use this information to target support and share information on best practice.

As part of this monitoring they will particularly look at what steps are being taken to tackle the inappropriate detention of people with a learning disability and autism and action to tackle the disproportionate rates of detention of ethnic minority people under the Mental Health Act. They are also likely to look at how ICBs are considering equality in their workforce including the experience of low paid ethnic minority staff.

The PSED also includes the obligation for public bodies with 250 or more staff to publish gender pay gap information each year. Whilst the former CCG has routinely published such data, the duty to publish information will apply to ICBs from March 2024 but relate to the workforce profile on 31 March 2023.

9 Recommendations

ICB members are asked to:

i) Note the up to date position of Gloucestershire's population against the 9 protected characteristics.

ii) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group and the ICB's Joint Staff Consultative Committee.

iii) Note and approve the improvement actions set out in Section 6.

iv) Approve the ICB's equality objectives set out in Section 7.

v) Note that information about the profile of our local population and the ICB's equality objectives will be published on our website on 31st March 2023.

Appendix 2: Membership of Working with People & Communities Advisory Group

The proposed 'lay' membership should be up to 12 individuals including the Chair. The WWPAC AG members should include individuals with recent and relevant experience of health and care services in Gloucestershire and have a mix of characteristics and interests:

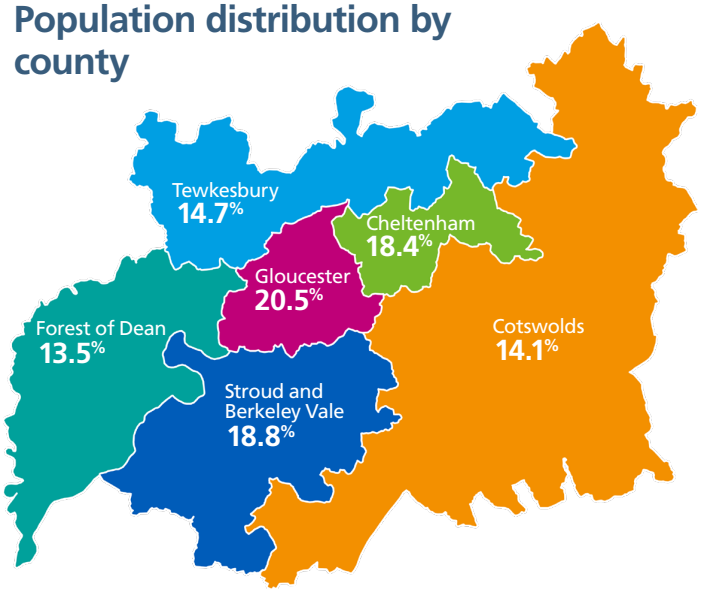
- Chair (Jenny Hepworth, NHS Gloucestershire ICB Lay Champion)
- John Lane - Healthwatch Gloucestershire
- Vicci-Livingston-Thompson – Inclusion Gloucestershire
- Rupert Walters – 4orty2 – Black Business Network
- Jennifer Skillen – Expert by Experience
- Pat Eagle – Foundation Trust Public Governor
- Jan Marriott – Trust Non-Executive Director/Partnership Board Co-Chair
- Riki Moody – Gloucestershire Care Home Providers Association TBC
- Matt Lennard / Gill Parker – VCS Alliance TBC
- Emma Mawby – LGBT+ Partnership TBC
- Becky Parish and Caroline Smithy - NHS Gloucestershire ICB Engagement/Insight/Equality and Diversity Leads
- Anthony Dallimore - NHS Gloucestershire ICB Communications Lead
- Clive Lewis - NHS Gloucestershire ICB Non-Executive Director TBC

