Gloucestershire ICB Board Meeting, Public Session, Wednesday 31st May 2023

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Agenda Topic **Page**

Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 31st May 2023

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

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** *Welcome: Stephen Otter, Douglas Blair, Benedict Leigh, Ann James* *Apologies: Dr Jo Bayley, Mark Cooke, Pete Bungard*	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 29 March 2023**	Approval	**Chair**
4.	2.04 – 2.05pm	**Action Log & Matters Arising** • Community Investment Fund at ICB Board	Discussion	**Chair**
		Business Items		
5.	2.05 – 2.10pm	**Questions from members of the public**	Discussion	**Chair**
6.	2.10 – 2.25pm	**Patient Story** – Healthwatch	Discussion	**Becky Parish**
7.	2.25 – 2.35pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
8.	2.35 – 2.45pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	2.45 – 3.05pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Mark Walkingshaw** **Tracey Cox** **Marion Andrews- Evans** **Cath Leech**
10	3.05 – 3.20pm	**Scheme Investments**		**Ellen Rule**
		Items for decision		
11.	3.20 – 3.35pm	**Neurodiversity Future Plans**	Approval	**Mary Hutton**
12.	3.35 – 3.55pm	**Digital Strategy**	Approval	**Paul Atkinson**
13.	3.55 – 4.05pm	**Changes to Committee Terms of Reference** • System Quality Committee • Primary Care & Direct Commissioning Committee	Approval	**Prof. Jane Cummings** **Colin Greaves**
		Information items		
14.	4:05 – 4:15pm	**Joint Forward Plan**	Information	**Ellen Rule**
15.1	4.15 – 4.25pm	**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 17 April 2023 and last set of **approved minutes.**	Information	**Colin Greaves**
15.2		**Chair's verbal report on the System Quality Committee** meeting held on 12 April 2023 and last set of **approved minutes.**		**Prof Jane Cummings**

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15.3		**Chair's verbal report on the People Committee** meeting held on 27 April 2023 and last set of **approved minutes.**	**Clive Lewis**
15.4		**Chair's verbal report on the Audit Committee** meeting held on 9 May 2023 and last set of **approved minutes.**	**Julie Soutter**
15.5		**Chair's verbal report on the Resources Committee** meeting held on 4 May and last set of **approved minutes.**	**Prof Jo Coast**
16.	4.25 – 4.30pm	**Any Other Business**	**Chair**

Time and date of the next meeting

Extraordinary meeting to be held on 28th June 2023 (Annual Accounts & Report)

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 29th March 2023, 14:00 – 16:45

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

Members Present:		
Dame Gill Morgan	**GM**	ICB Board Chair
Dr Andy Seymour	**AS**	Chief Medical Officer, NHS Gloucestershire
Colin Greaves	**CG**	Non-Executive Director, NHS Gloucestershire
Cath Leech	**CL**	Chief Finance Officer, NHS Gloucestershire
Clive Lewis	**CLe**	Non-Executive Director, NHS Gloucestershire
Deborah Lee	**DL**	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Ellen Rule	**ER**	Deputy CEO/Director of Strategy and Transformation, NHS Gloucestershire
Prof Jane Cummings	**JC**	Non-Executive Director, NHS Gloucestershire
Prof Jo Coast	**JCo**	Non-Executive Director, NHS Gloucestershire
Julie Soutter	**JSo**	Non-Executive Director, NHS Gloucestershire
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**	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
Chris Spencer	**CS**	Director of Children's Services, Gloucestershire County Council
Deborah Evans	**DE**	Chair, Gloucestershire Hospitals NHS Foundation Trust
Helen Goodey	**HG**	Director of Primary Care & Place, NHS Gloucestershire
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Julie Zatman-Symonds	**JZS**	Deputy Director of Nursing and Quality, NHS Gloucestershire
Kim Forey	**KF**	Director of Integrated Commissioning, NHS Gloucestershire
Mark Cooke	**MC**	Regional Director of Strategy & Transformation, NHS England
Martin Holloway	**MHo**	South Western Ambulance Service
Mark Walkingshaw	**MW**	Director of Operational Planning & Performance, NHS Gloucestershire
Dr Paul Atkinson	**PA**	Chief Clinical Information Officer, NHS Gloucestershire
Pete Bungard	**PB**	Chief Executive, Gloucestershire County Council

Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
In attendance:		
Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire
Leah Bamford	**LB**	Programme Officer, Ageing Well Programme, Integrated Commissioning, NHS Gloucestershire
Micky Griffith	**MG**	Fit For The Future Programme Director, NHS Gloucestershire
Simon Lanceley	**SL**	Director of Strategy and Transformation, Gloucestershire Hospitals NHS Foundation Trust

1. Apologies for Absence

1.1 Apologies were noted from Marion Andrews-Evans, Olesya Atkinson, Dr Jo Bayley, and Graham Russell.

1.2 The meeting was confirmed to be quorate.

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

1.4 GM announced that three Board members would be retiring and would be sadly missed. GM extended thanks from the Integrated Care Board (ICB) to Paul Roberts, Kim Forey and Chris Spencer for their success in bringing together meaningful partnerships for the people we had the privilege to serve. Appointments had been made to each of those roles and the Board looked forward to welcoming those people to future meetings.

1.5 GM acknowledged the results of the Staff Survey and stated that Gloucestershire Health & Care (GHC) results had been very good, which was an incredible legacy to PR and the work he had done around improving culture. Congratulations were extended to MH who had managed the transition of the Clinical Commissioning Group (CCG) into the ICB and had maintained very high satisfaction rates.

1.6 The Acute Trust's Staff Survey had shown the impact of all the pressures in the system, all the Urgent and Emergency Care (UEC) issues and the collective actions undertaken to try to address these. GM extended thanks to Gloucestershire Hospitals NHS Foundation Trust (GHFT) for all their work, acknowledging the pressures there, and saying that the Board would do all it could to help mitigate these.

1.7 The Citizens' Survey about satisfaction with the NHS was at an all-time low. This would be a challenge across the system as access remains a key priority for politicians and their constituents and work continues to prioritise the changes needed. Whilst undertaking these important activities, a broader view would be needed which would help in the medium and longer term.

1.8 GM acknowledged the length of the Agenda and apologised for this. It was difficult to go through the many papers which had been sent given the amount of reporting that had to be done at this time of the year.

1.9 The Chair drew attention to Board members that the financial paper in Item 9 should be in Item 12 and was for decision.

1.10 The Chair explained that for the Finance team, this year-end had been the most challenging she had ever come across due to the decision to delay the start of the ICB until July. This had resulted in having to shut down two sets of accounts which had been a phenomenal achievement. Finance had also had to manage through much of the planning round the huge amounts of paperwork being sent to Centre.

1.11 Unexpected allocations had come through from Centre within the last week and therefore there are late issues raised with the Board today and we recognise this is unsatisfactory. The Chair said there had been a great deal of pressure on the system and in particular on Finance colleagues to manage these pressures and ensure all opportunities are maximised.

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 25th January 2023 were agreed to be a true and accurate record of the meeting. The minutes were approved.

4. Action Log & Matters Arising

4.1 **30/11/2022, Min 8.14:** A presentation was provided as part of the papers on Vulnerable Pregnant Women. **Action item closed.**

4.2 **30/11/2022, Min 11.8:** This was covered as part of the Agenda. **Action item closed.**

4.3 **25/01/2023, Min 6.13, 6.15 & 6.16, Patient Story:** 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 Board members. The date for sharing with the Board the findings from the People Health and Wellbeing Survey is yet to be agreed. **Action to remain open.**

4.4 **25/01/2023, Min 7.4, Chairs Briefing:** 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 May meeting. **Action to remain open.**

4.5 **25/01/2023, Min 13.3, Committee Update.** The People Strategy is to be updated at May Board. **Action to remain open.**

4.6 **25/01/2023, Min 13.3, Committee Update** - an update was provided as part of the Chief Executive's Report on the POD Delegation Agreement. **Action closed.**

4.7 SF spoke about the co-terminus arrangements around the Integrated Care Partnership (ICP) and the Health & Wellbeing Board in Gloucestershire. The Health & Wellbeing Board's legislation had a very similar remit to that of the ICP and both having two statutory sets of similar responsibilities. The Health & Wellbeing Board, as part of their stated membership has on it, elected representatives from local government and the Office of Police and Crime Commissioner. The meetings will incorporate both parts of the organisations with Board members staying for the membership part should they so wish. Three of those events would be held per year and in the interim months there would be a meeting of the Health & Wellbeing Partnership.

4.8 SF informed that additional development sessions could be run to enhance the maturity of the Partnership. The first meeting on 28th March 2023 had gone well and the Board were asked to endorse that approach and whether the Board were in agreement to harmonise the two groups. This would then go to the Council's Constitution Committee on 31st March 2023 and would enter into the Constitution as a Joint Committee of the local authority and the Integrated Care system. It would be ratified to go to Council with a recommendation for full approval at the next Council meeting in April 2023.

4.9 ***RESOLUTION: The Board approved the harmonisation of the Integrated Care Partnership and the Health & Wellbeing Board ready to be taken forward for full approval by Gloucestershire County Council at their next meeting in April 2023.***

5. Questions from Members of the Public

Dr Andy Seymour read out the first two questions from members of the public: -

5.1

1. Therefore, what the group would like to ask the ICB is what is the funding strategy, in Gloucestershire, with regards to upholding the 2022 NICE guideline revisions for type 1 diabetics in Gloucestershire – specifically 1.6.10 Offer adults with type 1 diabetes a choice of real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM, commonly referred to as 'flash'), based on their individual preferences, needs, characteristics, and the functionality of the devices available.
2. It is understood that the current Covid Medicines Delivery Unit will cease to function from the end of March/beginning of April. As the NHS moves from a pandemic to an endemic response to COVID-19 infections, ICBs will be at the forefront of providing timely access to COVID-19 therapeutics to their local populations. I am interested to know, for the population of One Gloucestershire, what new provisions are being planned to ensure that those at high risk of developing severe COVID-19 will continue to be identified, notified and have access to appropriate treatments in the community?

MW read out the final question from a member of the public: -

3. What Assurance/reassurance does One Gloucestershire Integrated Care Service have that health and social care services delivered for the population of Gloucestershire meet the needs of patient/resident. How is this measured in terms of quality and performance so as to meet the needs of the patient at weekends and public holidays in an equitable way to that of Mon, Tues, Wed, Thurs and Fri.?

5.2 The ICB responses to the questions will be sent to the member of the public via email. A copy has also been posted on the ICB website
[The NHS Gloucestershire Board: NHS Gloucestershire ICB (nhsglos.nhs.uk)]

6 Patient Story – The Falls Prevention and Training Programme for Care Homes Film

6.1 LB presented on the Project to better support the independent care sector to prevent and respond to falls in care homes for older people.

ICB - Care Home - Discussion (Multicam) - YouTube

6.2 LB informed the meeting that falls were three times more common among care home residents than in people of a similar age living in their own homes. As of the 8th of February 2023, this financial year to date, there had been 2952 calls to South Western Ambulance Service NHS Foundation Trust (SWASFT) from care homes in Gloucestershire, 718 being for falls. Of those 718 calls, 265 resulted in a conveyance to Emergency Department (ED). In response to the identified need, a project team was formed with system partners to engage with the care sector, to establish what could be put in place to support them.

6.3 The project team engaged with various stakeholders and two surveys, one to the independent care sector and another to SWAST paramedics were sent out. Feedback from these was used to inform next steps. Four focus groups were held to examine where the difficulties were and how these could be supported. It was highlighted that building good relationships between care staff members and the emergency services would be beneficial to all

6.4 Often patients who had fallen had to have an ambulance simply due to the lack of equipment in helping them up. Homes also wanted an exemplar Falls Policy with a positive risk-taking approach which would enable them to safely pick their residents up from the floor where it was safe to do so. Being able to make decisions in the best interests of their residents and not to have to call SWAST because that was what their policy said, was really important to the homes.

6.5 The project team co-produced a training programme for the Falls Champions, which includes a resource pack that the Falls Champions will deliver to care staff once they have attended training themselves. A network will be developed for the Champions so that a two-way learning programme develops, enabling ongoing support.

The packs included:

- Training films
- Falls prevention and response toolkit
- Post-fall diagnostic tools
- Exemplar falls policy and guidance
- Signposting to further support/ training on specific issues

Homes who nominate staff to attend the training will be offered a Raizer lifting chair if they do not have access to their own lifting equipment.

https://youtu.be/v2Up3TT8KMQ (Featuring Tanya de Weymarn – newly appointed Clinical Lead for Frailty in Gloucestershire).

6.6 MHo said that this was a hugely positive project and he had total support for the initiative. MHo went on to say that so many policies in care homes had been very risk averse and to give the decision making, realistic risk assessments and empowerment to the staff and their care homes was so important. The Raizer chairs were far better than the lifting cushions that the ambulances carry. The lifting assessments were really sensible and would help give staff the confidence and the abilities to make good decisions.

6.7 JCo asked if there was any evaluation the training and whether the training package could also be made available to other ICBs. LB said that evaluations would be taking place around training and competencies and there would also be data available from SWAST. It was hoped to see an impact on those calls in a years' time. LB said that there was no reason as to why the training package could not be shared across other ICBs.

6.8 KF said that homes can be targeted through the Integrated Brokerage Service where there were a lot of falls. GM thanked LB for her inspirational presentation.

7. County Deal

7.1 PB explained that this was about English devolution and related back to a Government desire to have elected mayors who would become a single point of political accountability. If the Government wants to give money or invest, then it is also a single point of investment. The current Government for over a decade had been very wedded to this concept.
https://www.gloucester.gov.uk/devolution/

7.2 PB explained that having one piece of government over a whole area of geography with a mayor would not work as well in Gloucestershire as the county is the most co-terminus place in the country at the moment and there would be little value in having an elected mayor as well as six MPs, a County Council leader etc. After putting a letter in to this effect, a "not yet" letter was received but devolution will be implemented everywhere by 2030. Devolution is a framework whereby the Government could add new powers as it gains confidence in a mature system. In many areas, Gloucestershire are not losing out by not having undergone devolution. Gloucestershire were however on the long list for a cyber investment zone proposal and if this box is not ticked, this could become a potential barrier.

7.3 The Chair explained that it was better to have a marker in place and it will be a case of monitoring to see what happens next. The Chair said that the way that relationships were developing locally, involving respect, equality and demonstrating competence through delivery was giving Gloucestershire as good a platform as anywhere, as other areas who had seemed further ahead had had problems and had not produced the transformation they had hoped for.

7.4 ***RESOLUTION: The Board noted the verbal update on the County Deal.***

8. Board Assurance Framework

8.1 The Chair asked Board members to follow the substantive issues from the Framework after the meeting.

8.2 TC informed members that this was the third time the Board Assurance Framework (BAF) had been presented and was the second of the biggest strategic risks facing the ICB, in terms of the delivery agenda. This Framework will reflect some of today's agenda items and is now being populated with an improved degree of granularity over the management of some of those risks.

8.3 There was not a great deal of change in the overall rating position of those risks since the previous presentation. Red rated areas are still showing in Urgent Care, Workforce and Finance. The scoring for UEC had dropped from 20 down to 16 and gaps were being cited in assurance in relation to the additional capacity funds as part of the 2023/24 planning process.

8.4 The Workforce strategic route remains unchanged and the gaps in the assurance relate to uncertainties in relation to the continual professional development funding into 2023/24 as well as awaiting publication of the NHS Workforce Plan.

8.5 Finance is rated red and more will follow on the Financial Plan as this financial year ends and we move into the next. Actions are of course being monitored to mitigate these risks.

8.6 JSo said there had been a good discussion on this at the Audit Committee and a good deal of work had been undertaken to reflect key points on that discussion. JSo recognised the work that had been done and extended thanks to all involved for this. The Audit Committee would continue to examine and take the Board Assurance Framework forward.

8.7 DE asked whether the Workforce risk should be higher than the 16 currently rated, given the issues. She would place this as a strategic question as opposed to that of a scoring one.

8.8 DL wanted to understand more about what had changed which resulted in the downgrading the UEC risk.

8.9 The Chair posed a more generic question in that that some of these things were in ICB control, but some areas of concern were around things being tied in to national policies and national delivery. Any mitigations in ICB control could still fail and the Chair wondered if there was a way of teasing out how much of the mitigation was practical and that we could address, and how much of it was totally externally dependent, and whether that would help. This could be a question to come back to the Audit and Resources Committees, to think about those working extraordinarily hard without seeing any improvement. **Action: Improvement measures to be followed up at the next Audit and Resources Committee meetings.** **JSo & JCo**

8.10 TC informed the Board members that there was a People Committee on 27th April 2023, and she would take the workforce risk to that meeting and have a further look at that comparative piece of work.

8.11 ER spoke about the driver of the downgrading of the UEC risk, saying that an improvement in performance had been seen, albeit not necessarily robust and resilient

at this point. This quarter had considerably improved in comparison with last quarter across all the measurable key metrics. There was also a robust plan and programme coming together

8.12 DL said she recognised there was a risk around capacity and capability as opposed to performance, and she did not think that this had dropped in terms of risk.
Action: BAF to be discussed to refine the narrative around visibility and what is being measured in UEC. DL/ER/TC to be involved in the next version of the BAF. **ER, DL & TC**

8.13 JSo said that the BAF should be discussed at the beginning of the relevant Board Committees enabling clarity on how the strategic risks are being described and driven and where the assurance gaps and plans are. The Audit Committee will examine the process, but each Board Committee should have some focus discussions around the strategic risks. Thanks were extended by GM to JSo for overseeing the development of the BAF.

8.14 ***RESOLUTION: The Board noted the comments and actions to be taken forward on the Board Assurance Framework.***

9. ICB Chief Executive Officer Report

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

- **Transforming Care (Learning Disability and Autism Programme).** A key focus of the programme had been to facilitate discharges for those people who had been living in specialist Learning Disability and Autism inpatient services, back to appropriate community settings. Gloucestershire ICS currently has the second lowest number of placements in the SW region. There are seven ICB funded placements and 15 secure placements. Of the seven funded placements, two of the out of area placements will be moved into community settings by June 2023 and the other five are already in Berkeley House and of those, four will be moved into community services by the end of 2023.
- **Joint Commissioning of Specialised Services: New Arrangements For 2023/24.** The Board were assured that the ICB did not assume any responsibilities or liabilities in 2023/24 but we have an opportunity to take that shadow year to understand what is happening in Specialist Commissioning. Further engagement with the Board on the implications of this change will take place as the new arrangements are introduced.
- **Podiatry, Optometry and Dentistry (POD) Delegation.** The POD Delegation Agreement and MoU was sent to the Board members for their approval and due to large numbers of support, the ICB will proceed with delegated responsibility from 1st April 2023 for these services and work has commenced to move ahead with the transformation of those services, working with NHSE and other ICBs to improve those services for our population.
- **Extension to GICBs Procurement Strategy document.** 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. Some preparatory work is required in order to become ready for that change and set out the potential impact of new legislation. This had been done (Section 8 of the Report).

- **Chairs and CEO's action.** There had been some changes in allocations over the last month and we were asked to take the Chair's and CEO's action to ensure that some valuable Section 256 agreements were agreed between the ICB and GCC. This came to a total of £9.25m. Over the last number of days there had been further resources become available and additional s256 agreements drafted which would be of benefit and enable us to achieve better value through direct working and the value had moved to £11.5m. CG requested see a breakdown sent out to members of the Board. This breakdown was circulated in the meeting.

9.2 The Chair said that there was disappointment around the Board being unable to make the final decision on the POD Delegation Agreement due to a timescale which did not bear any relationship to the statutory Board meetings and the Chair said she would raise this at a future meeting.

9.3 PR agreed and said he was looking for some assurance that there would be sufficient capacity to do the local things around the POD Delegation as we knew our communities, and the intention would be do a lot more with these areas than we had done in the past.

9.4 CG said that he was reasonably confident that the Committee were well on the way to gaining that assurance and he hoped to give a far more positive response to that question at the Board meeting in May. There would be a first Primary Care & Direct Commissioning (PCDC) /POD meeting on 17th April 2023 when the Committee would be speaking to NHS England (NHSE) regional colleagues. There would be an opportunity to examine all the documentation being transferred. The Chair said that we were extremely fortunate in that there were people in the system who had a knowledge and passion for dentistry, whereas large numbers of ICBs were not so fortunate.

9.5 HG said that as far as offering assurances, Primary Care had been working on dentistry for the last few months and were progressing well towards a commissioning plan for dental services. A meeting with the Local Dental Committee (LDC) on 28th March 2023 had enabled a strong rapport to start to be built with them.

9.6 ***RESOLUTION:***

- ***The ICB Board approved a six-month extension to the Procurement Strategy from 1st April 2023 to 30th September 2023.***
- ***The ICB Board noted and approved the Chair's and CEO's action taken with regard to Section 256 agreements and approved the £11.5m of s256 agreements between the ICB and GCC.***
- ***Noted 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***
- ***Noted the update on the Joint Commissioning arrangements between NHSE and the ICB for specialised commissioning***
- ***Noted the CEO Officers Report***

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

10.1

- Performance for the system continues to be challenging around workforce and UEC pressures and the impact of industrial action during the period covered by the Report.