Our Gloucestershire Population

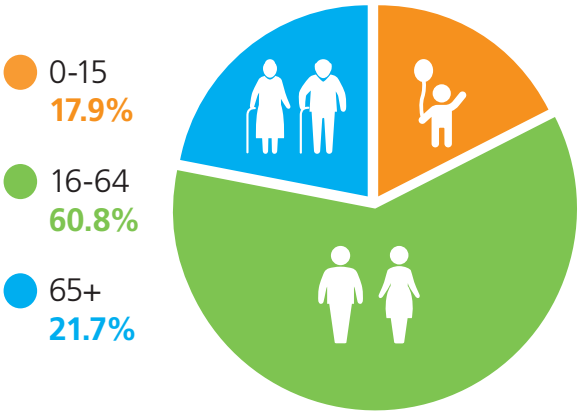
Total population

645,076

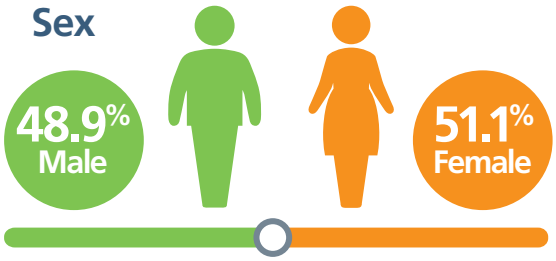
Population distribution by county



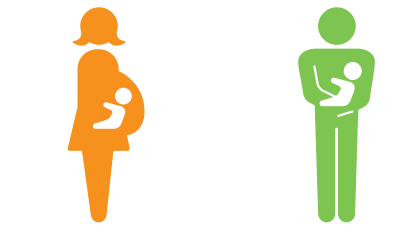
Broad age groups



Sex



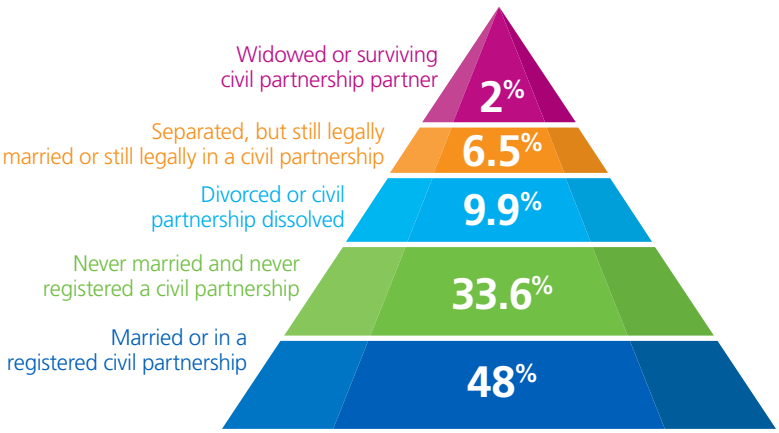
Pregnancy & birth



5,486
Women giving birth

5,571
Babies born

Marriage and civil partnership



Sexual orientation

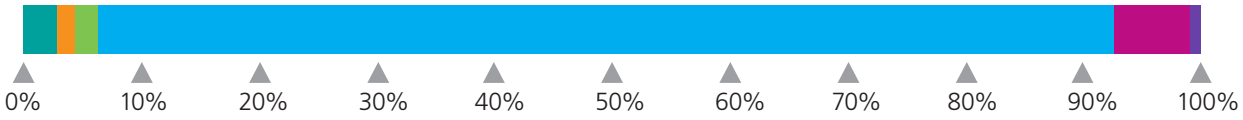
Source: Office for National Statistics (ONS), 2021 Census

Gender identity

- 94.4% Gender identity the same as sex registered at birth
- 0.4% Gender identity different from sex registered at birth
- 5.2% Not answered

Ethnic groups

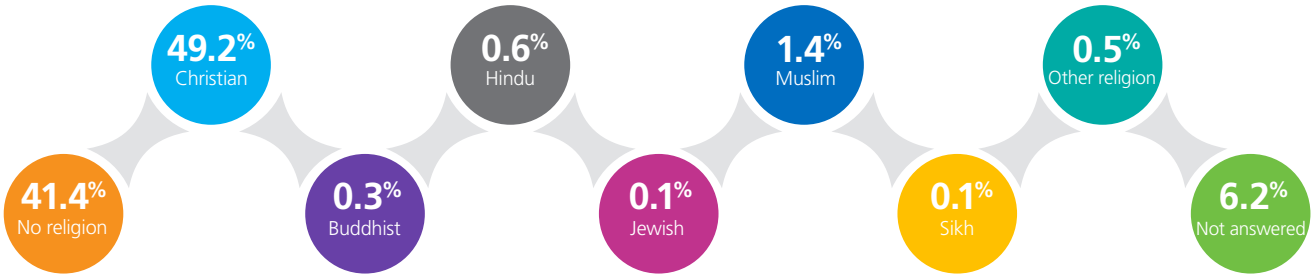
- 2.9% - Asian, Asian British or Asian Welsh
- 2.2% - Mixed or Multiple ethnic groups
- 5.4% - White other
- 1.2% - Black, Black British, Black Welsh
- 87.7% - White British
- 0.7% - Other ethnic group



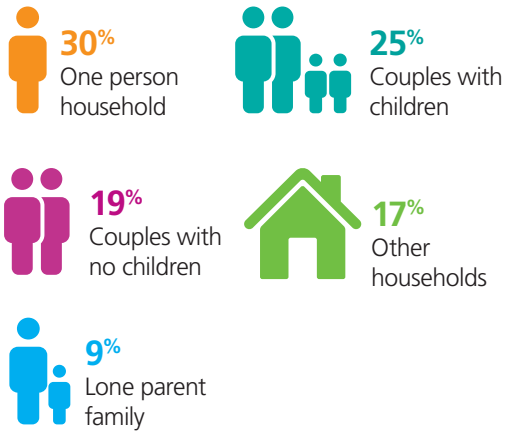
Disability

Unpaid Carers

Religion



Household composition



Armed Forces Veterans

1 in 20 people aged 16+ are armed forces veterans

Agenda Item 12

NHS Gloucestershire ICB Board (Public Session)

Wednesday 29th March 2023

Report Title	**Operational Planning update (Part I)**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X						
Route to this meeting	N/A – update only						
	ICB Internal		**Date**	**System Partner**		**Date**	
			dd/mm/yyyy			dd/mm/yyyy	
Executive Summary	To provide an overview of the Operational Planning process, current status, and next steps required for final submission.						
Key Issues to note	National requirement to submit system operational plan and supporting templates by 30th March 2023.						
Key Risks:	Failure to develop a plan which delivers against all key local and national ambitions and performance standards. Co-ordination of workforce, activity/performance and finance, including triangulation to meet the deadline of 30/3/23						
Management of Conflicts of Interest	None stated.						
Resource Impact (X)	**Financial**	X	**Information Management & Technology**				
	Human Resource	X	**Buildings**				
Financial Impact	The operational plan is a reflection of agreed financial allocations and funding decisions.						
Regulatory and Legal Issues (including NHS Constitution)	GICB has a regulatory duty to complete the annual operational plan and share this with NHSE in line with nationally agreed timescales.						
Impact on Health Inequalities	Addressing Health Inequalities is described in detail within the narrative submission of the operational plan.						
Impact on Equality and Diversity	Equality Impact Assessments will be completed as required for individual projects and initiatives relating to the operational plan.						

Impact on Sustainable Development	N/A		
Patient and Public Involvement	Public and patient engagement is conducted at an individual level where projects and initiatives contained within the operational plan will benefit from it.		
Recommendation	The Board is requested to **note** this update on progress towards the submission of our system operational plan		
Author	**Tom Hewish**	**Role Title**	**System Operational Planning Lead**
Sponsoring Director (if not author)	**Mark Walkingshaw, Director of Operational Planning & Performance**		

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

NHS Gloucestershire

Operational Planning Update (2023/24)