- Significant progress had been made by GHFT in reducing echocardiography (ECG) waits with the backlog now largely cleared.
- 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).
- There is evidence of the UEC position slowly stabilising, albeit still showing significant pressures within the system. Ambulance handover delays had risen in common with other parts of the SW, particularly in Cat 2 performance which was proving to be a challenge currently.
- Primary Care based services are exhibiting growing pressures and it is something the Board should note and there is a lot of work going on with HG and the wider primary care team to mitigate this.
- There are a significant number of patients waiting in Gloucestershire and those longest waits have performed very well compared to parts of the SW and England, but the push continues in terms of making further inroads into those waiting lists.
- The system will achieve the 104% target of value related activity against the 2019/20 pre-Covid baseline against which it is always measured, and it is planned to achieve a new 109% target.
- Cancer performance remains a concern, in particular, delays in urology. Additional capacity will be provided by the Community Diagnostic Centre in aiding with reducing ECGs.
- Appendix 1 of the Report details the work around health inequalities in terms of access to services. Work is being done around elective access, breaking the waiting list down in detail particularly for the core 20PLUS5 groups. Further work has started to address the management of long-term conditions and the use of emergency care by those groups.

10.2 TC provided an update on Workforce to the Board:

- One of the key issues occupying the system had been ongoing industrial action. There are a series of pay deals on offer across multiple staff groups and it will be another 2-3 weeks wait to find out whether this offer will be accepted by staff. Further strike action between 11th and 15th April will be taken by junior doctors as their position had not so far been resolved. This will impact the system and will further affect elective recovery.
- There had been ongoing support around the development of the One Gloucestershire People Strategy with the expectation that the NHS Workforce Plan would have been available to reference, and to provide some clarity around the national position. A leaked version had made its way into the Guardian this week which presented a very challenging picture of a 'do nothing' scenario if action were not to be taken around the current vacancy position. There was strong advocacy around investment in undergraduates and their recruitment into training programmes.
- Proposals are being developed for Health Education England (HEE) monies for 2023/24 despite being unaware of what that allocation may be, but prospective bids are being prepared in the anticipation of some funds being available.
- A small amount of funding was secured for staff coming into this country via the International Recruitment pipeline and to support those who had arrived to assist them with their transition and integration into our local system.

10.3 JZS provided an update on Quality to the Board:

- Work had commenced with other ICBs on the Quality Framework, Improvements had been seen within the Care Quality Commission (CQC) Maternity users' Survey which had been well received and had had a positive impact on staff morale. Gloucestershire is also a pilot site for the Black Maternity Matters Programme which will be seeking improved outcomes for those mothers and their babies.
- Gloucestershire is also a demonstrator site for the Vaccine Inequity Initiative.
- Implementation of the new Patient Safety Incident Response Framework had been a focus and a system debate held in county yesterday which went well but it is hoped to encourage wider engagement.
- Work is also underway to better understand the mortality data and it is the aim of the Quality Team to develop quality frameworks and have more specific metrics in place.
- Good progress had been made on the action plans against Section 29A in Maternity in GHFT, resulting in CQC being able to stand down their meetings.

10.4 CL provided an update on Finance to the Board:

- The forecast for the 2022/23 financial position is break even for both the ICB and for each of the system NHS Trusts. Changes to the position were being jointly managed. The focus had recently been around understanding how things would flow into 2023/24 as part of the budget setting.
- Key issues to note were elective recovery delivery for the system being around 105% which put the system into a good position for 2023/24 and was above average expectation. Workforce agency and bank spend had increased and was well above planned levels, so in terms of key issues to take away, these would be the two key factors which would feed into 2023/24.
- In terms of capital, there is a huge amount of work underway within both the system's provider organisations who both expect to be able to fully spend their capital resource limit for the benefit of Gloucestershire.

10.5 The Chair said it was important to talk about areas of excellence around performance as well as those areas which were not performing as desired. Often the really good things that people had done throughout Covid and areas which were exemplars, were not celebrated. Ideally the Board needed to find a way of ensuring that any assessment was well-rounded and not fixed on any one area of performance.

10.6 DE appreciated the Chairs acknowledgement that whilst things were difficult and performance was being challenged in many ways, there were also areas of very strong performance; elective and cancer being two as well as the inroads that had been made around Cat 2 ambulance delays. The numbers of patients boarded in February had also significantly dropped with only 75 incidents around safety being raised by colleagues in February.

10.7 DL said that the system had to be aware of not normalising scenarios for those patients who had been kept in a corridor for significant lengths of time. DL thanked colleagues for their support in areas where there were still delays in initiatives. There were concerns during any industrial action that safe care could continue to be delivered and a number of Trusts are considering raising injunctions under Section 240 of the Industrial Relations Act which would effectively make it unlawful for juniors to strike due to the known impact on safety.

10.8 DL drew the Board's attention to the fact that the next set of strikes would effectively be 10 days, due to the Easter Break and Bank Holiday Monday's level of staffing. This could not be coming at a more difficult time and previously where there had been a great deal of goodwill staff and practitioners, they were not feeling as supportive this time round due tiredness. The timing of the strikes had proved unpopular with other colleagues both medical and otherwise. The implications would be much more concerning and serious this time round.

10.9 DL said that a number of medical directors in the system in the SW had chosen to address the juniors and the British Medical Association (BMA) to implore them to conduct further talks with a view to postponing or cancelling the forthcoming industrial actions. The Chair agreed this was an exceptional situation saying that this was the time that representative bodies needed to step up and co-ordinate the views of the whole system.
Action: The Chair will follow this up to ensure that the ICB take steps to ensure that views are known. **GM**

10.10 ***RESOLUTION: The Board noted the contents of the Integrated Finance, Performance, Quality and Workforce Report.***

11. Fit for the Future Phase 2 – Decision Making Business Case (DMBC)

11.1 ER said that this significant and very involved piece of work had taken place over a considerable period of time, with the input of many to take the programme to this point. ER wished to credit all the hard work and input into this project, which had often involved clinical teams in service re-design activity, in the context of extremely tight service delivery conditions. This had not been easy, and ER thanked everyone for making and prioritising the time to do that as it had been a challenge in the lifespan of this programme.

11.2 A two-step process would not be applied this time to undertake formal consultation as extensive engagement had already taken place to inform the Decision-Making Business Case. If this were to be approved today, the programme would then proceed to implementation.

11.3 MG provided an overview of the process and the recommendations being made today. MG demonstrated Slide 2 which showed the Board the various gateways that the programme had undergone in order to bring it to today's position. ICB Board members would apply 'conscientious consideration' to all the information held and would then be asked to make a judgement to proceed to programme implementation.

11.4 Slide 4 showed that parts of Phase 1 had been completed and some of Phase 1 was yet to do; some of Phase 2 was awaiting formal approval and some of Phase 2 was yet to do. Slide 5 indicated the structure of the DMBC.
Slide 6 demonstrated Public, Patient and Staff engagement – of those people who completed surveys, it was good to note that there was a high level of support for the proposals.

11.5 Slide 7 - MG said there were five services in Phase 2 and within the DMBC a lot of information was provided around the case for change, the benefits, information on what the SW Clinical Senate as an external clinical assessment had been, and how we had responded to engagement.

11.6 The Integrated Impact Assessment (IIA) dealt with three elements; an Equality Impact Assessment, a Health Inequality Impact Assessment and a Health Impact Assessment. MG said he would go through resolutions with Board members if there were any questions.

11.7 CG said that this had been comprehensive, clear and very well laid out. He had a minor point on Page 18 of the DMBC: GRH Acute Medical Unit
AMU 2 (single side room with ensuite) – *February 2023 (Needs to be updated).*

11.8 CG said that transport was a theme throughout all the recommendations and within the scope this said it was a minor consideration, but CG said it needed to be recognised that for some people, all these changes did have implications.

11.9 CG supported the timelines. CG said that the document had been well put together and well-constructed. The only element for him was around stroke and, it looked as though some of the staff were not totally happy with the suggestion and it might be an idea to comment on that. Overall, the case looked very strong, and CG had no qualms about it.

11.10 MG conceded that stroke was the least strongly supported and most of the comments had come from vascular surgeons who had concerns around a number of areas, but the stroke team had met with them, and those concerns had been mitigated. This service not being on an emergency site is unusual but having patients sent straight to CT had proved hugely beneficial and it was felt that this was a positive step.

11.11 ER introduced her joint sponsor colleague Simon Lanceley (SL) saying that she and SL were joint sponsors of this work, and he was also available if there were any questions for him. The Chair pointed out that stroke was strongly supported by the Clinical Senate.

11.12 JC wanted to check whether if the stroke unit moved from Cheltenham General Hospital to Gloucestershire Royal Hospital completely, what would that do to a stroke service which was largely an emergency service on a non-emergency site and whether there would be enough back-up, particularly overnight.

11.13 MG said that this had been at the forefront of discussions, stroke would not move unless all the elements were in place and one of those areas would be around medical cover and Out of Hours cover. There were details in the Business Case around Medical Registrars Details and other support. SL said one of the big benefits had been that that SWAST paramedics had been able to bring possible stroke patients into a CT scanning area. In addition to Medical Registrar cover there was an Acute Care Response Team (from Phase 1) which were a support function at Cheltenham who would provide overnight cover.

11.14 JSo said she thought being a non-clinical person and new to Gloucestershire she had found the report clear and well written and had enjoyed reading it. She looked at the assurance provided from the SW Clinical Senate and there were a number of things raised in there that were mentioned in each section and put together in Appendix 5. However, there did not seem to be a plan or a timeline to cover off the Clinical Panel's comments and recommendations.

11.15 MG referenced page 27 of the document where there were a number of areas where the Clinical Senate left some open questions that they said the Trust when implementing made sure that they did not leave those undone. Some of the areas sat in part of the governance side of the Implementation Group and this is something that the Business Case had not been as clear with, and we might need to say that responsibility would lie with specific area. Similarly the Clinical Senate were very interested in that medical take move and the cover at Cheltenham so the Trust set up the Acute Take, Go, No Go.

11.16 In the Senate Panel sessions, the actual amount of ACP work was. bably not well demonstrated in the Trust and that was where questioning about our lack of ability to share with them what we were doing around the gap had come from. The Implementation Group would be responsible for implementing those actions on the spreadsheet and these will be monitored and reviewed by that group. SL said that this was a good reminder that the group had oversight of all those actions.

11.17 JSo said there were a number of things from an assurance perspective that she would like to see covered off, such as weekend cover for electrocardiogram (ECGs) which had been mentioned earlier around performance, so some of these things were tying in with other pressures and it would be good to see the assurance coming back.

11.18 ER said that an Implementation Update could be provided which was something that she and SL could take away and reflect.

11.19 SS referenced the Health Inequalities Impact Assessment and said it would be useful to know what had been done around engagement from the people we traditionally found it difficult to engage with, particularly those with protected characteristics.

11.20 MG said that there had been some disappointment around the responses received during engagement, despite extensive reaching out to the public in various ways. No protected characteristic analysis had been done as those figures were so low and interpretation would have been tenuous. Having a long-term engagement relationship with groups of people rather than having one-off sessions was an aspiration everyone all had and would give us more success in being able to build this into any future plans.

11.21 DL mentioned operational assurance. Many of the things of concern to the ICB would be assured through the operational assurance infrastructure within GHFT. DL thought this Board should be seeking assurance from GHFT rather than doing first party assurance as there was an opportunity to conduct third party assurance. DL said that the level of detail and knowledge base may not be constructive to a Board such as this.

11.22 The Chair agreed and said that this was very much in line with the way the Board wished to work. The strategic things need to come in but should be shared by GHFT very much in the way that the Quality Committee was trying to work, rather than the Board having to ask. The Chair said it was up to individual organisations to manage their business but for the Board to collectively assure that it was doing what it said it would, but this was not the same as having all the reports. The Chair thought that this was a point very well made. The Board would come back to ensure that it was close enough to what went on.

11.23 CAM asked why the costs were much lower in Phase 2 than in Phase 1. SL explained that the higher costs came in Phase 1 as those were the building blocks to facilitate all

the phases and the main costs needed for both Phases came in Phase 1. CL said that there were a number of benefits and how these were rolled into planning and the realisation of those benefits were monitored, would be a key consideration.

11.24 JC raised bed numbers and potential future capacity problems, with most moving to the Gloucester Royal Hospital (GRH) site for emergency admissions. SL said that there was a Strategic Site Development Programme which had been overseeing the £44m delivering the capacity, so at Cheltenham General Hospital (CGH), additional day surgery and theatre capacity had been put in to facilitate the planned care activity and operating capacity. At GRH, a larger ED, a bigger acute medical unit and a new ward (Gallery Wing 2) had been delivered, creating additional inpatient capacity here. A significant number of stroke beds had been moved over to the planned care site, so there was confidence in the bed modelling numbers having been balanced out.

11.25 DL said that demand on services was still exceeding current bed base. DL was hopeful and confident that the Newton work would negate any further conversations around this. DE said that the discussion was a very important one, reflecting that not everyone understood that beds had not been lost which needed to be explained, so that we were talking in the same currency.

11.26 The Chair finished by saying that the Stroke video presented to the Clinical Senate was absolutely outstanding and had been the strongest and clearest layout of the programme and had been an exemplar around having some of those really difficult conversations.

RESOLUTION: The Board approved the following Resolutions:

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 beds3 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.*

12. Progress Report – Public Sector Equality Duty and the Equality Delivery System

12.1 TC informed the Board that there was a duty in Public Sector organisations each year to publish quality information about the communities that we served and on the staff who were employed. Each year there was a requirement to publish one or more Equality Objectives that were specific, measurable and covered a period of up to four years. This was a process supported by the Equality Delivery System (EDS) which was an improvement tool designed to assist the ICB in assessing performance and identifying areas of improvement.

12.2 Through Covid, there had been a moratorium on organisations publicising and reporting on progress, but this had now been lifted and NHSE had been clear to ICBs in this regard. TC demonstrated two slides showing information from the County Council around the local population and its makeup in terms of the nine protected characteristics, which was clear and up to date and was reflective of the 2021 census position. Our teams will have access to this information which will be important to the ICB for planning and developing future community services.

12.3 New guidance came out in August 2022 to support organisations in the assessment process. The EDS comprises eleven outcomes spread across three domains:

- Commissioned or provided services
- Workforce health and well-being
- Inclusive leadership

The outcomes are evaluated, scored, and rated using available evidence and insight.

12.4 The ICB had looked at the performance for Cancer Services and Translation & Interpretation Services. Each organisation will review its own progress on Workforce Health and Wellbeing and Inclusive Leadership. Assessments are checked with an independent party and with local patient groups.

12.5 The ICB had collated evidence to support a review of the requirements against the three domains and 11 outcome areas and had engaged with both staff networks and the recently established Working with People & Communities Advisory Group (WPACG) to review the information and to independently assess performance.

12.6 TC said that due to the amount of information in the report, she would just comment on Commissioned or Provided Services which addressed how well we knew our communities and whether we knew we were providing services to different groups and meeting their needs.

12.7 There was good provision of cancer services across Gloucestershire, but more robust and detailed analysis is needed across all of those protected characteristics. A key challenge is that there are a lot of data sets, but these are not inter-linked, and the detailed sub-analysis around protected characteristics is not investigated and this needs to be strengthened. There are many targeted initiatives to address health inequalities around cancer provision and similarly regarding translation and interpretation services, once requests had been monitored, the ICB had struggled to compare that to the number of people who if they needed to, were able to access those services. This is reflected in the Integrated Care Partnership Strategy, and we are at the early stages in this journey.

12.8 Following the findings, there was an assessment process which showed that over the past year, the ICB was a system in development. TC thought that we had judged ourselves fairly harshly and clearly there was a desire to go further.

12.9 The proposed Equality Objectives are:

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 identifying opportunities to take improvement actions.
2. To deliver our programme of work in the Core 20 Plus5 clinical priority areas.

3. To work with system partners across One Gloucestershire on the implementation of the Equality Delivery System to share information, learning and good practice.

12.10 This report was a hybrid of both the system and the ICB. Different organisations had been at different points in what they had been working on and there had been collaboration over Domain 1 but there is commitment as things move forward to do this collectively. The toolkit was somewhat tired as had been around for over 10 years and needed updating. PR also said he would like to see a focus on a proper systematic programme approach on inequalities. PR said Andrew Fenton had been doing some work recently and it would be interesting to see what he had to say when this was completed.

12.11 SF said that the report was welcomed and said that work should continue to ensure that we could be the best we could with clear areas of development having been identified. Protected characteristics did not necessarily always cover the things thought about in health inequalities and it was important to think about these with a broad lens as race does tend to correlate with more deprived areas. SF referred to having good quality data and could look at doing an engagement piece around the importance of recording that data. People from different groups often did not feel confident in disclosing information and this was evident from their responses. It was evident that we needed to further engage with our population in order to provide better services for them. **Action: SF to follow up with a conversation with TC and Becky Parish.** **SF**

12.12 CS said that children and young people who were cared for should be a protected characteristic because access here was often late. A lack of dental care was a good example of that. CS thought we could be ahead of the curve and at the cutting edge as an ICB, if Children in Care and Care Leavers as a protected characteristic, were to be adopted.

12.13 ***RESOLUTION: The ICB Board noted the Public Sector Equality Duty and the Equality Delivery System Progress Report***

13. 2023/24 Operational Plan and 2023/24 Budget

13.1 MW said this built on the update of the draft Operational Plan in February. It was recognised that the national priorities were a much narrower set than those of the wider strategic plans, including the Integrated Care Strategy published in December and the Joint Forward Plan currently being developed. The Operational Plan had been built together as a system and MW wanted to thank all partners who had worked with ICB during a very busy period for the service to build this Plan together.

13.2 More than ever this year the ICB had sought to ground the key commitments in the Plan. Despite some risk still within the Plan, it was in a good position and had been assessed as such by NHSE. The next version of the Plan builds upon the progress made in the draft and was now compliant against all the key regional and national asks in terms of activity assumptions and performance measures, with the exception of two. One is around the follow up of outpatient work and the other one is that we would not be able to comply with the out of area placements target, which was zero. NHSE have accepted the rationale for those two areas of performance being non-compliant.

13.3 The Plan included a significant level of savings and risks. We had made very clear commitments particularly in terms of our ambition in relation to elective recovery and urgent and emergency care recovery, which would attract additional investment into the system which would be contingent upon delivery against those commitments.

13.4 The next version of the Operational Plan required us to get to a financially balanced system plan and we had been asked to join the extensive UEC Programme, so there was no criticism of our ambition and trajectories, but we needed to join up the various aspects of the narrative, which had been a request for the final version. We were required to give more information on our approach to addressing health inequalities in the system and work was put in to expand that section of the Plan with helpful input from PR and SF and the wider team.

13.5 The approach to productivity information was requested including responses to key regional and national programmes around productivity and that had been included in the next version. Further work was also required around triangulation which had proved challenging due to tight timescales for the next submission of the Plan. Work was conducted around aligning Activity Performance Workforce and Financial Assumptions.

13.6 MW said that all was on track concerning the next submission on 30th March 2023. The focus will now move quickly to delivery from Q1.

13.7 CL said that for the 23/24 Financial Plan a break-even position had been reached for the system as a whole and each organisation will submit a balanced plan for break even. The total allocation is £1.283b which included the new Primary Care allocations for Pharmacy, Optometry and Podiatry (POD). It was thought that the £50m will be delegated to the ICB on 1st April 2023. The main allocation was that of a programme allocation where growth was just under 5% and for Primary Care the growth was about 6% for this year.
There were also specific allocations for areas such as elective recovery, this was dependent upon delivery and so if we deliver, we will receive full allocation, but if we should under-deliver, then the full allocation would not be received. There are two smaller allocations which will allow focus on discharge and flow in the system.

13.8 There are minimal investments in the overall Plan apart from those relating to specific allocations. Discharge, flow and mental health investment standards are planned to be fully met and there are also quite significant savings across the system as a whole in the Plan. The ICB savings are c£13m; the ICS savings are just over £55m. This is a significant number and represents a high degree of risk. Whilst we as an ICB have to break even, we also have a responsibility as a system for that position, so we are all sharing in that risk, and it was essential that the necessary controls were in place.

13.9 The total proposed spend for the system capital is just under £72m which would primarily be spent by GHFT and GHC with a smaller amount for the ICB. The capital plan is to be published on 21st April 2023 formally to the Health & Wellbeing Board and if approved, will be taken forward. Guidance will have to be looked at around this.

13.10 It is important to secure this year's delivery and then to focus on the underling position to bring that to a financially sustainable position for the system as a whole.

13.11 CG thought that GHFT would face a challenge in achieving their levels of savings and he said the Fair Share allocation was reducing our total for the convergence adjustment

of .7% but for the last six years, we had been under target funding but there had been no compensation.

13.12 CL said that the convergence adjustment included a higher level of growth to reflect that we were under our target allocation for Primary Care.

13.13 The Chair thanked all three Directors of Finance and Steve Mawson from the County Council for all the work that had been put in around the late allocations which had been unexpected. Due to the late arrival of one of these yesterday, it was a remarkable position to be in and any further late allocations would certainly be difficult to manage.

13.14 ***RESOLUTION: The ICB Board agreed to:***

- ***Approve the proposed 2023/24 budgets, revenue and capital, including funding for existing schemes referenced in section 3 for Q1 whilst final decisions are made.***
- ***Support the measures required to deliver the proposed budget and improve the overall financial sustainability of the System and ICB.***

14.1 <u>Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 2 February 2023</u>

14.1.1 CG said that Helen Goodey had presented the Dental Strategy Group work which was formed on the basis that there was further work to do for our patient's around dental work.

14.1.2 There was also a briefing on Acute Respiratory Hubs

14.1.3 The Committee had information around transforming neighbourhood groups and whilst this was not the direct responsibility of the Committee, it was important to be aware of what was going on.

14.2 <u>Chair's verbal report on the Quality Committee meeting held on 16 February 2023</u>

14.2.1 JC had no further updates for the Board.

14.3 <u>Chair's verbal report on the Audit Committee meeting held on 16 March 2023</u>

14.3.1 JSo reported that there had been substantial assurance on the internal and external audit on the work conducted in preparation for this year's audit and the reports that internal audit had done on financial management control in the system, thanks to the Finance team and CL at this particularly difficult time of year.

14.3.2 Work on risk management and BAF was proceeding and there was green assurance across Counter Fraud and general financial management.

14.4 It was noted that the People Committee would be meeting in around two weeks' time and that there would be a longer session at the May meeting on System Resources Committee in June 2023.

14.5 ***RESOLUTION: The ICB Board noted the verbal updates provided from the Committee Chairs.***

15. Any Other Business

15.1 There were no further items of any other business.

The meeting closed at 4.45pm

Date and Time of the next meeting: 2.00pm – 4.30pm on 31st May 2023, in Boardroom, Sanger House

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

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.

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log

May 2023

Open actions only

Meeting Date Raised	Reference	Owner	Action	Due	Updates	Status
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. **29/03/23**: 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 Board members. The date for sharing with the Board the findings from the People Health and Wellbeing Survey is yet to be agreed. Action to remain open.	**Action 1&2 Closed.** **Action 3 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.	**July-23**	**29/03/23**: Committee Update. The People Strategy is to be updated at July Board. Action to remain open.	**Open**
29/03/2023	**Min 8.9 BAF**	**Julie Soutter & Jo Coast**	Any mitigations in ICB control could still fail and the Chair wondered if there was a way of teasing out how much of the mitigation was practical and that we could address, and how much of it was totally externally dependent, and whether that would help. Improvement measures to be followed up at the next Audit and Resources Committee meetings.	**May-23**		**Open**

29/03/2023	**Min 8.12 BAF**	**Deb Lee/Ellen Rule and Tracey Cox**	DL said she recognised there was a risk around capacity and capability as opposed to performance, and she did not think that this had dropped in terms of risk. BAF to be discussed to refine the narrative around visibility and what is being measured in UEC. DL/ER/TC to be involved in the next version of the BAF.	**July -23**	Further work is being undertaken on the BAF that will address the issues raised at the Board.	**Open**
29/03/2023	**Min 10.9 Junior Drs Strike**	**Dame Gill Morgan**	DL did not think that the Government really understood that this was an exceptional situation. The Chair agreed saying that this was the time that representative bodies needed to step up and co-ordinate the views of the whole system. The Chair will follow this up to ensure that views are known.	**May-23**		**Open**
29/03/2023	**Min 12.1 Health Inequalities**	**Sioban Farmer**	People from different groups often did not feel confident in disclosing information and this was evident from their responses. It was evident that we needed to further engage with our population in order to provide better services for them. SF to follow up with a conversation with TC and Becky Parish.	**May-23**		**Open**

Joined up health and social care services

By Rachael Veitch, Healthwatch Gloucestershire Engagement Officer (ICS)

Sandra and Bob's Story: A long struggle to care and cope at home

Sandra, originally from Gloucester, is 79 and lives in Cheltenham. She has two sons and four grandchildren, and she enjoys cookery and handicrafts. On 8th October 2022, Sandra's husband of 59 years, Bob, passed away whilst in respite care. Bob had a fulfilling career as an electrical engineer, and was a keen artist and sportsman. He'd always enjoyed reading historical works and newspapers, usually whilst listening to his favourite artists such as Willie Nelson and Elvis Presley. Diagnosed with dementia in 2014, Bob's health gradually declined, and Sandra dedicated herself to taking care of him at home. In the last few weeks of Bob's life, Sandra sought outside care and support, but her experiences of navigating the available services, understanding what she and Bob were entitled to, and arranging care, were incredibly challenging. Sandra shares her story hoping processes can be simplified, and communications improved, to prevent others from encountering such barriers.

A short stay in hospital

In September 2022, Bob was taken to hospital with a suspected urinary tract infection (UTI). After two nights in hospital, Bob was discharged with antibiotics, but Sandra was never informed whether it was, in fact, a UTI that Bob had been suffering from. "The word delirium came up on the hospital notes, but not mentioned to me. I had no idea what the hospital thought the problem was. The paramedics said it looked like a UTI so that's what I thought it was." Sandra questioned whether some staff lack dementia training as she did not think reasonable adjustments were made and felt Bob's treatment was less that satisfactory.

A turn for the worse

Once home, things took a turn for the worse and Bob began experiencing diarrhoea. Sandra called the doctor and was asked to collect a urine and stool sample from Bob, but a week later, having heard nothing about the results, Sandra phoned the surgery only to be told they might require further samples. "They didn't have Bob's name on, so they weren't tested… I spoke to the same doctor as before, who wasn't very helpful. She asked, could I get Bob to the surgery for an appointment, but he could barely stand, let alone get to the surgery."

Struggling to cope, before receiving excellent care from Rapid Response

Things were becoming increasingly difficult at home and the doctor arranged for Rapid Response to visit. Sandra remembers that the carer who first attended their home reassured her. "He said he would be here for as long as it took, and he was here for a good couple of hours. He checked Bob over and put him on a drip, and someone else came that evening to check on him, so that was brilliant." Rapid Response visited twice a day for the next couple of days, and Sandra valued the entire team. "[They were] a font of information. I could talk to them, and they gave me lots of information about dementia care." As

someone who was new to caring and had received little input or advice regarding how to support and assist her husband, Sandra was grateful for the opportunity to learn. "I learned about how to help Bob sit up… If you observe how the professionals do it, something rubs off and it makes life easier for you afterwards. You want to know if you're doing it right and for someone to say, 'You could've handled it this way', or, 'Try this'." The Rapid Response team also advised Sandra to seek further assistance from her doctor to be on a higher amount of attendance allowance. 'I phoned the doctor, but she said I'd need to phone the DWP because it wasn't her responsibility. She had no empathy or appreciation of the situation, to her it was a routine thing, but for the person in the situation you feel like a minnow. You're fighting all the time, which isn't your natural state."

Bureaucratic hurdles

It took Sandra four months to be approved for attendance allowance; her first application was rejected following a telephone interview that made her "feel very small." Eventually, with the help of one of the organizers of a local memory café, Sandra was approved. She also encountered great difficulty in attempting to complete an application for a Blue Badge. "I'm not stupid, but I'm not that quick at dealing with stuff like this [applications]. There are a lot of people worse off than me, and I feel the system is built to knock you down every time. It doesn't deal with people as they should be dealt with."

Desperately seeking support

Once Bob's health was stabilised, the Rapid Response visits ceased. "I'd phoned advice lines, carer helplines, all sorts because we were beginning not to cope very well… I rang the surgery again because we were getting nowhere, and it was only when I spoke to a different doctor that things changed. She seemed to really grasp the situation and was marvellous." This doctor advised a treatment option for Bob's diarrhoea, and appreciated that Sandra required more ongoing support, promising to arrange for someone to visit Sandra to assess what help and care was needed. A few days later, Critical Care at Home visited Sandra and Bob, and they were "fantastic… The lady came at 1.30pm and didn't leave until 5pm. We had a chat first, and then Bob was still having the diarrhoea so she came upstairs to help me change him, which meant she could see exactly what the situation was… [She] phoned up the next day to see how we'd managed the night." At a time when Sandra was struggling to find any help or support, this thoughtful act meant a great deal.

Not knowing what is available or what you're eligible for

Sandra explains that when Care Coordinators and Social Care team members asked her at this time about Bob's care requirements and possible care packages, she hadn't known "what was available or what was needed." It was only from support groups and speaking with others that Sandra learnt about what benefits were available, the care that could be funded, etc. "What's particularly good about the voluntary groups is that people share information - knowing I'm not the only one suddenly faced with this." Initially, Sandra didn't think they would qualify for any funding. "By the end of the conversation I still didn't fully

understand or trust what was being said, so I thought I might as well apply, but I would still like to understand... It's an unnecessary uncertainty when it ought to be straightforward."

Sandra also discovered that she and Bob had a designated dementia nurse, a person who had never met either of them in person, and had only spoken with them over the phone on one occasion. Sandra says this is what she has found "most shocking" about their entire experience. "No one made any attempt to actually see Bob. I haven't felt they've been interested, it's no good just talking to me... The hands-on people have a pretty good grasp of what's needed, but they are few and far between, the stars."

Reaching breaking point Sandra finally accepted respite

"We looked at some care homes and it was arranged for Bob to go into respite for two weeks... They did their best by him, the kitchen made up something rich and creamy to try to entice him to eat, and they tried very hard."

Sadly, Bob passed away in respite care and Sandra's experience in the wake of Bob's passing was no more straightforward. "We had to get a death certificate... but we were told Bob's own doctor had to provide the certificate. My son called the surgery and was 29th in the queue... as no doctor from the surgery had seen Bob for the past month, they said it might have to be referred to the coroner's court... Departments just don't talk to each other... I thought that was the whole idea of computerizing everything, so everyone has access to the same information" For Sandra, this was just another demonstration that "they really can't be bothered to deal with the person, you're just a tick-box."

Although she says, "it's going to be a different life", Sandra is determined to keep on living it, and she shares her story because "Bob deserved better," and so, she suspects, do other individuals and carers across the county.

What was good?

• Rapid Response and Critical Care at Home teams were quick to arrive once referrals had been made, and helped tremendously

• The home that Bob stayed in delivered quality care in his last few days

What could be done differently to improve care for everyone?

• Health and care services to be more joined-up; communicate with each other, share information, and work collaboratively

• Application process for allowances, blue badges, etc. could be far simpler, and support provided to complete the necessary paperwork

• One dedicated and consistent point of contact designated to helping people navigate the care system: a central, local information site to offer support, signpost to appropriate care providers, and advise on eligibility for funded care/allowance

Agenda Item 7

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 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**		
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 2023-24 as agreed by ICS partners.					
Key Issues to note	The BAF has been reviewed by directorate risk leads and Directors. The BAF contains: • 10 strategic risks under 9 categories • 3 Red Rated risks (urgent care – 16; workforce – 20 and finance 16) • 7 Amber Rated risks It is worth noting that Risk Ref: 2 has increased from a score of 16 to 20 and Risk Ref: 8 has decreased from a score of 9 to 6 for this version of the BAF.					
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)					

<table>
<tr><td>Impact on Health Inequalities</td><td colspan="3">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.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="3">See health inequalities risk</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="3">The BAF includes a strategic risk on Sustainability</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="3">There is no public and patient involvement in creating the BAF</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board is requested to:
• Note the Board Assurance Framework</td></tr>
<tr><td>Author</td><td>Christina Gradowski / Ryan Brunsdon</td><td>Role Title</td><td>Governance Team</td></tr>
<tr><td>Sponsoring Director (if not author)</td><td colspan="3">Tracey Cox, Director of People, Culture and Engagement</td></tr>
</table>

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: 22/05/2023

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:**	**23rd May 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 to be mobilised by July 2023 (Transformation Programme Board, Workstream Delivery groups and Benefits Monitoring Group to be in place).	• Reporting into the ICB Quality Committee • Reporting to the Board of the ICB on key metrics via Integrated Performance Report • Ongoing monitoring of agreed system wide Sloman metrics • NHSEI Reporting	• Further development of the benefits realisation trajectories in relation to investment requests.

Document Last Updated: 22/05/2023

<table>
<tr><td>• Strong governance through system meetings (UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG).
• Use of demand and capacity, additional capacity, discharge and BCF funds to deliver improvements within UEC system flow</td><td></td><td></td><td></td></tr>
<tr><th colspan="2">Actions to mitigate risk & implementation dates</th><th colspan="2">Director's update on actions to date (quarterly update)</th></tr>
<tr><td colspan="2">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.</td><td colspan="2">Updated: 23/05/2023
1. Delivery Partner sourced, final stages of contractual agreement under way (GCC lead on behalf of ICS).
2. Final operating plan submission agreed by system partners (via T&F group) and submitted on 30th March 2023.
3. HOSC report shared in March regarding winter so far. Winter De-Brief events held in April and May with system partners to consolidate learning and inform plan for 23/24.
4. Outline Transformation programme in place, with identified priorities. Programme delivery approach to be mobilised through June/July 2023, building on existing arrangements.
5. Schemes within priority committee process to be notified of outcome. Increased focus on benefits realisation across all schemes.
6. Systems Thinking and Leadership masterclasses underway, with colleagues from across the UEC in attendance.</td></tr>
<tr><td></td><td colspan="3">Relevant Key Performance Indicators: (taken from the Integrated Performance report)
○ IPR Reporting for Acute, Winter monitoring and Ambulance metrics</td></tr>
</table>

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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**

		Original Score (I x L)	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
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.				↓ ⟷ ↑
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)**

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		28/02/2023: Work continues in this area and we are beginning to see some positive, albeit limited, outputs from this work stream
	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: 22/05/2023

Strategic Objective					
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**					
Risk Ref: 2 **Strategic Risk**	**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.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Cautious**	**4x4=16**	**5X4=20**	**3x2=6**	
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	GHC – BAF Risks 4, 5 and 6 (Recruitment & Retention, Workforce Wellbeing and Culture) GHFT – BAF Risk SR3 (Inability to attract & recruit a compassionate, skilful, and sustainable workforce) and & SR4: Failure to retain our workforce and create a positive working culture.				
Aligned to current ICB Risks	7 identified risks rated 15 and above: 1. Inadequate Workforce Supply (risk score 20) 2. On-going industrial action (risk score 16) 3. Band 2/3 HCA pay issue (risk score 16) 4. Cost of living impact of staff (risk score 16) 5. Placement capacity expansion (risk score 16) 6. Future Clinical Professional Development (CPD) funding (risk score 20, this is an increased risk score) 7. Workforce transformation (risk score 16) - risk of inadequate links to training and education from CPGs & risk relating to recruiting staff when funding is non-recurrent				

Committee	People Committee	**Review Date:**	Reviewed on 12th January 2023 with next review scheduled for 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**
• Utilisation of HEE monies on Continuing Professional Development to support staff training & development	• Lack of an adequately defined and resourced system-wide and	• Reporting to the People Board, People Committee and the Board of the ICB	• National issues include uncertainty on continued funding for Continuing

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• Some leadership learning and development programmes in place • Shared and targeted recruitment initiatives including international recruitment • Further promotion of resources and support available to staff including The Wellbeing Line • Development of summary delivery plans focusing on agreed priority areas for action in 23/24 for each Steering Group.	medium-term plan for staff and leadership development	• On-going monitoring progress on key workforce metrics through Integrated Performance Report (see below)	Professional Development funding. • Awaiting publication of NHS Workforce Plan.

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. Delivery of existing HEE funded projects e.g., 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) (started April 2023) 4. Implementation of five high-impact actions for recruitment 5. ICS People Framework to enable cross-organisational working (in place). 6. Initiation of system-wide project on agency spend - Mobilise: March 2023 7. On-going recruitment activities at organisational level and at system level &development of a system wide recruitment campaign "Be in Gloucestershire" 8. On-going focus on health and Wellbeing initiatives for staff	**Updated 20/05/233** 1.Bids and new initiatives and proposals being developed with Clinical Programme Groups for 2023/24 HEE funding round) 2. System wide meeting on staff accommodation & international recruitment held 25/5/23 to identify potential areas of joint working 3. Retention lead is completing diagnostic position for system to inform future retention plan. 4. No change 5. No change 6. System wide meeting on agency spend delayed to 30/5/23 with review of position against regional self-assessment framework. 7. No change 8. Focus on potential to develop a system wide induction process relating to health and wellbeing.

	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

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<table>
<tr><td colspan="6">Strategic Objective</td></tr>
<tr><td colspan="6">Work together to address the financial challenge we have across the system to narrow the financial gap and deliver efficiencies</td></tr>
<tr><td>Risk Ref: 3
Strategic Risk</td><td>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</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>Open</td><td rowspan="3">4x4=16</td><td rowspan="3">4x4=16</td><td rowspan="3">4x2=8</td><td rowspan="3">↔</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Cath Leech, Chief Finance Officer</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>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.</td></tr>
</table>

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<table>
<tr><td>Aligned to current ICB Risks</td><td colspan="4">F&BI 18 - The ICB does not meet its breakeven control total in 2023-24 (noted that these risks are to be updated on ICB risk management system)
F&BI 21 - The ICS does not meet its breakeven financial duty in 2023-/24 (noted that these risks are to be updated on ICB risk management system)
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</td></tr>
<tr><td>Committee</td><td colspan="2">System Resources Committee
Audit Committee</td><td>Last Review & Update Date:</td><td>21/05/2023</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>Current Assurances (how do we know the controls are working?)</td><td>Gaps in Assurance</td></tr>
<tr><td colspan="2">• 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</td><td>• 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</td><td>• 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</td><td>• Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk</td></tr>
<tr><td colspan="3">Actions to mitigate risk & implementation dates</td><td colspan="2">Director’s update on actions to date (quarterly update)</td></tr>
<tr><td colspan="3">• 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.</td><td colspan="2">Updated: 21/05/2023
• 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
• Urgent care diagnostic implementation being planned, Directors of Finance will sit on the benefits realisation programme
• System wide financial risk sharing protocol in development</td></tr>
</table>

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	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

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Strategic Objective					
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.					
Risk Ref: 4 **Strategic Risk**	**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.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Zero**	**3x4=12**	**3x4=12**	**3x2=6**	
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	GHC 3 There is a risk of demand for services beyond planned and commissioned capacity				
Aligned to current ICB Risks	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				

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<table>
<tr><th>Committee</th><th colspan="2">Quality Committee</th><th>Last Review & Update Date:</th><th>23rd May 2023</th></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">• 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.</td><td>• 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</td><td colspan="2">• 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.</td><td>• Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.</td></tr>
<tr><td colspan="3">Actions to mitigate risk & implementation dates</td><td colspan="3">Director’s update on actions to date (quarterly update)</td></tr>
<tr><td colspan="3">1) 23/24 plan in place and submitted nationally. Awaiting full feedback from national team but moving to operationalisation.
2) Additional capacity investments via ERF approved and recruitment underway.
3) Additional capital investment (new theatres) with associated revenue funding agreed.</td><td colspan="3">Updated: 23/05/2023
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.</td></tr>
</table>

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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 delivery. 7) 19/20 baseline adjustment in place for 22/23 monitoring and 23/24 plans.		3) Two additional theatres at CGH to be completed by 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 in place in GHFT to assist with delivery of the 23/24 plan. 5) CDC on track for delivery as planned. 6) IAPs with ISPs currently in negotiation, ready for sign off alongside planning deadline. 7) Planning monitoring set up underway – assurance to be conducted through the Planned Care Delivery Board monthly through 23/24.
	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	

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Strategic Objective					
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					
Risk Ref: 5 **Strategic Risk**	**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.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Zero**	**5x2 = 10**	**5x2=10**	**5x1=5**	⟷
Strategic Risk Owner (Director)	**Dr Marion Andrews-Evans, Chief Nursing Officer** **Dr Andy Seymour, Chief Medical Officer**				
Aligned to other system partners risks (include ref no.)	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…				
Aligned to current ICB Risks	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				
Committee	**System Quality Committee**	**Last Review & Update Date:**	**23rd May 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**		

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<table>
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- 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

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- System Mortality Group (a previous gap) now set up. See directors comments)
- We have established that we need to develop more robust oversight of deviations from NICE.
- Our next ambition is to develop a System Safety Group linked to the development of the new Patient Safety Incident Response Framework.

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- Reporting to Quality Committee
- Quality Assurance discussions
- Contract Management Boards
- Regulatory reviews

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- We are assured that the governance process in place mean that we have full oversight.

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<tr>
<th colspan="2">Actions to mitigate risk & implementation dates</th>
<th colspan="2">Director's update on actions to date (quarterly update)</th>
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- 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)

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Update: 23/05/2023

- We have now set up our One Gloucestershire System Mortality Group which brings together representatives from the system's two main trusts, ambulance service, social care, primary care, public health and medical examiner to review how mortality is reviewed in each area and to share experience, learning and best practice across the system.
- The System Effectiveness Group (SEG) met recently and have established that we need more robust oversights on deviations from NICE, this includes deviations where we exceed NICE guidelines. The SEG will now work to close this control gap.
- A workshop for the Quality Committee is planned for 7th June to look at quality priorities and will reflect controls in assurance processes.

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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

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		Code	Description	
		S039a	Consistency of reporting patient safety incidents	
		S040a	Methicillin-resistant Staphylococcus aureus (MRSA infections)	
		S041a	Clostridium difficile infections	
		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	

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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 Risk Ref 4 – System Recovery (Restoring services inclusively)				
Committee	**People Committee**	**Review Date:**	**23rd May 2023**		
Current Controls (*what do we have in place to mitigate the risk?*)	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

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		(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.	• Coordinated 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. • Local Health Inequalities Improvement Dashboard (HIID) developed. Developed initially through the Health Inequalities Panel (HIP) comprising of quantitative indicators already identified in Marmot's Health Equity in England: The Marmot Review 10 Years On (2020), Marmot's Build Back Fairer: The COVID-19 Marmot Review (2020) and the NHS Long Term Plan (2019). • Incorporation of regular health inequalities measures into Integrated Performance Report to be undertaken (to commence June 2023).	**Updated: 23/05/2023** • Health Inequalities Improvement Manager post to commence 19th June 2023. • Provided additional detail on approach to identifying and responding to Health Inequalities within final Operational Plan submission for 23/24, especially the inclusive recovery of services. • Development work for reporting on health inequalities workstreams and progress is ongoing. • Work ongoing around ICB board level leadership for Health Inequalities. • Stocktake of all health inequality funded (non-recurrent and recurrent through programme budgets) underway. • Instigation of Health inequalities HI analysis mapping session taken place and cross organisational HI analytical network has been suggested to improve joint working across the ICS. • Stocktake of all health inequality funded (non-recurrent and recurrent through programme budgets) underway.

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

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	• Under development. • Health inequalities narrative at programme level to be included in bi-monthly integrated performance report.