Mark Walkingshaw, Director of Operational Planning & Performance

ICB Update 29/03/23

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

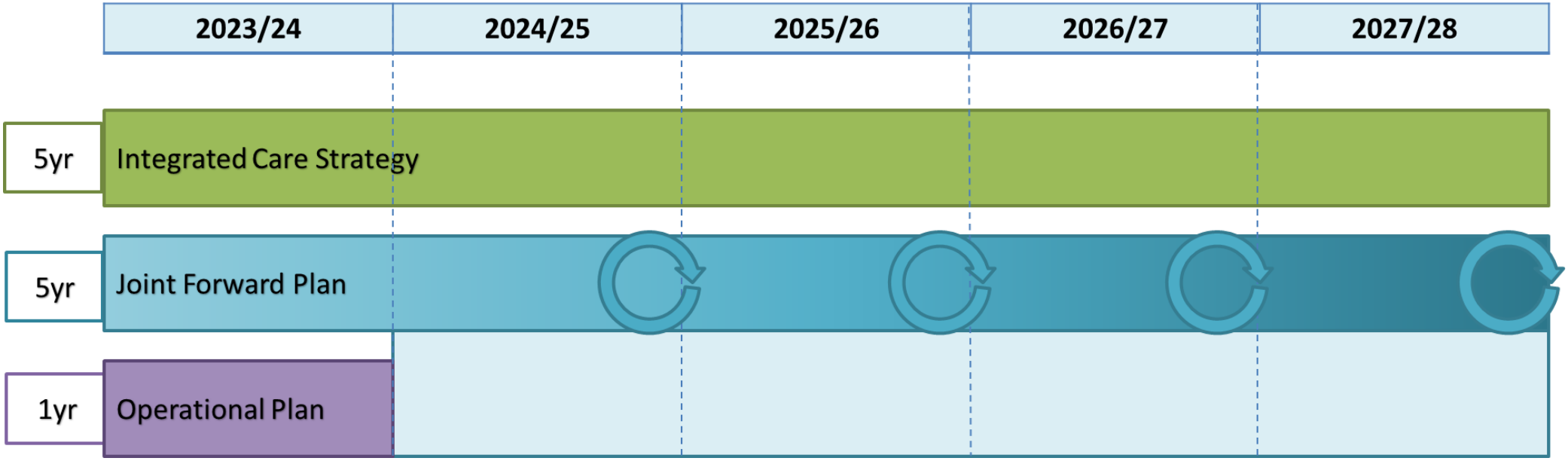
System strategic priorities: context for Operational Plan

- Integrated Care Strategy is the blueprint for delivering better health and care with and for the people of Gloucestershire - interim strategy published December 2022
- Joint forward plan – in development content drawn from system transformation programme delivery plans

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

National planning submissions



Note: The Operational Plan is largely a 1 year submission but some elements of finance and workforce go beyond 2023/24.

2023/24 Operational Plan NHS England's priorities

1. Prioritise recovering core services and productivity
2. Return to delivering the key ambitions in the NHS Long Term Plan
3. Continue transforming the NHS for the future Plan

31 Objectives Across 12 Areas
Urgent & emergency care
Community Health Services
Primary care
Elective care
Cancer
Diagnostics
Maternity
Use of resources - productivity emphasis
Workforce
Mental health
People with a learning disability, and autistic people
Prevention and health inequalities

- Narrower focus than our system strategic priorities
- Significant emphasis on recovering core service in the submission templates
- Draft submission submitted 23rd February 2023
- Final submission due 30th March 2023

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Overview of Gloucestershire final Operational Plan submission 2023/24

- Operational plan has been developed with strong engagement from all partners, with emphasis upon getting to a plan which is realistic and deliverable for our population and *is informed by the much wider Integrated Care Strategy and system transformation programmes.*

- Operational plan for 2023/24 builds upon the progress we have made as a system in:
  - delivering against all key elective standards;
  - stabilising urgent and emergency care position;
  - strong mental health and community performance;
  - resilient primary care services;
  - strong integrated approach to health and social care commissioning;
  - financial delivery.

- Final plan is broadly compliant against all key regional/national asks for activity and performance (with clear rationale for any deviation from these) but major challenge remains bridging financial gap – *update will be provided today but at time of writing work still ongoing on this in the run up to final submission and to complete final triangulation process.*

Main feedback from NHSE on draft submission

- Positive feedback – awarded ‘Category 1’ overall.
- Extensive feedback received but key activity and performance measures are almost fully compliant.

Main areas of focus within feedback:

- System challenged to get to financially balanced plan.
- ‘Join up’ of extensive Urgent and Emergency Care programme.
- Request for further detail on our approach to addressing health inequalities.
- Additional information requested regarding productivity programmes.
- Further final work on triangulation (of activity/performance, workforce and finance).

Summary

- On track for the final submission (12 noon 30th March).
- Key challenge for final version remains agreeing a financially balanced system plan.
- Major emphasis this year remains upon:
  - comprehensive elective recovery and urgent and emergency care plans;
  - use of the national triangulation tool;
  - health inequalities focus.

Attention now moves onto focus upon delivery from Quarter 1