Document Last Updated: 22/05/2023

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:**	**21st May 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	**Updated: 21/05/2023** • ICS contribution to Climate Leadership' Gloucestershire finalised including contribution to Gloucestershire Adaptation Plan • Initial meeting between GCC and the ICB on green travel plan
Relevant Key Performance Indicators: (taken from the Integrated Performance report)	

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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**	**2X3=6**	**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 7: Partnership Culture GHFT; BAF risk SR7: Failure to engage and ensure participation with public, patients and communities.					
Aligned to current ICB Risks						
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

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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. Internal audit and governance review of the ICB undertaken. 3. Individual review of the effectiveness of Committees to be carried out at an appropriate point 4. On-going ICB Board development programme 5. Evolution of ways of working to support system development and confidence around collaboration and risk sharing.	**Updated 20/05/233** 1. This group has now been mobilised. Group supporting review of draft People strategy. 2. BDO report on review of ICB Committee Effectiveness completed and will shortly be shared with ICB Board. The outcome of that audit will be reflected in the assurances. 3. o be confirmed subject to the review of the above. 4. Next development date scheduled for 6 June 2023 and programme of support for rest of year being developed. 5. Framework under development to enable system wide agreement to recruit staff substantively to key service development areas to improve viability, whilst specifying how potential risks will be managed and supported by partners.

	Relevant Key Performance Indicators: (taken from the Integrated Performance report) TBC – Annual 360 survey as part of review of effectiveness of ICB

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Strategic Objective
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB

		Original Score (I x L)	Current Score (I x L)	Target score (I x L)	Movement in score
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.				⬇ ⟷ ⬆
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:**	**23rd May 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.	• Prioritising EPRR on-call training is a priority to meet core standards. • Training is being offered monthly.	• 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)**
• We have now updated our On-Call rota system matching skills where possible to compliment those on-call. We have also brought titles in line with EPPR frameworks, with Manager and Senior on call being replaced with Tactical and Strategic leads. • A full programme of training has been set up, with a dedicated EPPR training manager in place.	• Our largest risk remain take up of ongoing EPPR training. By resetting On-Call processes we hope to be able to demonstrate the importance of remaining current with EPPR skills and knowledge. • Training is available each month via our dedicated EPRR training manager. • The reset rota for on-call Tactical and Strategic leads commences in June and runs until December, when we will have balanced on-call sessions for staff.

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

5x5 Risk Matrix

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

	Consequence				
Likelihood	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

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ICB Risk Appetite levels

Level	Description
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 31st May 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 ○ **Gloucestershire Primary Care Developments and Services** ○ **Cultural Commissioning – Our Creative Health Programmes** ○ **Clinical Programme Groups (CPG) working with Voluntary Care Services (VCS)** ○ **Operational Plan 23/24 update** ○ **NHS response to COVID-19: Stepping down from NHS level 3 incident**				
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.				
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)					

Impact on Health Inequalities	There are a host of schemes and services which are designed to tackle health inequalities in particular the work in the Cotswolds – cookery classes and Forest of Dean Diabetes projects both focusing on areas of deprivation West Cheltenham Health Inequalities Group has arranged for a family fun day is being planned for the summer linked to the Holiday and Activity Fund (HAF) programme. Our engagement has highlighted themes around public transport, food poverty, digital exclusion and the number of individuals with caring responsibilities within the community. Further data analysis has uncovered high levels of smoking, mental ill health and substance misuse (see more information contained in the report s.2.3.4)
Impact on Equality and Diversity	The Primary Care Dental Strategy concentrates of delivering services in all areas of the county with specific focus on areas of deprivation and groups that have had poor access to dental services. The ICB plans include offering specific training in oral health promotion to staff working with other vulnerable groups including but not limited to Looked After Children, care leavers, people seeking asylum, those who are homeless, people with a learning disability and Gypsy Roma Travellers. In addition, we will encourage take up locally of programmes already commissioned by NHS England, for example Supervised Toothbrushing and First Dental Steps.
Impact on Sustainable Development	Programmes of work are delivered as close to the local population as possible see the work on primary care and CPGs and VCS ensuring that people can access local services and not travel across the county to obtain support.
Patient and Public Involvement	A new Dental Strategy Group for the county which commenced work prior to the ICB taking delegated responsibility for the planning and commissioning of primary, community and acute dental services on the 1st of April 2023. Membership includes ***Healthwatch, two patient representatives***, Gloucestershire Local Dental Committee (LDC), NHSE, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHFT), the Southwest Dental Network, Gloucestershire County Council Public Health team and ICB staff.
Recommendation	The Board is requested to: • Note the contents of the CEO report
Sponsoring Director	**Mary Hutton, ICB Chief Executive Officer**

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

NHS Gloucestershire Integrated Care Board (ICB)

Chief Executive Officer Report

Wednesday 31st May 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. Gloucestershire Primary Care Dental Strategy

2.1.1 In my last update on this topic in January I reported on the formation of a new Dental Strategy Group for the county which commenced work prior to the ICB taking delegated responsibility for the planning and commissioning of primary, community and acute dental services on the 1st of April 2023. Membership includes Healthwatch, two patient representatives, Gloucestershire Local Dental Committee (LDC), NHSE, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHFT), the Southwest Dental Network, Gloucestershire County Council Public Health team and ICB staff.

2.1.2 The group has utilised NHS England's dental roadmap and is in the process of working with local dentists via Gloucestershire's Local Dental Committee to address the dental challenges of access, workforce and oral health. Plans, which are in draft form currently and which need to go through due diligence and governance processes, include: increasing access to urgent appointments across the county; the development of a primary care access centre in Gloucester City; developing & extending local apprenticeship, T level and training offers in conjunction with local college and university providers; developing a service model for enhanced dental health in care homes which could include dedicated Dental Care Practitioner support to care home staff, a Train the Champion Oral Health Training Programme and a pathway to enable residents to access dental care when needed.

2.1.3 Our plans also include offering specific training in oral health promotion to staff working with other vulnerable groups including but not limited to Looked After Children, care leavers, people seeking asylum, those who are homeless, people with a learning disability and Gypsy Roma Travellers. In addition, we will encourage take up locally of programmes already commissioned by NHS England, for example Supervised Toothbrushing and First Dental Steps.

2.2 Primary Care Networks (PCN) Quality Improvement Projects

2.2.1 In March 2021 and March 2022 PCNs received (non-recurrently) £1.6 & £1 million respectively to support Quality Improvement (QI) initiatives. These initiatives are driven by population health management (PHM) to support the identified population needs. The funding was for new schemes/initiatives or to complement an existing scheme but could not duplicate any other

funding. They are aimed at both recovery and sustainable change within PCNs. The projects are ground up initiatives to target PCNs specific population health challenges. Topic areas being delivered between our 15 PCNs include: Frailty, Dementia, Respiratory, Children & Young People (CYP) Mental Health and Dermatology. We are monitoring and supporting PCNs with evaluating their QI Projects to help learn and share the impact this funding has made for the differing PCN populations. So far, we have had promising information for many of the projects, for example Tewkesbury with Newent and Staunton PCN's frailty project has supported the identification of moderately frail patients and implementing interventions such as strength and balance classes to help people stay well for longer. Inner City has focused on respiratory care and developed a Community Respiratory Clinic supported by secondary care as well streamlining the approach to respiratory care across the PCN to ensure it is consistent. Earlier this week, the Respiratory Champion leading this work won a National award for respiratory excellence at the Association of Respiratory Nurse Specialists annual conference.

2.2.2 A further £950k has been secured for 2023/24 Quality Improvement Initiatives. PCNs have been asked to share proposals which use Population Health Management (PHM) methodology and health inequalities information to prioritise projects which either continue existing schemes or within the parameters of Chronic Disease (i.e. Respiratory, Diabetes), Mental Health (adults and Young People), Frailty and Dementia (incl. palliative care) and/or linked to the ICP priorities (e.g. Hypertension and reducing smoking).

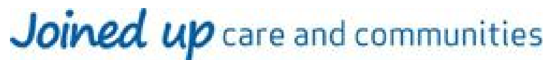
2.3 Integrated Locality Partnerships

2.3.1 Partners from our six Integrated Locality Partnerships deliver a range of projects to promote heath and wellbeing, impact the root causes of health inequality and support people to live well at home. Three examples of our work are shown below.

2.4 Areas of greatest deprivation in the Cotswolds

2.4.1 One of the ways that we have been able to engage the community in the Beeches area of Cirencester was by hosting healthy eating and cooking classes. The classes offered families the opportunity to attend free sessions to increase their cooking skills as a family, learn to cook affordable healthy meals, share a meal with other families and take home a cookbook and utensils to encourage them to continue to cook at home. The healthy cooking sessions were funded from the Community Investment Fund which was a sum of money from NHSE which was allocated to each ILP in the county to help address the health impact of the cost of living crisis. The YouTube clip here https://youtu.be/9K8FwU-wtV8 features the cooking classes. The next steps are to run a series of family fun days, continue the healthy cooking and eating classes and host a Look Again Mindful Photography for Mental Health Wellbeing and Resilience workshop to introduce people to mindful photography and use this as another way of gathering different insights and perspectives on the strengths on which to build on with the local community.

2.5 Forest of Dean and Pre-Diabetes



2.5.1 The Forest of Dean has the highest prevalence of both diabetes and pre-diabetes compared to the county as a whole with the rate of pre-diabetes in individuals under the age of 50 increasing. An initial focus was on people aged 50 and under who had not taken up the offer of referral to the National Diabetes Prevention Programme (NDPP). Following learning from a health coaching model used successfully in primary care in another locality, a similar approach was taken to offer a localised, face-to-face alternative to those who had previously declined the NDPP. This was run with support from a practice nurse and a health coach from the District Council. This initial cohort has recently finished the local programme and whilst the number of participants was smaller than hoped initial findings have been very positive. A second cohort is planned with the possibility of a hybrid delivery model offering both face-to-face and online access for individuals. Once sufficient individuals have completed the programme fuller evaluation will take place on the feasibility of this offer longer term.

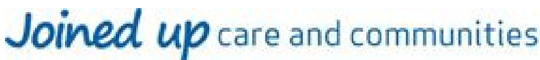
2.6 Health Equality in West Cheltenham

2.6.1 The West Cheltenham Health Equalities Project group was established following a review of health inequality data at Cheltenham ILP which showed a 10 year life expectancy gap. These 'life years lost' for males in West Cheltenham wards compared to the rest of Cheltenham prompted the coming together of organisations and agencies to promote health and wellbeing in the community. The West Cheltenham project group, which includes ILP members have been working with the community over the past year. To date we have held six workshops, two community engagements and wider engagement via a questionnaire, and a recruitment event for a Health and Wellbeing Champion Lead funded for two years by the Strengthening Local Communities funding. A family fun day is being planned for the summer linked to the Holiday and Activity Fund (HAF) programme. Our engagement has highlighted themes around public transport, food poverty, digital exclusion and the number of individuals with caring responsibilities within the community. Further data analysis has uncovered high levels of smoking, mental ill health and substance misuse. By taking time to build relationships with residents, local voluntary sector and service providers the group hope to increase opportunities to build on the strengths that already exist in the community and increase take up of local health and wellbeing offers.

3. Our Creative Health Programme

3.1 Our Creative Health programme continues to develop and thrive. These programmes aim to support people with various health conditions offering psychosocial support and an element of teaching and embedding self-management techniques in people's daily lives. The peer support people get from the programmes is a crucial element of this, as are the progression routes the programmes offer to ensure the support is sustainable. Our current programmes are listed in the table below.

3.2 We work closely with Gloucestershire Creative Health Consortium for most of these programmes. The 5 partners in this are Artlift, Artspace, Art Shape, The Music Works and Mindsong. We utilise a variety of evaluation methods, including an adapted Public Health England template, case studies and films and we have also worked closely with these organisations to develop a robust minimum dataset to collect and analyse the quantitative evidence of the impact this is having on



the individuals involved as well as the wider system. This is in part achieved through the Consortium partners collecting NHS numbers so that we are able to demonstrate system impact, as well as using validated outcome measures for each programme. This is supported by our co-production approach to the programme, ensuring we are continuously improving. Our current programmes are listed below. As one Mindsong participant recently said “You are not just looking after your chest and breathing, you are looking after the whole of yourself and your whole body”.

3.3. Cultural Commissioning programme

Title	Health conditions supported	Provider	Referral Route
Living Well with Pain	Adult Persistent Pain	Artlift	referrals@artlift.org
Breathe in Sing Out	Adult respiratory and Long Covid	Mindsong	ruth.melhuish@mindsong.org.uk / self referral
Sing 2 Remember	Dementia / Isolation/ loneliness in community	Mindsong	paige.halliwell@mindsong.org.uk
Music Therapy @ Home	Dementia / carer support at home	Mindsong	maggie.grady@mindsong.org.uk
Mindset	Dementia at diagnosis (8 wk psychotherapy course)	Mindsong	paige.halliwell@mindsong.org.uk
Create Well	Adult mental health	Artlift	Website/Self referral or referrals@artlift.org
Social Isolation and Loneliness support	Perinatal	Art Shape	Through midwives/health visitors/social prescribers – yet to start
Social Isolation and Loneliness support	Post ICU	Artlift	Through Post ICU Community Clinics
Create Well After Covid	Covid 19 and employment	Gloucestershire Creative Health Consortium	
Work in progress	Cardiac Rehab – heart failure	Gloucestershire Creative Health Consortium	Yet to start

4. Clinical Programme Groups (CPG) working with Voluntary Care Services (VCS)

4.1 NHS Gloucestershire ICB and Gloucestershire VCS Alliance are planning to run a joint event focusing on connecting the work of Clinical Programme Groups to the wide ranging work of VCS Organisations. The event will be an opportunity for shared learning between the local VCS and clinical programmes using focus groups and networking sessions to discover how we can work together better, to improve the health and wellbeing of the population. There will be shared information about the work of the VCS, the priorities of a range of NHS led clinical programmes as well as sharing of examples of partnership working that are already leading the way in Gloucestershire.

5 Operational Planning 2023/24: Update

5.1 Operational Planning guidance is published each year by NHSE in late December. Systems are required to produce a draft plan by the end of February, with the final plan confirmed at the end of March. However, this year the planning round extended to the beginning of May. The scope of the Operational Plan is defined by the NHSE published guidance and templates, with a focus upon key national priorities.

5.2 The operational plan consists of three central components: activity/performance, finance and workforce numerical submissions, supported by accompanying narratives for both activity/performance and workforce. The plan is therefore not reflective of the full remit of the ICB; it provides an opportunity for Gloucestershire to respond to national priorities detailed within the planning guidance as well as locally determined priorities for our system. The Operational Plan aligns to the wider Joint Forward Plan and Integrated Care Strategy – both of which span a longer duration (5 years) and reflect the wider scope of the ICB:

5.3

2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28
5yr Integrated Care Strategy
5yr Joint Forward Plan
1yr Operational Plan 23/24

5.4 Gloucestershire's Operational Plan is informed by the Integrated Care Partnership Strategy as well as national priorities. It was developed jointly with system partners and submitted on 30th March. The 4th March resubmission allowed us to make a number of final minor revisions in

response to feedback received from the NHSE regional and national teams. The Board has reviewed previous drafts of the 23/24 Operational Plan. This update outlines the key aspects of the plan and details revisions contained in the May 4th submission from previous iterations.

5.5 National priorities are communicated through the Operational Plan templates, and included a focus on Elective Recovery, Urgent and Emergency Care, and Mental Health. Key commitments within the plan for Gloucestershire include:

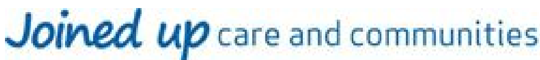
Domain	Commitments
UEC	• Average G&A bed occupancy of 92% • Cat 2 ambulance average handover time of <45 mins (agreed at regional level, not system) • Reach 80% adherence to 4-Hour A&E performance by November '23 • Provide capacity for 223 'beds' on Virtual Wards by March '24
Elective	• 109% Cost-weighted activity (compared with 19/20 baseline) • Eliminate all non-admitted >52 week waits by December '23
Cancer	• Meet the Cancer Faster Diagnosis Standard (75% within 6 weeks) • No more than 150 patients waiting >62 days between referral and starting treatment by March '24
Mental Health	• No more than 50 inappropriate out of County bed days in Q4 • 66.7% Diagnosis rate for people with dementia by March '24

The changes made in the May 4th submission were minor changes to the Urgent and Emergency Care and Workforce assumptions.

5.6 There are risks relating to full delivery of the plan. The Operational Plan is financially balanced. However, within the plan there are efficiency and savings targets for system partners. Inflation also presents a risk to financial balance, including inflation within the care market and cost of drugs. Elective activity within early Q1 of 23/24 has also been affected by industrial action, and it is crucial to ensure the pace of elective activity recovers to ensure the delivery of the additional activity detailed within the Operational Plan. Full achievement of the Elective Recovery Fund is also assumed within our plan for financial balance. Urgent and emergency care challenges are still evident within the system, and it is important that transformation schemes deliver improvement if we are to achieve the Urgent and Emergency Care performance commitments within the Operational Plan.

5.7 It will also be important to closely monitor in-year delivery of the plan to provide assurance that performance is on-track and to inform corrective action when it is not. We are therefore incorporating monitoring of the Operational Plan within routine performance monitoring. Key monitoring arrangements include the production of an Operational Plan performance dashboard. The dashboard will provide in-year monitoring for all commitments detailed within the Operational Plan. The dashboard will be produced in collaboration across the system and will be analysed by cross-organisational groups to flag and highlight areas of concern or underperformance to the relevant programme groups /Boards in order that corrective actions can be agreed and implemented.

6. NHS response to COVID-19: Stepping down from NHS level 3 incident



6.1 On 19 May 2022, the ICB received a letter from Amanda Pritchard, NHS Chief Executive Sir David Sloman, NHS Chief Operating Officer outlining the steps the NHS would need to take to transition from COVID-19 response to recovery. As part of that response, the national NHS level 4 incident was stepped down to a level 3 incident.

6.2 It is noted that the NHS continues to see waves of COVID-19 infection. But, partly thanks to the outstanding NHS vaccination programme, none have been as significant in terms of loss of life as those in 2020-21. Although the NHS will continue to care for COVID-positive patients the NHS is now in a position to move to the next stage in its COVID-19 response. England is not alone in seeing this trend. The World Health Organization has also recently announced that COVID-19 is no longer a Public Health Emergency of International Concern.

6.3 Stepping down the incident is of course done in the knowledge that COVID-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and we will also need to continue to provide services for those suffering the effects of 'long COVID'. The NHS will continue to collect data on individuals who have died with COVID-19 and collecting outbreak information as part of its incident management plan.

7. Retirement of Deborah Lee, Gloucestershire Hospitals NHS Foundation Trust

7.1 Deborah Lee will be retiring from her role as Chief Executive Officer of GHFT after a total of 40 years working in the NHS. The ICB Board wishes to thank Deborah for the contribution she has made to working collaboratively and collegiately with colleagues across the ICS allowing a sound bedrock to the creation of the ICB and the successful continuation of the ICS. Deborah remains in post until March 2024 with a challenging plan to deliver.

8. Review of Gloucestershire plan by the national NHSE Executive team

8.1 On April 24th Gloucestershire ICB met with the NHSE Executive team to discuss the 2023/24 plan. This was a helpful discussion where the progress to date was recognised. We also had a discussion on the risks in the plan and explored the underlying financial position and the actions in place to ensure our financial delivery will ensure we improve our underlying position.

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Agenda Item 9

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

<table>
<tr><td>Report Title</td><td colspan="5">Integrated Performance Report</td></tr>
<tr><td>Purpose (X)</td><td>For Information</td><td></td><td>For Discussion
X</td><td></td><td>For Decision</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">N/A
<table><tr><td>ICB Internal</td><td>Date</td><td>System Partner</td><td>Date</td></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>Executive Summary</td><td colspan="5">This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for May 2023. The report focuses on our closing position for 2022/23 (where information is available). Please note that the financial position is currently unaudited and ICB will receive the final audited accounts at the Extraordinary meeting on 28th June.

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. Ensure that the measures and trajectories for 2023/24 are as confirmed in operational planning are incorporated into the plan so that we are assessing progress in delivery.
3. We will also be giving visibility to the ICB of longer-term outcomes (report to be available every 6-12 months).</td></tr>
</table>

<table>
<tr><td rowspan="2">Key Issues to note</td><td colspan="4">Areas of key exceptions have been included at the front of the Integrated Performance Report.</td></tr>
<tr></tr>
<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">See Performance section of the report.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">See Performance section of the report.</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 or development points that may be required</td></tr>
</table>

Author	**Performance:** **Kat Doherty** **Workforce:** **Tracey Cox** **Finance:** **Chris Trout** **Quality:** **Rob Mauler** **PMO:** **Mark Golledge**	**Role Title**	Senior Performance Management Lead Director for People, Culture & Engagement 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** – Director for 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

Integrated Performance Report

May 2023

Please note – this report will be a public report *(published bi-monthly)*

System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	4th May 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Health Economics Board Development Session	N/A	Committee reviewed and discussed plans for Board Development session at the end of June, to focus on Health Economics and how we understand future demographic changes – and what that means for the health system in Gloucestershire.	Finalise plans for the Board Development Session in June.	End of June 2023.
Approach to Evaluation	Limited	Committee received presentation on the approach to evaluation undertaken by the Cultural Commissioning Programme and discussed work required to strengthen our approach to evaluation.	Evaluation Task & Finish Group to be set up and inform work being undertaken on evaluation (including the areas of respiratory and diabetes)	End of June 2023.
Performance	Limited	Reports provided to the Committee detailing performance achieved in 2022/23 and 2023/24 areas of focus & priorities. Summary produced showing 2022/23 outturn and 2023/34 outcast against system plans. Whilst not all targets have been met in full, we have made significant progress throughout the year and forecasting improvements in performance for 2023/24.	Present performance update to ICB and establish monitoring arrangements for 2023/24 against the planning commitments.	End of May 2023.
Finance	Awaiting Audit Opinion	Committee reviewed the unaudited outturn position for 2022/23 (Audited outturn to be presented to ICB at end of June 2023). The committee also discussed the 2023/24 Financial Plan, including the delegation arrangements for Pharmacy, Optometry and Dentistry (POD)	Auditor review of 2022/23 financial position and presentation to ICB at the end of June 2023. Monitoring arrangements to commence for 2023/24 against planning commitments.	End of June 2023.

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

People Committee

Accountable Non-Executive Director	Tracey Cox
Meeting Date	27th April 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
On-going threat of industrial action and uncertainty around acceptance of pay offer by various Unions	Limited	Committee was informed of pending NHS Staff Council discussions on 2nd May at which national pay award would be confirmed. (Now completed). Further risk of further industrial action by nursing and ambulance staff despite pay award.	Communications to staff on pay award arrangements including option to request instalment arrangements as may be required for staff in receipt of universal credit payments.	May/ June 2023
Inadequate workforce supply & challenges with recruitment and retention 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. System wide retention lead now in post and completing initial diagnostic work,.	Mobilisation of system wide campaign highlighting the benefits of working and living in Gloucestershire	Some slippage- June/July 2023
System wide review of staff survey results	Significant	System partners set out high level actions in response to recent staff survey results	Delivery of organisational level plans and identification of shared approaches.	Remainder of 2023/24 with further review in 6 months time.
Delays in national allocations of Continuing professional development funding and workforce transformation allocations for 2023/24	Limited	We are waiting for notification from NHS/HEE on 23/24 position but partners continue to plan on assumption of last year's allocation	Bids for transformation funds are being developed	Review of bids at People Board meeting in June

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

Topic	Committee
None	

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	12th April 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Recruitment figures for the Children in Care Team	Limited	The Designated Doctor Children in Care and Child Death vacancy remained open with no applicants having come forward. No function currently in place as of March 2023. Recruitment is underway for this post but it is proving difficult to fill.	Discussions re the Child Death medical function are underway with Executive Chief Nurse and GHFT but this remains an ongoing risk. An updated will be brought to the June Quality Committee.	June
Delay Related Harm	Limited	The committee had previously received information on community based delay related harm. At this meeting this was widened and issues raised by adult social care in relation to delay related harm in Discharge to Assess beds, and with the discharge process in general.	More information has been requested by the committee and will be brought to the next meeting. Additionally, targeted work is underway by the UEC team regarding the patients in the D2A beds.	June
Podiatry, Optometry and Dentistry (POD)	Limited	Many of the South West ICBs had attended a recent event in Taunton about the delegation of POD commissioning. The ICB remain concerned at the lack of clarity around responsibility for service quality following delegation.	The GICB had asked for a Transition Plan but there are still concerns around the quality of data and information in respect of service quality and safety. Regular meetings are now taking place with NHSE to address the concerns.	June

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
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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

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

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements in 2022/23

- A number of new pathways and services have been operationalised in 2022/23 to support timely care in the most appropriate setting: for example the Community Assessment and Treatment Unit (CATU) supporting frail patients who would otherwise have had an acute admission, non-specific symptoms pathway for suspected cancer, and falls service expansion to cover both injurious and non-injurious falls.

- Gloucestershire is on track for the new diagnostic hub in Gloucester city to be fully operational by October 2023. Additional capacity across Non-obstetric ultrasound, CT, plain film x-ray and MRI is already operational. Focus on diagnostic recovery has led to significant reductions in the number of patients waiting over 6 weeks in all modalities, particularly echocardiography which has now cleared its backlog.

- Good progress has been made throughout the year reducing the number of long elective waits – Gloucestershire providers continue to have no 104 week waits for elective care, with GHFT declaring zero 78 week waiters at the end of 2022/23.

- The system has collaborated to mitigate the impact of industrial action which has been successful, with minimal disruption to Urgent Care provision and system mitigations including temporary changes at Cheltenham General Emergency Department to support staffing where necessary.

- Improvements in access to services and wider support for people with Serious Mental Illness have been seen throughout 2022/23, with many more people having a full physical health check and taking up subsequent interventions to manage their health across primary care and community mental health.
- Gloucestershire primary care practices continue to provide high levels of appointments, with good results compared to the national picture for patient satisfaction and access in the national GP survey.

Improving Services & Delivering Outcomes

Our Performance

2023 / 24 Areas of Focus and Priorities

- Elective recovery – an ambitious recovery plan has been submitted for 23/24 to achieve the equivalent to 109% cost weighted activity compared with our 2019/20 baseline. This will be a significant challenge and relies on all parts of the system (GHFT, Independent Sector and Out of County NHS hospitals) delivering activity in line with our forecasts. Industrial action has had more and more impact on elective activity especially in more recent months – there is a risk that this plan will be unachievable if this continues. Pathway transformation will continue to support the elective programme - 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, as well as scoping work to learn from areas currently undertaking hip surgery as day cases.

- 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 require the delivery of additional activity and increased productivity to achieve this, with an expected increase in 52 week waits temporarily seen during 2023/24 while longest waits are reduced.

- The Urgent and Emergency Care Clinical Programme Group will focus on delivery of the commitments made for 23/24, including reduction of waiting times in emergency departments and reduction in stays in acute hospital. While the national operational plan for 23/24 is focussed on the acute metrics, Gloucestershire system plans will widen the spotlight to ensure our plans are reflective of all partners contributing to the delivery of urgent care. The ongoing transformation programme will ensure that during 23/24 our virtual ward provision will increase with a new digital provider coming online in year (Doccla), further alternatives to acute hospital care will be rolled out and the system will work towards a single point of access for many urgent care services – for example the roll out of the secure email referral to the SPCA from SWAST.

Improving Services & Delivering Outcomes

Our Performance

2023 / 24 Areas of Focus and Priorities

- A national Delivery Plan for Recovering Access to Primary Care is expected to be published imminently, which will support practices nationally to improve access. This will be a focus for Primary Care alongside ongoing work to support staff and increase resilience in the face of continued high demand.
- The system will continue to focus on reducing waiting times and increasing access across mental health services – in particular focussing on the provision of IAPT (Talking Therapies Service), and community support for people with Serious Mental Illness.
- New commissioning responsibilities/ transition arrangements for the delegation of NHS England's direct commissioning functions to integrated care boards will continue throughout 2023/24 (for pharmaceutical, general ophthalmic and dental services).
- Following CQC visits, work will continue with maternity, surgical services and PPG to address points raised by the regulator. In all cases action plans have been developed and the system will continue to assure their progress into 2023/24.
- For cancer services, a new trajectory has been set out to ensure patients are not waiting more than 62 days for cancer treatment unless unavoidable. 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). The non-specific symptoms pathway is set for further expansion with additional resource due to commence in 2023/24.
- The endoscopy recovery programme at GHFT will support continued improvements in waiting times for colonoscopy, flexi sigmoidoscopy and gastroscopy throughout 2023/24 in order to meet the national target of no more than 15% of the waiting list waiting more than 6 weeks (in 23/24). All other tests are currently meeting this expectation locally.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Apprenticeships:
- 13% increase in apprenticeship starts across the system in 22/23
- 22% Increase in levy transfer spend and 32% reduction in expired levy in 22/23

Widening participation:
- 'We want you' outreach project lead appointed and 2 x project officers to be appointed in May. Preliminary scoping work underway
- Primary care work experience and outreach projects to promote and centralise work experience opportunities in primary care (particularly non-clinical roles)
- 50/50 and 30/30 initiatives being explored to support 50 over 50's into a health and social care work setting and 30 people with additional barriers into work experience opportunities across the system

ICS People Strategy Development
- ICS wide engagement workshops were held focusing on Health and Wellbeing and (clinical) Education and Professional Development
- First draft of strategy published and shared with ICS People Board and People Committee including 'Strategy on a Page' Summary.

ICS People Function
- Recruitment of Programme Manager to support strategy development and Implementation

Areas of Focus

Apprenticeships:
- Develop a system-wide apprenticeship and widening participation strategy, to include and easy access 'one stop shop' apprenticeship guide
- Utilisation of data metrics to accurately forecast and monitor apprenticeships across the system
- Continue to promote and encourage apprenticeships across the system at all levels for new to role and role development opportunities

Widening participation:
- Development of a widening participation system-wide network to develop a set of key priorities for the system for the next 12 months, that will capture the current and planned work streams in this area.

ICS People Strategy
- On-going engagement to support development of strategy

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality

Key Achievements

- The ICB has established a new System Mortality Group with support from all partners. This new strategic group aims to bring together information and data on mortality to challenge and explore how we can improve areas identified as outliers with a focus on population health.
- The number of 'boarded' patients in GHFT has been slowly reducing from December and this practice has ceased being used by May. Staff had raised concerns that they wanted boarding to stop as this affected the privacy and dignity of the patients and the movement between hospital wards impacting on continuity of care.
- Successful recruitment of Midwives to Senior Matron, Head of Midwifery roles and Consultant Midwife roles.
- The local maternity service has become a pilot for 'Black Maternity Matters'.
- Gloucestershire Local Maternity & Neonatal Equality & Equity Strategy and action plan has been published. This strategy aims to improve outcomes and experiences for women/birthing people and families.

Areas of Focus

- The Quality Committee agreed to support work to develop a proactive approach to risk and system pressure management based around clinical pathways and patient outcomes.
- The new Head of Quality and Performance for Adult Social Care is conducting a review of Quality. The Review will provide information on what the current situation is across the county and will lead to the development of the Adult Social Care Quality Assurance Management plan.
- The CQC has released interim guidance on how they will inspect the ICS. We will be working with system partners to start to prepare for the new inspection regime which unlikely to commence until 2024 though pilots will be run in 2023.
- The 3 year Maternity & Neonatal Delivery Plan has been published by NHSE. The LMNS and GHFT are working closely to implement it recommendations by developing one integrated action plan.

Finance and Use of Resources

Finance

Headline Summary

- The ICS unaudited outturn for 2022/23 is £113k surplus;

	£'000
GICB	19
GHFT	51
GHC	38
Total Surplus	**108**

- During the year, the ICS has had a number of key financial pressures. These included:
  - Under-delivery of savings and efficiency plans
  - Workforce pressures leading to increased expenditure on agency and locum staff
  - Inflation – pay and price; one significant element of this is No Cheaper Stock Obtainable (NCSO) with a pressure of £3.3m.
  - Demand and growth pressures; specifically for CHC and children's placements.
  - Provision for estimated costs for Band 2 to 3 for certain staffing groups.

- These pressures have been mitigated through a number of primarily non-recurrent means, including additional allocations, non-recurrent savings, slippage in investments and other non recurrent measures.

- Recurrent pressures from 22/23 have been built in to the 23/24 plan. This is at a point in time and certain pressures such as inflation have been estimated and there is now growing information that suggests inflation in specific areas, will continue.

- Within the ICS's capital envelope, capital expenditure has variance by £3.6m against the budget for the year, which mainly relates to changes and slippage against lease implementations for IFRS16. Additional allocations were received for a number of schemes for both GHC and GHFT, and which now show as forecast variances.

Improving Services & Delivering Outcomes (Our Performance) (System Resources Committee)	Our People (People Committee)
Quality (Safety, Experience and Effectiveness) (Quality Committee)	Finance and Use of Resources (System Resources Committee)

Our Themes

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Improving Services & Delivering Outcomes

Urgent & Emergency Care 22/23

- Annual Emergency Department (ED) type 1 performance was 57.7% (GHFT) in 2022/23, with all ED (including MIIU) performance reaching 72.1%. Performance has improved slightly throughout the year, with March 2023 at 58.9% against the 4 hour target for Type 1 activity and whole system performance including Type 3 (MIIU) attendances at 72.3%. Gloucestershire system ranked 17/41 ICSs with Type 1 ED activity nationally.

- The national standards for Ambulance Response times are 7 minutes for Category 1 (life threatening) calls, and 18 minutes for Category 2 (serious conditions which may require urgent transport) calls. In common with many areas of the country, these targets have been missed in Gloucestershire throughout 2022/23. Average Category 1 response times have been in excess of 9 minutes throughout the year, and the yearly average for Category 2 response times in 58 minutes, although this has improved in Q4 of 2022/23 to an average of 37 minutes. Improved performance has been supported by improving handover times – with time lost to handover delay reducing considerably over the year (March average was 2743 hours lost compared to a yearly average of 3762 hours lost.

- 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 (NCTR) (at the end of 22/23 an average of 180 patients were in the acute hospital with NCTR, down from previous levels of ~250) and are continuing to improve.

- A review of winter 22/23 was carried out on April 24th 2023, with the whole system represented. This was a positive day with good engagement from all stakeholders. The feedback from the session will be fed into the transformation programme going into 23/24 and to support a year round plan.

- Community services have seen an increase in MIIU use by people over winter – potentially due to focussed work on directing patients to appropriate alternatives to ED. The launch of the CATU at Tewkesbury, widening of the community falls service and continued use of rapid response has shown good outcomes in keeping people out of the acute hospital where possible throughout 22/23, with further work planned for 23/24 to support the transformation programme.

Improving Services & Delivering Outcomes

Elective Care 22/23

- The waiting list for elective care has been growing throughout 22/23, Overall the waiting list has grown by 25.3% (57,674 in March 2022 to 72,237 in March 2023) with the majority waiting at GHFT. 71.2% of the RTT waiting list had been waiting less than 18 weeks in March (against a target of 92%), with 1,795 patients waiting over 52 weeks, 250 waiting over 65 weeks, 10 waiting over 78 weeks and 1 waiting over 104 weeks. GHFT eliminated all over 78 week waits in March 2023 in line with national expectations (over 78 week/ 104 week waits for Gloucestershire patients in March occurred at out of county providers).

- The majority of elective long waits are currently occurring in surgical specialties (ENT, T&O, Upper and Lower GI surgery, Vascular Surgery, Urology and Gynaecology). To support surgical activity a number of actions have been identified to support all specialties:
  - Additional locum and substantive posts across specialties with long waits.
  - Ring fencing of elective capacity (particularly through the winter period to ensure stable throughput).
  - Additional GLANSO and insourcing lists where required.
  - Two 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).
  - Productivity and efficiency schemes: including the implementation of the Four Eyes Insight review recommendations, system visit to Devon to adopt day surgery for hip & knee replacement.
  - Strategic site development to include reconfiguration of surgical beds (to help address capacity issues) and further ringfence elective beds.

- Recovery of weighted cost activity for the Elective Recovery Fund target is currently expected to achieve the 104% target in March 2023 once all data is available (activity will continue to be coded for some time – a full position is likely to be available at the end of May 2023). *N.B. Counting and coding changes have been agreed with NHSE which resolves issues with underreporting of system recovery rates. Note that historic activity data will not have had these changes applied.*

- Theatre utilisation rates have been improving throughout the year – future lists are booked above 85% at GHFT.

Improving Services & Delivering Outcomes

Primary Care 22/23

- Activity in primary care has been increasing year on year as patient demand remains high – with 2022/23 seeing an increase of 16.5% on the number of appointments in general practice (national appointment data) compared with the 2019/20 baseline.
- Primary care metrics are all performing well with rates of appointments, rates of GPs workforce, rates of direct patient care staff, and experience of making a GP appointment all benchmarking in the top quartile compared to other ICBs across England. Gloucestershire ICS is ranked 1/42 systems for both rate of GP appointments carried out and for experience of making a GP appointment (Annual GP survey, July 2022).
- Primary care has been instrumental in the roll out of vaccination for COVID and other vaccines throughout 2022/23. The Primary Care Network delivery model for COVID vaccination has been particularly successful and has led to Gloucestershire ranking 13/149 local authorities for uptake of the primary COVID vaccination course (Dose 1 and 2).

NHS111 and OOH 22/23

- Call answering performance has been challenging in the NHS111 service throughout 22/23, but particularly during the pre-Christmas period due to increased demand on the service (Strep A and COVID/Influenza peaks). Staffing remains a significant challenge across the service (in common with the Out of Hours service) meaning performance has remained below target, though has generally been stable.
- Out of Hours performance for call back times have been an area of focus throughout 22/23, as around 30% of call backs have been occurring outside of target times (regardless of call severity). Staffing remains the main barrier to performance improvement with shift fill challenging particularly over weekends and bank holidays.
- Our focus continues to be upon working with our provider (PPG) to improve performance, with a particular focus upon timely access.

Improving Services & Delivering Outcomes

Diagnostics

- Due to the severe service disruption seen in the early part of 2020/21, there was a significant decline in diagnostic activity with a dramatic increase in patients waiting longer for a diagnostic test. Recovery from this has continued throughout 2022/23, with national expectations set to ensure that by the end of 2023/24 less than 15% (rather than 1%) of the waiting list have waited for 6 weeks or more for their test. Performance in Gloucestershire has already met this target ahead of plan – with 6.3% of patients waiting more than 6 weeks in February 2023.
- Diagnostic waiting lists have continued to decrease with 8,477 patients on the waiting list at the end of February 2023, down from 9,244 in January. This is 13% lower than the 19/20 pre-COVID average of 9719.
- Additional echo insourcing capacity has been established and continues 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 150 patients are waiting over 6 weeks for echocardiography (at the end of February 2023). Activity planned for this test will ensure that the backlog is cleared by the end of March 2023.

Cancer 22/23

- While we have seen a slight deterioration in our 2-week wait (patients to be seen within 2 weeks of an urgent suspected cancer referral) performance in 22/23, we continue to benchmark well against other systems nationally and have delivered the 75% Faster diagnosis standard (75% of patients receiving a diagnosis or “all clear” conformation within 28 days of referral). Performance improvement will be supported by the ongoing recovery in diagnostics and the provision of additional capacity from the Community Diagnostic Centre, use of timed pathways and the development of the Non-specific symptoms pathway which was rolled out in 2022/23.
- Cancer treatment activity has remained high throughout 2022/23; this has been achieved by protecting cancer services during periods of operational pressure and continuing service redesign. The majority of breaches of the treatment target have been for Lower GI and Urological cancers, where specialties and diagnostic provision are still recovering from disruption during the pandemic. Targeted work to support improvement includes additional capacity for specialist surgery in Urology and LGI and increased use of Faecal Immunoprecipitation Testing (FIT) to improve triaging of patients with suspected LGI cancer.

Improving Services & Delivering Outcomes

Adult and Children's Mental Health 22/23

- Out of Area Placements have exceeded planned levels (963 days declared in 22/23 against a plan of 800) but saw a substantial decline in use in the final two months of the year (13 days in February and March 2023). The system is currently focussed on improving discharge across all settings. This is expected to contribute to an improving picture throughout 23/24 acknowledging the difficulty in eliminating these placements completely.

- Uptake of physical health checks for people with Serious Mental Illness (SMI) have increased significantly in 22/23, with the full year position at over 56% of the SMI register receiving a full physical health check. While below the 80% national ambition, this represents a huge improvement from under 10% compliance at the start of the year.

- Improving Access to Psychological Therapies (IAPT) access has been below the planned levels throughout 2022/23. Referral volume continues to be below the level needed to meet this target, and higher than expected drop out levels in Q4 also contributed to the lower than planned access rates. Recovery performance continues to be on target, with March performance at 51.5% patients entering recovery, and the target met in all but two months in 22/23.

- Eating disorders - All waiting times targets for routine and urgent CYP and Adult referral to treatment were missed throughout 22/23 with the service under pressure from high demand and significant workforce challenges. Over 22/23, the team has significantly reduced the urgent adolescent assessment waiting list numbers and waiting times and focussed on providing alternative support to those who are waiting in collaboration with voluntary sector partners.

- Children and Young people's mental health access has continued to be high across all providers (GHC, TiC+ and Young Gloucestershire) throughout 22/23, with pressure on core CAHMS in particular to deliver the assessment within 4 weeks target. Additional capacity has been rolled out during 22/23, particularly for Mental Health Support teams, with further planned to support 23/24 access targets and reducing waiting lists across CYP services.

Year End Summary

	22/23 Outturn	23/24 Forecast
Urgent and Emergency Care	Amber	Amber/Green
Elective Care	Amber	Amber/Green
Cancer	Amber/Green	Amber/Green
Mental Health	Amber	Amber/Green
Community Care	Green	Green
Primary Care	Green	Green

The table shows our performance assessment against system plans for 22/23 – with recovery from the COVID pandemic, workforce pressures and the impact of industrial action still having an impact across most health and social care services. While not all targets have been met in full, we have made significant progress throughout the year and are forecasting our performance into 23/24 to continue to improve, meeting our commitments made through the operational planning process.

Improving Services & Delivering Outcomes (Our Performance) (System Resources Committee)	Our People (People Committee)
Quality (Safety, Experience and Effectiveness) (Quality Committee)	Finance and Use of Resources (System Resources Committee)

Our Themes

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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

- System-wide apprenticeship network in place to promote apprenticeship opportunities and drive workstreams forward. Whilst good progress on increasing apprenticeship numbers, we spent 74.8% of levy monies across the system in 22/23, so scope for further progress.
- TNA's in social care project- good connections being made and system-wide collaborations helping to drive project forward
- Support and development of widening participation and outreach initiatives across the system with the launch of the 'We want you' outreach project in May
- First meeting of the ICS Volunteering Network took place on 10th May with the aim of :-
    - Raising the profile of volunteering and increasing the number of active volunteers in the ICS
    - Diversifying the ICS pool of volunteers
    - Finding ways of supporting people into employment via volunteering

Looking After Our People

- International Recruitment (IR) - Focus on pastoral care for International recruits with cross system working on approaches including sharing of approaches with Gloucestershire Care Provider Association who are leading a regional IR project for social care.
- Health and Wellbeing - proposal to develop a shared system staff health and wellbeing induction approach
- Systems Thinking Master Classes commenced in early May

Belonging in the NHS

- ICS wide Reciprocal Mentoring programme launched on 25th April 2023.

New Ways of Working

- A briefing paper on challenges and opportunities in relation to staff accommodation has been prepared. Meeting to be held with Estates, Finance and HR leads to look at options for a strategic and shared approach to creating solutions.

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Our Themes

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Community and Mental Health

- Data relating to long length of stay in community hospitals continues to be monitored by GHC NHSFT with acknowledgement of the detrimental effect that prolonged hospital stays have on patients. Unfortunately, due to flow and capacity challenges across the system, some patients can experience a delay in discharge and the Trust continues to focus on escalation and working with system partners to expedite their discharge pathway. The Trust continues to collect data and identify themes in delays to inform and target their approach to escalation and requests of support.

- A recent NACEL Audit (National Audit of Care at the End of Life) has demonstrated high performance by GHC NHSFT within a number of End of Life metrics that demonstrate a continued commitment to providing an excellent standard of care to those patients at the end of their life across the Trust whether at home or in a community hospital.

Urgent and Emergency Care

- Work continues to systematically redesign the way care is delivered in the One Gloucestershire system. There has been an overall reduction seen in length of stay for patients at GHFT so far this year and work continues to focus on the 7 KPIs for the key system risk objectives. This includes work to cease ward boarding and continue to reduce handover delays.

Primary Care

- PPG - The ICB are proactively supporting the GP out of hours provider to address the recommendations in the CQC report and good progress is being made against the action plan,. All medication concerns have been addressed and resolved. PPG colleagues are now invited to and attending key UEC system meeting, including the daily position call. CQC re inspection was took place in April and we await the feedback.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- Gloucestershire ICB Assumed delegation of POD services as of the 1st of April 2023. Representatives from several ICB directorates (including Quality) attended a primary care delegation event in Taunton on the 29th of March. All SW ICB's were in attendance and discussions centred around how we collectively prepare for delegation. Gloucestershire ICB are one of several ICB's that have requested a POD transition plan and process, with work underway to formulate a draft transition plan. The ICB POD project group re-commence on the 26th of April with a focus on transition and operational aspects.

- Concerns regarding the timeliness and quality of data from NHSE continue however. Quality profiles for each service area have been received which provide some overview and detail regarding background, quality oversight and assurance, inspection visits, and current live quality issues for each service area.

Maternity

- Two final HSIB reports were received in April, both of which identify recommendations for the GHFT. These recommendations will be actioned and implementation monitored at the Trust Safety and Experience Review Group and by the LMNS/ICB.

- The CQC reinspected against the section 29A notice in the last week of April, the trust are expecting the letter of feedback imminently. 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 are being regularly reviewed.

- Ockenden update; the LMNS and GHT are undertaking a gap analysis regarding the actions for 'Ockenden 2'. Insight visits being led by the LMNS are being undertaken in July – planning is in progress, with the regional team. The Maternity Support Programme remains in place, currently undertaking a diagnostic review of Governance and leadership/structure

- Maternity Independent Senior Advocate (ISA) interviews are to be held in May. This role helps parents-to-be, new parents and families to have a voice and provide help.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Serious Incidents in March and April 2023

Incidents declared under the current framework

- One incident declared by NewMedica was classed as a Never Event. This involved the wrong interocular lens which had been used. The incorrect lens was replaced and the patient came to no harm.

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.

Mortality

- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has now reduced back to be within expected levels, as predicted.
- The first meeting of the new System Mortality Group met on 4th May. The group aims to bring together partners to look beyond mortality issues in individual areas or providers and focus our work at a population level.
- The whole system is represented on the group with everyone supporting the strategic approach. It was agreed that for the next meeting, the focus will be on some of the morality issues linked to urban and deprived areas flagged by a South-West report.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Patient Safety Incident Response Framework (PSIRF)

- Our Conversation Café held on 28th March brought together nearly 40 people from organisations from across the ICS. We also included the Academic Health Science Network and NHSE colleagues.
- The event was well received and focused on the opportunities that PSIRF will bring.
- Everyone will need to have transitioned from Serious Incidents to PSIRF by the autumn.
- The outcomes from the event will enable the ICB to start developing our own plan.
- Comments left by participants included:
  - PSIRF isn't about not investigating it's about taking a broader perspective.
  - I hope the new framework and plan will be 'Collaborative, communicative and relational'
- Stroud Town Council also presented on the day to show how their Community Hubs (which are supported by the ICB) have helped citizens to reduce health needs. The way these hubs have grown links with the strategic aspiration of PSIRF to look beyond the traditional safety investigation to influence pathways and how we commissioner services.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test Results: April 22 – February 23

		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	Jan-23 Provider	Feb-23 Provider	Mar-23 Provider
GHT Inpatients	% Positive	88%	87%	87%	89%	No data	89%	88%	No data	No data	91%	92%	
	% Negative	7%	8%	7%	6%	No data	6%	7%	No data	No data	4%	5%	
GHT A&E	% Positive	63%	67%	70%	68%	71%	69%	69%	71%	70%	80%	80%	
	% Negative	27%	23%	20%	23%	18%	23%	22%	20%	20%	13%	13%	
GHC Mental Health	% Positive	81%	81%	83%	84%	79%	89%	78%	81%	82%	84%	87%	
	% Negative	8%	10%	10%	8%	11%	7%	12%	7%	7%	10%	4%	
GHC Community	% Positive	95%	95%	95%	96%	96%	95%	95%	94%	94%	95%	93%	
	% Negative	3%	2%	3%	2%	2%	2%	2%	3%	4%	2%	2%	

General Practice FFT

- Analysis of data has not been completed nationally for Feb 2023.
- In Jan 2023 all England responses totaled 280,669 with 2,895 responses reported from Gloucestershire GP practices.
- Percentage positive responses (England average: 91% - Gloucestershire average 92%)
- Percentage negative responses (England average: 5% - Gloucestershire average 4%)
- 33 GP practices in Gloucestershire submitted no FFT results in the last reported month (Feb 2023)

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 eleven month's published results can be found opposite.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

System Effectiveness Group

- The System Clinical Effectiveness Group (SCEG) was held on Monday 17th April, the group is now meeting monthly..

- It has been agreed that we will review the process of signing off changes to policy or new polices, the meeting is set to take place in May with the Executive Chief Nurse and the Chief Medical officer.

- The Group have agreed the adoption of the national CQUINs (below) which will have a Quality Improvement focus. The group are also planning a longer agenda item at the next meeting 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)

- While there are a range of CQUINs, trusts need to choose their 'top 5' which payment is attached to.
  - GHNHSFT have agreed for the following CQUINs to be their top 5:
  - CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
  - CQUIN04: Prompt switching of intravenous to oral antimicrobial treatment
  - CQUIN05: Identification and response to frailty in emergency departments
  - CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions
  - CQUIN12: Assessment and documentation of pressure ulcer risk

- GHC have agreed for the following CQUINs to be their top 5:
  - CQUIN 1: Flu vaccinations for frontline healthcare workers
  - CQUIN 12: Assessment and documentation of pressure ulcer risk
  - CQUIN 14: Malnutrition screening for community hospital inpatients
  - CQUIN 15: Routine outcome monitoring in CYP and community perinatal mental health services
  - CQUIN 17: Reducing the need for restrictive practice in adult/older adult settings

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Our Themes

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Finance and Use of Resources

Financial Overview & Key Risks

- The ICS unaudited financial position for 2022/23 is a small underspend of £108k

	£'000
GICB	19
GHFT	51
GHC	38
Total Surplus	**108**

- The financial position has been balanced to deliver breakeven through a number of means which include the impact of additional allocations where spend had already been included, slippage in investments and other non recurrent measures.

- The recurrent impact of both cost pressures, underspends and non delivery of savings has been brought into the 2023/24 financial plan for the system and within the organisational financial plans at a point in time. Changes between the plan and actual outturn are being assessed in terms of the impact and risk for 2023/24. Inflation remains a key risk for the system for 23/24 in a number of areas where the rate of increase is not slowing, this includes medicines and building costs. In addition, the pay award for 2022/23 remains unresolved; the outturn includes an assumption of full funding for the 2022/23 pay award.

- Under-delivery of savings and efficiency plans:
  - GHFT saving plans under delivered by c£2.8m against the plan, this has been offset by non recurrent savings elsewhere.
  - Within the ICB's Medicines Optimisation programme, the project relating to Direct Oral Anticoagulation (DOACs) medications is under-delivering. Under delivery has been offset by non recurrent savings.
  - Under delivery of recurrent savings, c£11m for the system has included in the 2023/24 financial plan.

- Capital: the main capital allocation has been fully spent, however, there is an underspend of c£3.6m against the allocations relating to new leases under IFRS16 due to slippage in lease timings and also changes to plans for some lease expenditure.

**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

- Workforce is a key driver of overspends within the financial position with vacancies within GHFT and the wider care sector. Vacancies have led 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) to provide additional support for complex patients. The total cost pressure for RMNs in 2022/23 is just over £4m. 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 against 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. The ICS's providers have reported expenditure of £35.1m in 2022/23, which is a 21.4% 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 moving forwards, with a particular focus on ensuring aligned agency rates and caps across a number of neighbouring ICSs.

- The System agency cap for 2023/24 is £25.6m, 2023/24 savings plans include some spend reduction, however, delivery against this cap will be challenging to achieve.

Finance and Use of Resources

Financial Overview & Key Risks

- Elective Recovery Funding is shown as breakeven, with reporting to month 11 (flex position) now showing a small under-delivery for the system as a whole with NHS providers under-delivering and Independent Sector providers over-delivering against the planned position. The 2023/24 financial plan includes delivery of an average of 109% value weighted activity throughout the year. In order to deliver this, the System needs to start in April with 104% delivery.

- The annual plan for ESRF was based on the ICS achieving the 104% delivery target. After ten months of confirmed activity (the 'freeze' position), actual delivery is around 102.9% against a YTD weighted-target of around 105.2% 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.

- Continuing Health Care: the month 12 position is a £2.8m overspend. This overspend is primarily in domiciliary care, and on-going work is being undertaken in conjunction with GCC colleagues to improve data flows between the organisations to improve the accuracy and timeliness of forecasting. The spend for Hospital Discharge scheme 1 is fully spent, total £4.604m. The spend for Hospital Discharge Fund scheme 2 is £1.5m and the ICB received an allocation to cover this expenditure.

- Children's Placements has an overspend (£2.9m). 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 was over 100% for the year. The total expenditure was £97.301m against a target level of £97.13m which was 0.18% over target.

Finance and Use of Resources

Financial and Use of Resources: Dashboard

Month 12 2022/23 – March Statement of Comprehensive Income	Month 12 Plan Surplus / (Deficit)	Month 12 Actual Position Surplus / (Deficit) £'000	Full Year Variance to Plan Favourable / (Adverse) £'000
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	(0)	51	51
Gloucestershire Health and Care NHS Foundation Trust (GHC)	(0)	38	38
Gloucestershire CCG / Integrated Care Board (ICB	(0)	19	19
System Surplus/ (Deficit)	**(0)**	**108**	**108**

Key

Green arrow up = favourable variance to plan

Red arrow down = adverse variance to plan

Yellow horizontal arrow = breakeven

Month 12 2022/23 – March Efficiency Programme	Full Year Efficiency Plan £'000	Forecast Outtrun 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 (GHFT)	19,038	16,244	(2,794)	85%	**AMBER – Medium Risk**
Gloucestershire Health and Care NHS Foundation Trust (GHC)	6,822	6,776	(47)	100%	**GREEN - Low Risk**
Gloucestershire CCG / Integrated Care Board (ICB	11,097	11,077	(20)	100%	**AMBER – Medium Risk**
Total	**36,957**	**34,097**	**(2,861)**	**92%**	**AMBER – Medium Risk**

Month 12 2022/23 – March Other Metrics	GHFT	GHC	GICB	ICS
Better Payment Practice Code (total paid within 30 days or due date by value)	95%	95%	100%	98%
Capital Forecast Variance to Plan (Under) / Over Delivery – £'000	433	9	(33)	409
Cash Status	**GREEN**	**GREEN**	**GREEN**	**GREEN**

Finance and Use of Resources

Elective Services Recovery Fund

ICS-Commissioned Activity	M10 Year to Date - FREEZE			M11 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	156,815	153,299	(3,516)	172,079	166,715	(5,364)	190,049	190,049	0
Elective Recovery Funding							**19,257**	**19,257**	**0**
Cost Weighted Activity % of Baseline by PoD									
Elective Ordinary (EL)	105.3%	88.7%	-16.5%	103.8%	86.8%	-17.0%	104.1%	104.1%	0.0%
Day Case (DC)	104.2%	107.7%	3.5%	104.3%	106.5%	2.2%	109.2%	109.2%	0.0%
Outpatient Procedure (OPPROC)	89.4%	100.0%	10.6%	91.7%	99.6%	7.9%	97.9%	97.9%	0.0%
First Outpatient Appointment (OPFA)	104.3%	99.5%	-4.8%	104.3%	99.4%	-4.9%	104.0%	104.0%	0.0%
Outpatient Follow-Up Appointment (OPFUP)	88.1%	104.1%	16.0%	88.1%	103.3%	15.3%	91.7%	91.7%	0.0%
Elective Pathway Activity	**101.3%**	**99.8%**	**-1.6%**	**101.2%**	**98.7%**	**-2.4%**	**101.6%**	**101.6%**	**0.0%**
Advice and Guidance (A&G)	476.2%	354.0%	-122.2%	472.1%	347.6%	-124.4%	470.5%	470.5%	0.0%
Total ICS-Commissioned Activity	**105.2%**	**102.9%**	**-2.4%**	**104.9%**	**101.7%**	**-3.3%**	**104.8%**	**104.8%**	**0.0%**
Cost Weighted Activity % of Baseline by PoD									
Gloucestershire Hospitals NHSFT	101.6%	96.7%	-4.9%	101.4%	95.7%	-5.7%	101.9%	101.9%	0.0%
NHS Out-of-County Providers	94.7%	89.0%	-5.7%	94.9%	88.5%	-6.3%	94.9%	94.9%	0.0%
Independent Sector Providers	107.8%	131.6%	23.8%	107.8%	130.0%	22.1%	107.7%	107.7%	0.0%
Elective Pathway Activity	**101.3%**	**99.8%**	**-1.6%**	**101.2%**	**98.7%**	**-2.4%**	**101.6%**	**101.6%**	**0.0%**
Advice and Guidance (A&G)	476.2%	354.0%	-122.2%	472.1%	347.6%	-124.4%	470.5%	470.5%	0.0%
Total ICS-Commissioned Activity	**105.2%**	**102.9%**	**-2.4%**	**104.9%**	**101.7%**	**-3.3%**	**104.8%**	**104.8%**	**0.0%**

The annual plan for ESRF is based on the ICS achieving the 104% delivery target, although with a lower trajectory in Q1. After ten months of confirmed activity (the ‘freeze’ position), actual delivery is around 102.9% against a YTD weighted-target of around 105.2% of 2019/20's activity.

Work continues 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.

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 M10 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.

Finance and Use of Resources

Savings and Efficiencies

Month 12 2022/23 – March Efficiency Programme	Full Year Efficiency Plan £'000	Forecast Outtrun 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 (GHFT)	19,038	16,244	(2,794)	85%	**AMBER – Medium Risk**
Gloucestershire Health and Care NHS Foundation Trust (GHC)	6,822	6,776	(47)	100%	**GREEN - Low Risk**
Gloucestershire CCG / Integrated Care Board (ICB	11,097	11,077	(20)	100%	**AMBER – Medium Risk**
Total	**36,957**	**34,097**	**(2,861)**	**92%**	**AMBER – Medium Risk**

- The forecast outturn against savings for each organisation is shown below, this information is based on actuals to month 11 for most schemes but month 10 for the ICB medicines programme (NHS Business Services Authority information is received two months in arrears) plus a forecast for the remaining month(s). Recurrent under delivery of savings has been offset by non recurrently within organisations.
- GHFT schemes have under-delivered by £2.8m. This is a slight improvement from the previously reported position of £2.9m. A number of schemes, mainly relating to workforce, did not deliver
- GHC has a small under delivery against its planned recurrent savings of £47k and delivered all non-recurrent savings required
- ICB's savings programme has under-delivered by £20k. The variance is due to under delivery against the Continuing Health Care & placement high cost case reviews.

Finance and Use of Resources

Capital: Organisational Positions, Challenges and Opportunities

Month 12 2022/23 - March Capital Expenditure	Month 12 Plan £'000	Month 12 Actual Position £'000		Year End Variance to Plan (Under) / Over Delivery £'000
Gloucestershire Hospitals NHS Foundation Trust	51,742	66,135	↑	14,394
Gloucestershire Health and Care NHS Foundation Trust	17,665	19,511	↑	1,846
Gloucestershire CCG / Integrated Care Board	1,336	1,303	↓	(33)
Total System CDEL (NHS)	**70,743**	**85,646**	↑	**16,207**
IFRS16 Lease Capital				
Gloucestershire Hospitals NHS Foundation Trust	15,355	2,583	↓	(12,772)
Gloucestershire Health and Care NHS Foundation Trust	9,721	2,603	↓	(7,118)
Total System Capital including IFRS16 Leases (NHS)	**95,818**	**90,832**	↓	**(3,683)**

Capital Expenditure Category	£'000	£'000		£'000
Equipment	18,457	4,590	↓	(13,867)
IT	11,329	16,678	↑	5,349
Plant & Machinery	0	1,393	↑	1,393
New Build	42,718	43,269	↑	551
Backlog Maintenance	4,500	6,099	↑	1,599
Routine Maintenance	2,917	2,717	↓	(200)
Net Zero Carbon	500	0	↓	(500)
Fire Safety	730	604	↓	(126)
Fleet, Vehicles & Transport	3,167	165	↓	(3,002)
Forest of Dean	11,500	13,455	↑	1,955
GP Surgery Developments	0	0	→	0
Brokerage	0	0	→	0
Other	0	3,165	↑	3,165
Total	**95,818**	**92,135**	↓	**(3,683)**

Funding Sources	£'000	£'000		£'000
System Capital	43,933	43,119	↓	(814)
National Programme	24,711	39,139	↑	14,427
Donations & Government Grants	1,281	3,876	↑	2,595
Lease Liability - IFRS16	25,076	5,186	↓	(19,890)
Residual Interest	0	0	→	0
IRFIC	817	816	↓	(1)
CCG Capital Allocation	0	0	→	0
Total	**95,818**	**92,135**	↓	**(3,683)**

	CDEL	IFRS16	TOTAL
GHFT	£433k	£1,189k	£1,622k
GHC	£9k	(£5,281k)	(£5,272k)
ICB	(£33k)		(£33k)
TOTAL	**£409k**	**(£4,092k)**	**(£3,683k)**

- Within the ICS's capital envelope, capital expenditure is showing a £3.6m underspend which is due to slippage in lease commitments as a number of leases, treated as capital under IFRS16, were not taken out by Providers within this financial year, leading to an overall lower capital spend. Some of this slippage will lead to an increased request to NHSE in 2023/24 for IFRS16 capital.
- Additional allocations have now been received for a number of schemes for both GHC and GHFT, and which now show as forecast variances against the original plan. These additional schemes are listed overleaf.

Finance and Use of Resources

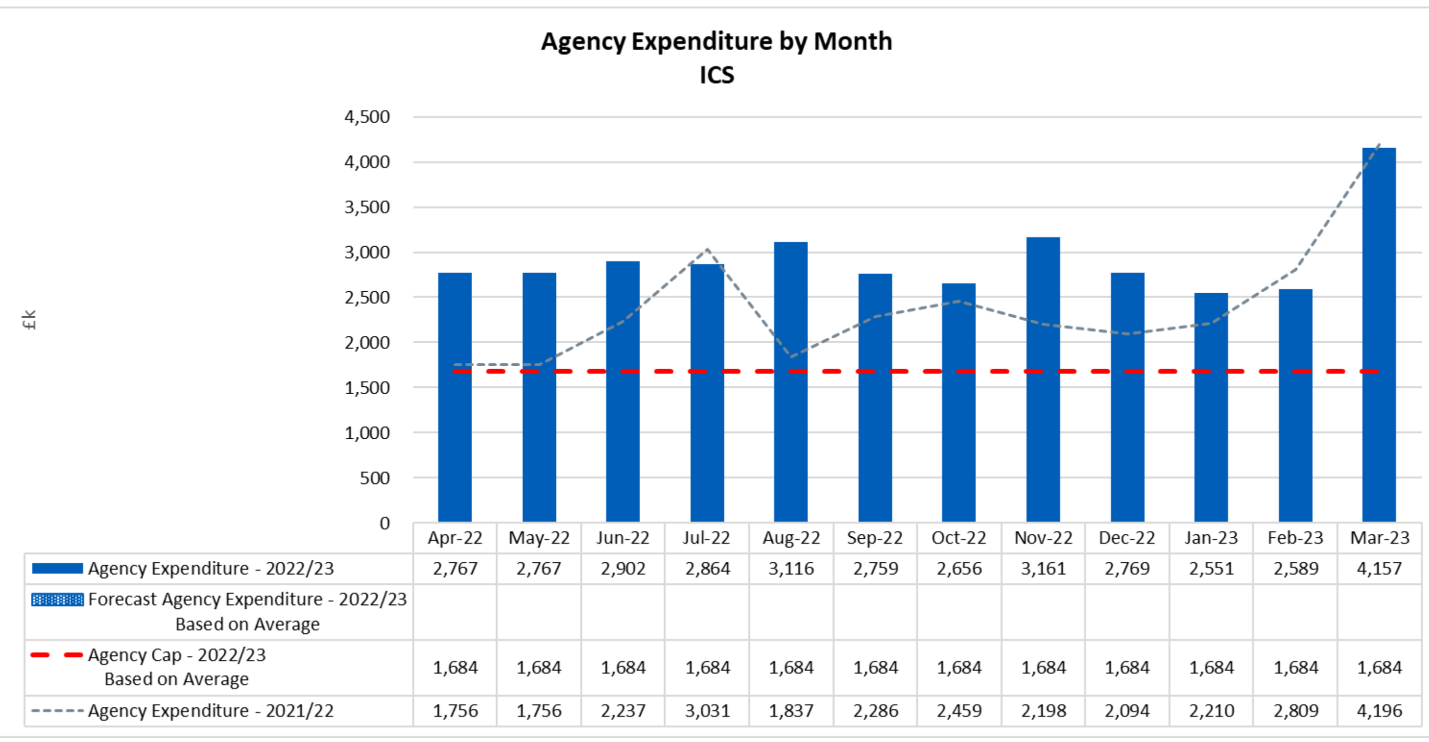
Capital: Organisational Positions, Challenges and Opportunities

GHC	£'000
Front Line Digitisation	1,671
Wotton Lawn – Clinic Rooms Refurbishment	215
Capital Programme Slippage	(40)
GHC Total	**1,846**
GHFT	
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	429
Gamma Camera – Donated Asset Slippage to 2023/24	(955)
Other	1,136
GHFT Total	**14,394**
Gloucestershire ICS Total	**16,240**

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.

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	2,589	4,157
Forecast Agency Expenditure - 2022/23 Based on Average												
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	**£35.057m**
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. Reported spend for ICS providers us just under £36.1mver £35m in 2022/23, which is a 21.4% increase on last year's agency expenditure.
- ICSs have been notified of a draft agency cap for 2023/24, which stands at £25.609m for Gloucestershire ICS

Finance and Use of Resources

COVID Expenditure

Month 12 2022/23 – March COVID Expenditure	Prior Year Expenditure £'000	Month 12 Actual Position £'000	Full Year Plan £'000
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	15,357	226	7,452
Gloucestershire Health and Care NHS Foundation Trust (GHC)	2,350	1,020	851
Gloucestershire CCG / Integrated Care Board (ICB)	7,588	0	0
Total System (NHS)	**25,295**	**1,246**	**8,303**

System Surplus / (Deficit) COVID Expenditure	Prior Year Expenditure £'000	Month 12 Actual Position £'000
Expand NHS Workforce	5,859	558
Existing workforce additional shifts to meet increased demand	3,721	5
Backfill for higher sickness absence	237	119
Remote management of patients	177	0
Segregation of patient pathways	2,708	0
Decontamination	78	11
Additional PTS Costs	557	0
Long COVID	595	0
Remote working for non-patient activities	177	0
International quarantine costs	7	0
Deployment of final year student nurses	22	0
GP Services – COVID expansion fund	1,303	0
Hospital Discharge Programme	5,521	0
Testing Programme	2,962	0
Vaccination Programme	1,371	554
Total System (NHS)	**25,295**	**1,246**

- 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 final month 12 position shows expenditure being significantly below the full year plan

ICB Finance Report

April 2023

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Finance and Use of Resources

Financial Overview and Key Risks

Overview

- NHS Gloucestershire ICB month 12 unaudited outturn position is showing a £19.3k surplus. The ICB has received a share of the historic surplus, totalling £13.9m, with remainder retained by NHSE in line with their financial framework.
- Prescribing has overspent by £3.1m for the year, this is mainly due to No Cheaper Stock Obtainable (NCSO) costs. The 22/23 year to date actual costs for NCSO are £3.3m, with a outturn expected at £3.7m compared to 2021/22 costs of £0.6m. Other prescribing cost pressures relate to national price increases of Category M Drugs with additional £0.63m costs.
- The Continuing Healthcare month 12 position was a £2.8m overspend. This overspend is primarily in domiciliary care, and on-going work is being undertaken in conjunction with GCC colleagues to improve data flows between the organisations which should lead to a better forecasting methodology moving forward. The spend for Hospital Discharge scheme 1 is fully spent (Total £4.604m). The spend for Hospital Discharge Fund scheme 2 is £1.5m for which the ICB received additional allocation.
- Children's Placements has overspent by c£2.9m. Two new placements arose in Month 8 with a cost of £1m, in addition to the two new placements in Trevone House which had a cost of £2.3m.
- The Mental Health Investment Standard (MHIS) achievement was delivered for the financial year. The total expenditure was £97.301m against a target level of £97.13m which was 0.18% over target; this is subject to external review.
- The position is subject to audit.

Finance and Use of Resources

ICB Allocation – M12

- The ICB's confirmed allocation as at 31st March 2023 is £951m 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 £278m, 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 totalling £13,938k. The remainder is retained by NHSE in line with the NHS financial framework.

Organisation	As reported M11 £'000	CCG M1-3 Surplus Adjustment £'000	M12 Additional Allocation £'000	2022/23 Allocation £'000
CCG Allocation M1-3	286,977	(10,017)	782	277,742
ICB Allocation M4-12	918,441	10,017	8,928	937,386
TOTAL IN-YEAR ALLOCATION	**1,205,418**	**0**	**9,710**	**1,215,128**
CCG carry forward historic surplus	13,938			13,938
TOTAL ALLOCATION	**1,219,356**	**0**	**9,710**	**1,229,066**

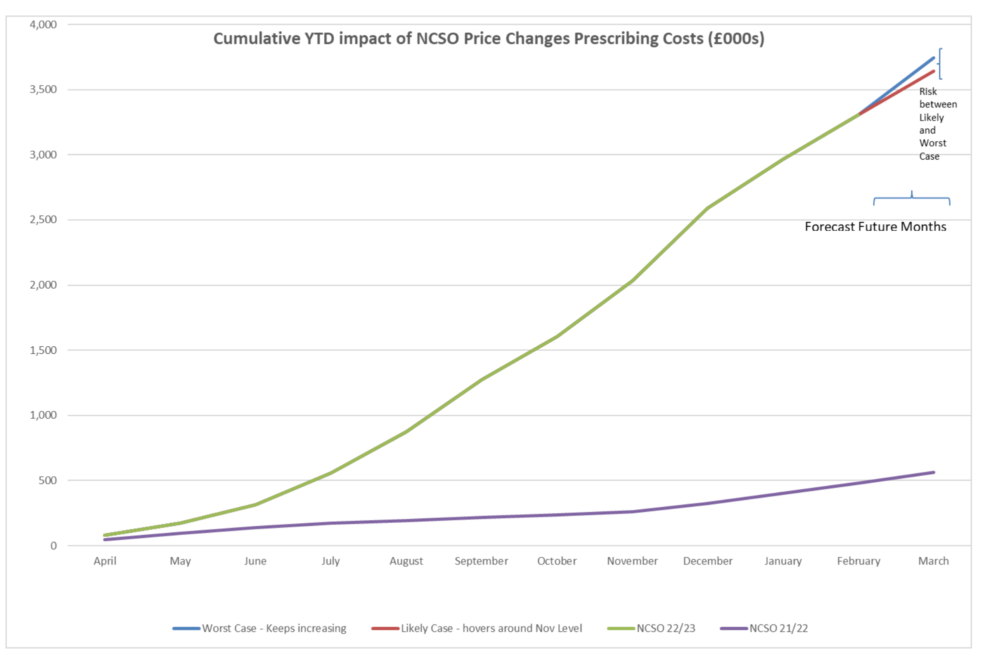
Finance and Use of Resources

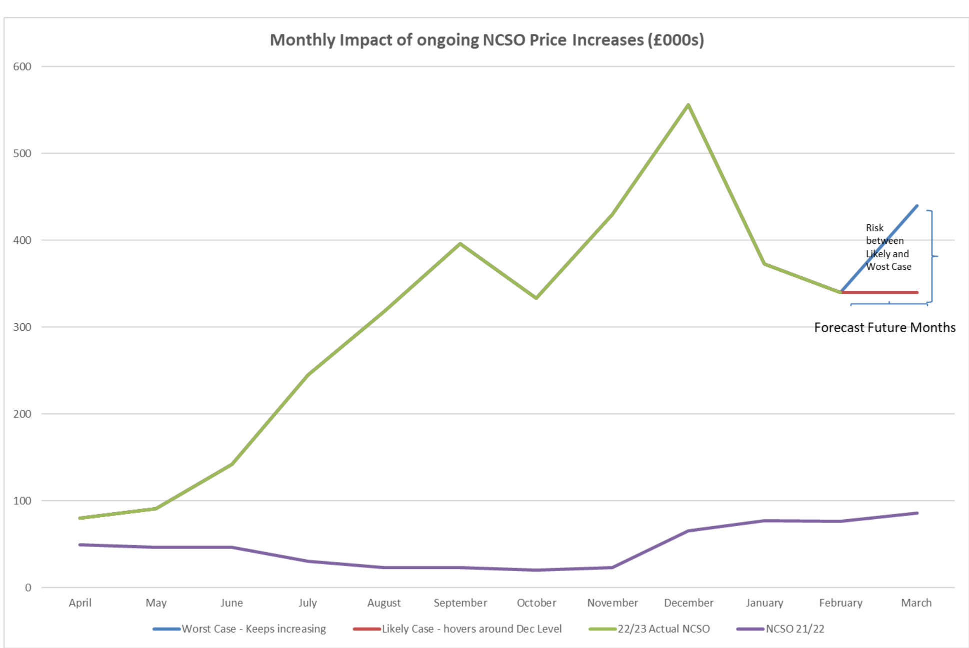
HEADER

Month 12 2022/23 – March Statement of Comprehensive Income	M12 Plan £'000	M12 Actual Position £'000	Year End Variance to Plan *Favourable / (Adverse)* £'000
Acute Services	588,207	589,997	(1,791)
Mental Health Services	117,952	116,203	1,750
Community Health Services	126,254	125,406	847
Continuing Care Services	77,449	77,898	(449)
Primary Care Services	143,642	145,660	(2,017)
Delegated Primary Care Commissioning	110,083	109,479	604
Other Commissioned Services	25,473	25,299	174
Programme Reserve and Contingency	(3,839)	0	(3,839)
Other Programme Services	15,185	11,728	3,457
TOTAL COMMISSIONING SERVICES	**1,200,406**	**1,201,670**	**(1,264)**
Running Costs	14,722	13,439	1,283
TOTAL NET EXPENDITURE	**1,215,128**	**1,215,109**	**19**
ALLOCATION	1,215,128	1,215,128	0
Outside of Envelope	0	0	0
UNDERSPEND / (DEFECIT)	**0**	**19**	**19**

Finance and Use of Resources

ICB Prescribing – No Cheaper Stock Obtainable M12





- The graphs have been completed to illustrate the 22/23 NCSO costs compared to 21/22 costs.
- The 22/23 YTD actual (February) costs for NCSO are £3.3m, with a outturn expected at £3.7m compared to 2021/22 costs of £0.6m.

Finance and Use of Resources

2022/23 Efficiencies Programme – As At Month 12

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 MEDICINES OPTIMISATION	Direct Oral Anticoagulants (DOACs)	2,365	1,243	(1,122)	2,365	1,648	(717)	69.68%	RED – High Risk
	Primary Care Medicines Savings; Medicines Optimisation (MO) Value Savings; and Medicines Optimisation (MO) Variation Projects	1,450	1,629	179	1,450	2,292	842	158.07%	GREEN – Low Risk
	TOTALS	**3,815**	**2,872**	**(943)**	**3,815**	**3,940**	**125**	**103.28%**	
CONTINUING HEALTHCARE	Electronic Call Monitoring (ECM)	806	806	0	806	806	0	100%	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%)	200	-	(200)	200	-	(200)	0%	RED – High Risk
	TOTALS	**1,525**	**1,380**	**(145)**	**1,525**	**1,380**	**(145)**	**90.48%**	
OTHER	1.1% Contract Efficiency, Running Cost Savings and Additional Efficiencies	5,757	5,757	-	5,757	5,757	-	100%	GREEN – Low Risk
	TOTALS	**5,757**	**5,757**	**-**	**5,757**	**5,757**	**-**	**100%**	
2022/23 ICB Savings Programme TOTALS		**11,097**	**10,009**	**(1,088)**	**11,097**	**11,077**	**(20)**	**99.83%**	AMBER – Medium Risk

Finance and Use of Resources

ICB Savings and Efficiencies

Overall Position

- Based on Operational Lead updates and latest available data, the ICB is anticipating delivery of £11.077 of it's £11.097m Savings Programme for 2022/23, equating to 99.83% of the plan. The position has moved favourably by £0.451m from that reported in Month 11 (February 2023).

Medicines Optimisation

- We have continued to see a sustained over-delivery on Medicines Optimisation Projects this month and this indicates a projected forecast outturn of £3.940m against a £3.815m planned saving for the Medicines Optimisation Programme for the 2022/23 financial year (a £0.125m forecast over-delivery). It should be noted that this is a forecast outturn position as the timeliness of ePact data used to monitor progress of Medicines Optimisation schemes means that we do not yet have actual data for February and March 2023. As such the year to date actual position and associated variances for these programmes include 10 months of data, whereas the forecast includes 12 months. We have reviewed trends in the data that we have available thus far for the 2022/23 financial year and combined this with soft intelligence obtained from the Medicines Optimisation Team to arrive at the Month 12 forecast outturn position.

Continuing Healthcare (CHC)

- The overall position of the CHC efficiencies programme remains unchanged from that reported in Month 11 (February 2023) and shows an outturn position at Month 12 (March 2023) of £1.380m against a plan of £1.525m; a shortfall of £0.145m.
- Electronic Call Monitoring (ECM) has proved challenging during the 2022/23 financial year, specifically in terms of the validity and accuracy of the ECM reports received from Gloucestershire County Council (GCC). Work continues to develop the reports so that Gloucestershire Integrated Care Board (ICB) has the assurance that it needs to safely report savings in this area during the 2023/24 financial year. In view of the work being progressed, we are currently reporting this scheme as 'Amber' which reflects concerns around the monitoring process; we are reporting the Month 12 outturn for 2022/23 to be one of 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. Whilst we have seen a reduction in costs of some care packages during the 2022/23 financial year, other care packages have increased significantly thus negating any savings made. Given the volatility, we are not expecting this scheme to deliver any savings in 2023/24 or beyond.

Finance and Use of Resources

CCG / ICB Statement of Financial Position

	Closing Position as at 31/01/2023 £'000	Opening Position as at 01/07/2022 £'000
Property, Plant & Equipment	285	713
Intangible Assets	0	0
Total Non-Current Assets	**285**	**713**
Trade & Other Receivables	6,984	6,563
Cash & Cash Equivalents	7	21
Total Current Assets	**6,991**	**6,584**
TOTAL ASSETS	**7,276**	**7,297**
Trade & Other Payables	(83,369)	(53,308)
Provisions	(4,840)	(5,552)
Total Current Liabilities	**(88,209)**	**(58,860)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**(80,933)**	**(51,563)**
Non-Current Liabilities	0	(143)
Total Non-Current Liabilities	**0**	**(143)**
TOTAL ASSETS LESS TOTAL LIABILITIES	**(80,933)**	**(51,706)**
General Fund	(80,933)	51,706
Reserves		0
TOTAL EQUITY	**80,933**	**51,706**

Agenda Item 10

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

<table>
<tr><td>Report Title</td><td colspan="4">Scheme Investment</td></tr>
<tr><td>Purpose (X)</td><td colspan="4">For Information: X
For Discussion:
For Decision:</td></tr>
<tr><td rowspan="2">Route to this meeting</td><td colspan="4">Strategic Executive</td></tr>
<tr><td>ICB Internal
Strategic Executive</td><td>Date
18th May 2023</td><td>System Partner
Programme Development Group
UEC Task & Finish Group</td><td>Date
5th May 2023
Various</td></tr>
<tr><td>Executive Summary</td><td colspan="4">As part of the operational and financial planning approach, work has been undertaken to coordinate the process for scheme investment for 2023/24. For schemes that either do not have access to national funding or require additional investment a priorities process has been completed, with the aim to agree how we allocate the Demand and Capacity Fund as the primary funding source for the remaining schemes.

18 schemes were felt to be eligible for Demand and Capacity Funding. These schemes have all been supported through a priorities process, and subsequently mapped to a category following discussion with Strategic Executives.

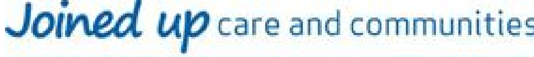
The total schemes requests for 2023/24 are non-recurrently within the £9.087m funding allocation across all three categories for this current financial year. Non-recurrent slippage will be used to support the System Financial Position.

The schemes currently within category one (supported recurrently) are recurrently within our £9.087m financial allocation (acknowledging the key issue set out below). There will be a process in place to ensure that the final list of recurrent schemes will remain within the recurrent Demand and Capacity financial envelope.

Key considerations are shared in the paper in the context of benefits realisation, substantive recruitment, and financial due diligence.</td></tr>
<tr><td>Next Steps</td><td colspan="4">Communication to be shared with all schemes identifying next steps, providing support for substantive recruitment if required.
Benefits Realisation process to be put in place alongside ongoing financial due diligence.</td></tr>
<tr><td>Key Issues to note</td><td colspan="4">As a system we are making assumptions that this will be recurrent funding although no formal confirmation has been received from NHS England.</td></tr>
</table>

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	*Risk:* There is a risk that either the demand and capacity funding and/or additional capacity funding is not confirmed as recurrent (4x3=12) *Mitigation:* Demand and Capacity (£9.087m) more likely to be confirmed as recurrent. Additional capacity (£4.080m) required to show delivery against our operating plan commitments, delivery plans in place within UEC Task and Finish Group and CPG. Review use of the two funding sources in respect of recurrent and non-recurrent requirements (which may impact on the £9.087m). *Risk:* There is a risk that the recurrent ask from schemes will be greater than the funding source available (4x3=12) *Mitigation*: Focus on benefits realisation across all schemes to support delivery of outcomes and value for money. Financial due diligence ongoing. Testing of schemes not approved recurrently. Continued exploration of alternative funding sources. *Risk:* There is a risk to ongoing service delivery whilst the due diligence assessment is completed for a small number of schemes (4x3=12) *Mitigation*: Support to recruit substantively where appropriate, risk to be managed across the system within the vacancy factor.			
Management of Conflicts of Interest	None			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	X
	Human Resource	X	**Buildings**	
Financial Impact	The scheme investment to remain recurrently within the Demand and Capacity funding allocation (£9.087m) and Additional Capacity funding allocation (£4.080m).			
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	Not overtly covered in the report. Some of the schemes will seek to address health inequalities.			
Impact on Equality and Diversity	Not overtly covered in the report. Schemes will seek to impact positively on equality and diversity.			
Impact on Sustainable Development	Not covered.			
Patient and Public Involvement	Not overtly covered. Each scheme will consider patient and public involvement, ensuring we comply with our legal duties.			
Recommendation	The Board is asked to note the update provided in the paper.			
Author	Kelly Matthews	**Role Title**	Programme Delivery Director	
Sponsoring Director (if not author)	Ellen Rule Deputy CEO/Director of Strategy and Transformation			

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
GCC	Gloucestershire County Council
GHC	Gloucestershire Health & Care Foundation Trust



Glossary of Terms	Explanation or clarification of abbreviations used in the paper
GHFT	Gloucestershire Hospitals NHS Foundation Trust
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
JFP	Joint Forward Plan
VCSE	Voluntary, Community and Social Enterprise

Scheme Investment

1.0 Background and Context

As part of the operational and financial planning approach, work has been undertaken to coordinate the process for scheme investment for 2023/24. Schemes are funded through a range of mechanisms, some which have agreed decision making processes in place (such as those relating to the Mental Health Investment Standard or System Development Funding). For schemes that either do not have access to national funding or require additional investment a priorities process has been completed.

This paper relates specifically to the schemes considered as part of the Demand and Capacity Fund as the primary funding source for the remaining schemes. The local allocation for Gloucestershire in 23/24 is £9.087m. This includes £2.077m of funding for utilisation on Virtual Wards. As a system we are making assumptions that this will be recurrent funding although no confirmation has been received from NHS England. The purpose of the funding is to increase physical and virtual bed capacity as well as specifically support admission avoidance schemes as well as timely hospital discharge.

For transparency, the breakdown of the funding commitments for the Additional Capacity Fund (£4.080m) was also considered within the final stages of the process. Similarly, to Demand and Capacity Funding, as a system we are making assumptions this is recurrent funding although no confirmation has been received from NHS England. The additional capacity funding is contingent on demonstrating performance in urgent and emergency care and submissions to NHS England on the use of this funding was made during operational planning.

2.0 Scheme Investment

In total 24 schemes were considered through this process. Existing schemes had 3 months of funding approved covering April 2023 through to the end of June 2023 whilst the decision-making process was underway. The purpose of this short-term funding was to enable continuation of service delivery whilst the necessary due diligence was completed across the schemes.

Through the process:

- 18 schemes were felt to be eligible for Demand and Capacity Funding *(to which this paper relates).*
- 2 schemes (both of which relate to Neurodiversity) whilst not eligible for Demand and Capacity funding are to be considered by the ICB. A separate paper regarding the Neurodiversity Future Plans will be shared with Board in the May 2023 meeting.
- The remaining 4 schemes were removed from the process to be considered through alternative funding routes.

Whilst the demand and capacity fund is £9.087m in total there are existing commitments to consider prior to scheme investment. Once the Virtual wards (2.087m), existing commitments (£1.814m) and out of county provider growth at 0.9% is taken into consideration (£0.400m) there is £4.796m left within the demand and capacity funds available for the scheme proposals under consideration.

The recommendations for scheme investments were considered by Strategic Executive on 18th May 2023, with schemes to be grouped into three categories:

Category	Description
1	Recurrent support for scheme (Benefits are identified, with clear trajectories and/or being delivered for existing).
2	Non recurrently supported. Recurrent support expected following further work on the investment proposal (including clarity on the benefits).
3	Non recurrent scheme for 23/24 only, with an exit strategy agreed. (Note: There is only 1 scheme in this category)

The schemes requests for 2023/24 are all non-recurrently within the £9.087m funding allocation across all three categories for this current financial year. Non-recurrent slippage will be used to support the System Financial Position.

The schemes currently within category one are recurrently within our £9.087m financial allocation, whilst we have not had confirmation that this funding is recurrent we believe that this will be recurrent (acknowledging the risk set out in section 1 regarding the absence of confirmation regarding the recurrent nature of the funding source). There will be a process in place to ensure that the final list of recurrent schemes will remain within the recurrent Demand and Capacity financial envelope. See Appendix A for a list of the schemes and financial requirements split between the categories.

The schemes considered against the additional capacity funding envelope are both non recurrently and recurrently within the £4.080m envelope (also acknowledging the risk set out in section 1 regarding the absence of confirmation regarding the recurrent nature of the funding source). See Appendix B for a list of the schemes and financial requirements split between the categories.

3.0 Key Considerations

The ICB Board are asked to note the following key considerations:

- There is agreement for increased focus on Benefits Realisation across all schemes to ensure funding is used effectively to deliver the improved outcomes and/or benefits identified within our strategic, operational and programme plans. A process will be implemented to ensure that benefits across key schemes are being monitored and evaluated, informing decision making through 2023/24 and for 2024/25 onwards. Schemes which do not evidence realised benefit will not be put forward for continued/new recurrent funding.
- Schemes will be supported to recruit substantively where appropriate, recognising the importance of a sustainable workforce strategy across our schemes. A process will be put in place to ensure there is a clear record of which schemes are being approved non-recurrently, but recruitment is permanent.
- Financial due diligence will remain ongoing to ensure robust costing (including building in the impact of the pay award) and a continued focus on value for money.

4.0 Recommendations

The Board is asked to note the update provided in the paper.

Appendix A: Scheme level summary of Demand and Capacity allocation

Project Ref.	Scheme	Programme	Provider(s)	Assumed Funding 23/24	Expected Recurrent Funding Commitment
Schemes supported recurrently as Category 1					
FY2223-56	Enhanced Supportive Care	Palliative and End of Life Care	GHFT	199,564	£267,781
FY2324-02	Specialist Children's Respiratory Physiotherapy (Community Based)	Children and Young People	GHC	£128,270	£135,087
FY2324-16	Discharge Lounge (GRH) **Note: This is 50% of funding required, remainder is in additional capacity*	Urgent and Emergency Care	GHFT	£492,292	£492,292
FY2324-18	Community Assessment Treatment Unit (Tewkesbury Hospital) **Note: This is 50% of funding required, remainder is in additional capacity*	Urgent and Emergency Care	GHC	£265,929	£265,929
FY2324-24	Integrated Heart Failure Service (Community Provision)	Circulatory CPG	GHC	£476,651	£476,651
FY2324-31	High Intensity User Service (HIUs) **Note: This is for the existing service; expansion is in additional capacity*	Ageing Well	GHFT & Social Prescribing	£124,370	£124,370
FY2324-61	Blood Pressure Monitoring (LES) - PCN Champions	Primary Care and Circulatory	Primary Care	£150,000	£150,000
FY2324-10	Respiratory Diagnostic (LES)	Respiratory CPG	Primary Care	£332,566	£332,566
FY2324-53	GHAC 8-8 Primary Care Access Centre (Additional locum cover)	Primary Care	Primary Care	Alternative funding for 23/24	£350,000
FY2324-52	QI Projects in Primary Care	Primary Care	Primary Care	Alternative funding for 23/24	£500,000
FY2324-62	ILP Strengthening Local Communities	ILPs	Localities	Alternative funding for 23/24	£600,000
FY2324-58	Migrant Hotel (LES)	Primary Care	Primary Care	£67,500	£67,500
n/a	Growth in OOC contracts (0.9%)	-	OOC Providers Growth in demand (0.9%)	£400,000	£400,000
n/a	Other Commitments	-	GHFT	£1,814,300	£1,814,300

Project Ref.	Scheme	Programme	Provider(s)	Assumed Funding 23/24	Expected Recurrent Funding Commitment
Multiple	Virtual Wards	-	Across partners	£2,077,000	£2,077,000
Schemes supported recurrently as Category 2					
FY2324-54	Surgical Assessment Unit (SDEC Expansion) **Note: This is 50% of funding required, remainder is in Virtual ward allocation*	Urgent and Emergency Care	GHFT	£428,000	£428,000
FY2324-59	Therapies and Onward Care Teams (GHFT)	Urgent and Emergency Care	GHFT	£644,050	*In discussion with GHFT as part of staffing/bed model*
FY2324-71	Acute Respiratory Infection Hubs for Adults and Children (Glos/Chelt)	Respiratory CPG	Primary Care	£381,507	*TBC (No recurrent request made in the process)*
FY2324-07	COVID Medicines Delivery Unit (CMDU)	Medicines Optimisation	Currently GHC *(see right)*	£318,534	*TBC (No recurrent request made in the process)*
FY2324-11	Nebulisers Service	Respiratory CPG	Independent Provider	£112,552	£112,552
Schemes supported recurrently as Category 3					
FY2324-50	Minor Injury Unit Telephone Triage	Urgent and Emergency Care	GHC	£527,407	N/A
Current Pipeline - awaiting further information					
FY2324-61	Blood Pressure Monitoring (LES) - Targeted work	Primary Care and Circulatory	Primary Care	£100,000	£100,000
TOTAL REQUEST				**£9,040,492**	**£8,694,028**
TOTAL AVAILABLE				**£9,087,000**	**£9,087,000**

Appendix B: Scheme level summary of Additional Capacity allocation

Project Ref.	Scheme	Programme	Provider(s)	Assumed Funding 23/24	Expected Recurrent Funding Commitment
Schemes supported recurrently as Category 1					
FY2324-16	Discharge Lounge (GRH) **Note: This is 50% of funding required, remainder is in demand and capacity*	Urgent and Emergency Care	GHFT	£492,292	£492,292
FY2324-18	Community Assessment Treatment Unit (Tewkesbury Hospital) **Note: This is 50% of funding required, remainder is in demand and capacity capacity*	Urgent and Emergency Care	GHC	£265,929	£265,929
-	Respiratory High Care (Phase 2 Fit for the Future)	Fit for the Future	GHFT	£252,000	£252,000
-	Length of stay reductions through focused improvement work - Multiple schemes (including Mental Health and Social worker capacity within the acute trust)	Urgent and Emergency Care	Various	£905,000	£905,000
Schemes supported recurrently as Category 2					
FY2324-31	High Intensity User Service (HIUs) **Note: This is 50% of funding required, remainder is in additional capacity*	Ageing Well	GHFT & Social Prescribing	£117,116	£117,116
-	Bed Based Reviews (Discharge to Assess Beds)	Urgent and Emergency Care	TBC	£350,000	£350,000
Schemes supported recurrently as Category 3					
	None to Report				
Escalation Capacity (To be worked through)					
-	Escalation capacity to be used within the year (schemes to be developed and reviewed)	Urgent and Emergency Care	TBC	£1,494,000	£1,494,000
TOTAL REQUEST				**£3,876,337**	**£3,876,337**
TOTAL AVAILABLE				**£4,080,000**	**£4,080,000**

Agenda Item 11

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

Report Title	**Neurodiversity Pathway (0-18 and 18+)**			
Purpose (X)	**For Information**	**For Discussion**	**For Decision**	
		X		
Route to this meeting	The plans outlined within this paper regarding Neurodiversity have been considered within the Learning Disabilities and Autism Clinical Programme Group as well as with ICS Strategic Executive.			
	ICB Internal	**Date**	**System Partner**	**Date**
			LD & Autism CPG and Adults and Children's CPG partners ICS Strategic Executive	 20/04/23
Executive Summary	Neurodiversity is an umbrella term which encompasses Attention Deficit Hyperactivity Disorder (ADHD), Autism and other conditions relating to how the brain functions. Similar to other systems across the country Gloucestershire has experienced a significant increase in the number of referrals for ADHD and Autism assessment services. As a result, we now have a significant backlog of people waiting for triage and assessment with lengthy wait times. The paper sets out plans to improve the pathways for ADHD and Autism for both children and young people aged 0-18 and adults. The plans include work to bring together pathways to just two neurodiversity assessment pathways – under 18 and over 18. As partners together we want to move towards a sustainable approach to care in this area. This work includes front-door support through better signposting and work with partners to improve the effectiveness of the pathway. We recognise the importance of early identification and access to support for people who are neurodiverse. That is why we must work together to ensure that individuals living with ADHD and/or Autism have the support they need.			

<table>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The key risks to deliver of this proposal are outlined in Section 5 below but in summary are:

Risk #1: There is a risk of being unable to recruit to the positions and/or that this will pull existing staff from other services.
Mitigation: This is being mitigated by recruiting to roles in the phases identified.
Original Score: 16 (likelihood: 4 / impact: 4)
Target Score: 12 (likelihood: 3 / impact: 4)

Risk #2: There is a risk that referrals rise beyond existing levels impacting on our ability to deliver outcomes.
Mitigation: Modelling projections are being finalised. Front-end triage work is a key principle of both proposals.
Original Score: 12 (likelihood: 4 / impact: 3)
Target Score: 8 (likelihood: 4 / impact: 2)

Risk #3: There is a risk in the capacity to be able to deliver the change required in this proposal.
Mitigation: This is being seen as a strategic priority for the system and partners will ensure support to delivery.
Original Score: 12 (likelihood: 4 / impact: 3)
Target Score: 8 (likelihood: 4 / impact: 2)</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>X</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">Initial funding has already been made to reducing the backlog of people waiting for assessment. To move towards a sustainable model as outlined in this paper, the plans will require investment as summarised.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">Autism wait times are not currently NICE compliant (12-week pathway for assessments) as well as other elements of the ADHD pathway. This is a local priority for us as a system and reflects feedback from the recent SEND peer review assessment that has been undertaken.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">Autistic people are experiencing high rates of chronic conditions alongside difficulties with accessing healthcare. Studies have suggested that autistic people have poorer physical and mental health as well as a higher risk of premature mortality. A clear pathway for autism diagnosis and post-diagnostic support will help to reduce these health inequalities.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">Autistic people are a vulnerable population who are socially disadvantaged and often ‘hidden’ from existing health and social care services, particularly if they are undiagnosed and not accessing the support available to them.</td></tr>
</table>

Impact on Sustainable Development	-		
Patient and Public Involvement	Autism and ADHD assessments are an area of significant focus for the public and feedback has been provided on existing services to both providers and NHS Gloucestershire ICB. Implementation of this plan will be undertaken in collaboration with individuals and their families.		
Recommendation	**A request is made for delegated financial approval for the investment schemes to the Chair, Chief Executive Officer and Chief Finance Officer of NHS Gloucestershire ICB once review of impact modelling has been completed.**		
Authors	**Karl Gluck** **Jess Glenn**	**Role Title**	**Head of Integrated Commissioning (Adult Mental Health, Advocacy and Autism)** **Head of Integrated Commissioning – Children and Families**
Sponsoring Director (if not author)	**Mary Hutton, Chief Executive Officer, NHS Gloucestershire Integrated Care Board**		

Neurodiversity Pathway (0-18 and 18+)

1. Background and Context

1.1. Neurodiversity is an umbrella term which encompasses Attention Deficit Hyperactivity Disorder (ADHD), Autism and other conditions relating to how the brain functions. ADHD and Autism often co-occur and have overlapping traits.

1.2. Within Gloucestershire the current provision of assessment and support is undertaken across different organisations with pathways defined according to age and whether an assessment is needed for either ADHD or Autism.

Under 11s:

- Autism service provided by Gloucestershire Health and Care: Social Communication and Autism Assessment Service
- ADHD service provided by Gloucestershire Hospitals NHS Foundation Trust: Community Paediatrics

11-18s:

- Combined ADHD and Autism service provided by Gloucestershire Health and Care: CAMHS Neurodiversity Team

18+:

- Autism service provided by Gloucestershire Health and Care: Autism Spectrum Diagnostic Service
- ADHD service provided by Gloucestershire Health and Care: Adult ADHD service

1.3. In 2020 £250,000 of recurrent funding was agreed for the under 11s Autism service (Social Communication and Autism Assessment Service) which became fully operational from September 2022. The service provides a multi-disciplinary team approach to autism assessment and diagnosis for children under the age of 11 years.

1.4. However, similar to other systems across the country Gloucestershire has experienced a significant increase in the number of referrals for ADHD and/or Autism diagnosis. The existing pathways are not as effective as they could be and therefore this paper summarises both the current position as well as plans for improvement.

2. Neurodiversity: Existing pathways

2.1. All services have, over the last two years, seen a significant increase in referrals as well as growing complexity of referrals. This is a pattern that is being seen across the country. The adult ADHD service saw a 200% increase in referrals between 2019/20 and 2021/22 with similar patterns across both children and adult services.

2.2. These changes, coupled with the existing levels of staffing (including shortages of specialist staff in some areas) means that the existing services are unable to effectively respond to the now higher number of referrals received. The consequences of this are that we now have

higher numbers of people waiting for triage and assessment with lengthy wait times. All autism services are unable to meet the NICE 12-week assessment guidelines.

Numbers waiting for assessment and wait times		
	Number waiting	**Length of wait**
Under 11s	ADHD: 121 awaiting assessment May ‘23	ADHD: Over 1 year
	Autism: 916 awaiting screening / 246 awaiting assessment May ‘23	Autism: 18 months
11-18s	ADHD: 146 awaiting screening / 103 awaiting assessment May ‘23	Information currently unavailable
	Autism: 185 awaiting screening / 150 awaiting assessment May ‘23	
Over 18s	ADHD: 932 awaiting triage, 548 awaiting assessment April ‘23	ADHD: 1.3 years (triage) / 4.1 years (assessment) April ’23
	Autism: Awaiting triage: 111 Awaiting assessment: 334 April ’23 (includes awaiting triage)	Autism: 1.2 years (triage) / 2.7 years (assessment) April ‘23

2.3. In response to growing numbers of people awaiting an assessment, work was undertaken to reduce the impact as part of a waiting list initiative funded by NHS Gloucestershire ICB. Non recurrent funding was made available to reduce the waiting list with 582 children and young people awaiting assessment for ADHD and 344 people over the age of 18 awaiting autism assessment.

2.4. Whilst further work is needed to reduce the numbers of people waiting for assessment and move towards a more sustainable service for assessment and support, there are other opportunities to improve the pathways:

- At present, services are currently organised according to age and pathway. This means that an individual who is waiting a diagnosis for both ADHD and Autism (circa 25%) currently sits on two individual waiting lists and is reviewed by separate teams.

- Our evidence suggests that a significant number of referrals being received have insufficient information adding to inefficiencies in the pathway. Around 35-40% of children’s referrals and 60% of adult referrals are being returned due to lack of sufficient information or because of inappropriate referrals.

- There are workforce opportunities with services currently organised according to age and condition. Whilst there will be challenges in recruiting to the number of suitably qualified staff required, there are opportunities for staff (as well as patients) in bringing some services together.

2.5. Importantly, our response is not just an NHS response. Research shows that people who are undiagnosed and unsupported are more likely to have mental health challenges and difficulties in relationships with friends and family. They are also more likely to be excluded from school and come into contact with the youth justice system.

2.6. The right support at the right time can have a significant impact for individuals and their families and therefore we will also prioritise partnership working with early help, preventative and universal services.

3. Neurodiversity: Improvement Plans

3.1. It is evident that there is a need to improve neurodiversity pathways both for children and young people as well as adults. The improvement plans are based around four key changes:

a). Integrating Autism and ADHD Pathways

3.2. In order to move towards more sustainable pathways and in line with good practice, our plan is to bring together a single neurodiversity service for children and young people aged 0-18 and a single neurodiversity service for adults over the age of 18.

3.3. Both services would bring together currently separate pathways for Autism and ADHD into a single pathway and therefore mean moving the existing under 11s ADHD service from Gloucestershire Hospitals NHS Foundation Trust (GHFT) to Gloucestershire Health and Care (GHC). This will mean that people awaiting an assessment for both ADHD and Autism only wait once rather than multiple times.

b). Improving Front-Door Triage

3.4. Importantly, this work will include targeted referral and triage activity so that more of the referrals made have the necessary information available and reducing inefficiencies in current arrangements.

3.5. This will include widening referrals (for children) to Health, Education or Social Care who are in direct contact with the individual and their families, educational work with primary care and improved signposting to other services that may be appropriate for individuals (for example, given the co-existence of a range of mental health issues or substance misuse for some individuals).

c). Increasing Staffing Capacity

3.6. Alongside bringing pathways together, work will be needed to enhance the existing staffing capacity across both children and adult services. Partners recognise the challenges that there will be to recruiting specialist staff in these areas. By bringing together the pathways and phasing the implementation it is hoped that this will enable more success in recruiting to these positions.

d). Backlog Reduction

3.7. It is recognised that whilst work is needed to improve the long-term sustainability of the neurodiversity pathways, further work will still be required to reduce the size of the backlog for both children and adult services. This will take into account learning from previous approaches.

3.8. The plans are for these changes to be implemented in phases - across 2023/24 and 2024/25 as summarised in the table below.

0-18 Neurodiversity Pathway	
Phase 1: 2023/24	• Continue work on backlogs across the existing services and understand ongoing demand levels. • Plan for movement of the under 11s ADHD service from Gloucestershire Hospitals NHS Foundation Trust (GHFT) to Gloucestershire Health and Care (GHC).
Phase 2: 2024/25	• Commence movement of the under 11s ADHD service from Gloucestershire Hospitals NHS Foundation Trust (GHFT) to Gloucestershire Health and Care (GHC). • Create one single 0-18 neurodiversity service within GHC – working closely with Gloucestershire County Council to ensure that as a system we are meeting the needs of neurodiverse children.
18+ Neurodiversity Pathway	
Phase 1: 2023/24	• Front-end interventions to strengthen triage, signposting and improve the quality of referrals. This phase is critical in ensuring that the right quality information is being received and support is available to those who need it most. This is expected to reduce inappropriate referrals and improve the quality of referrals.
Phase 2: 2023/24	• Targeted capacity increase in the team to increase the number of assessments carried out.
Phase 3: 2024/25	• Targeted capacity increase in the team to increase the number of assessments carried out.
Phase 4: 2025/26	• Strengthened clinical leadership and sustainable long-term model.

3.9. As highlighted above, plans are in place to support pathway improvements. Modelling work is in progress to confirm the specific impact that will be made on performance as a result of investment. Given the pressures on the service there is a need for investment and given that service redesign plans are progressed, delegated authority to the CEO, CFO and Chair of NHS Gloucestershire ICB is requested to enable decisions to be made swiftly once this modelling has been completed.

0-18 Neurodiversity Pathway				
	2023/24	**2024/25**	**2025/26**	**Recurrent**
Pay / Workforce Costs	£228,208	£366,249	£366,249	£366,249

Non-Pay Costs (Revenue)	£11,508	£12,319	£12,319	£12,319
Overheads	£35,957	£56,785	£56,785	£56,785
Funded via NHSE	-£74,488	-£101,003	-£101,003	-£101,003
Total	**£201,185**	**£334,350**	**£334,350**	**£334,350**
18+ Neurodiversity Pathway				
	2023/24	**2024/25**	**2025/26**	**Recurrent**
Pay / Workforce Costs	£284,817	£475,340	£561,307	£561,308
Non-Pay Costs (Revenue)	£16,552	£26,131	£29,624	£29,624
Overheads	£45,205	£75,221	£88,640	£88,640
Total	**£346,575**	**£576,691**	**£679,571**	**£679,571**
Across both pathways				
Total	**£547,760**	**£911,040**	**£1,013,921**	**£1,013,921**

3.10. In the long-term it is important that we work together to improve and enhance the partnership offer of support made to individuals and families, including universal service, prevention and early help, education as well as those services providing support following assessment. This partnership working is vital to move us to effective, multi-agency services for neurodiverse children and adults.

4. Summary

4.1. The changes proposed above start to move the services onto a more sustainable footing for the longer-term. By bringing pathways together, increasing staffing capacity, improving front-door triage and undertaking specific work on the backlog this is expected to have an impact in this area.

4.2. By making these changes:

- People waiting both ADHD and Autism assessment will need to only wait once – rather than on two separate pathways
- We expect the number of referrals that are returned (because they lack sufficient information) to reduce and being able (for children) to receive referrals from Education, Health or Care professionals working with the child will also support this
- Professionals will be able to work more flexibly across either the 0-18 or 18+ age range
- It is expected to slow the length of time that people are awaiting an assessment for ADHD and Autism.

4.3. We also expect that over the longer-term, the benefit of diagnosing people earlier will help to improve health and wellbeing outcomes for these individuals as described in 2.5 above.

4.4. It is important to note that given the significant increase in referrals the impact this will have will not be immediately felt for everyone waiting. Like other systems we have important work to do in this area. It is though important that we work with people awaiting assessment and their families to implement the changes described.

Agenda Item 12

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

<table>
<tr><td>Report Title</td><td colspan="4">ICS Digital Strategy</td></tr>
<tr><td>Purpose (X)</td><td>For Information</td><td colspan="2">For Discussion</td><td>For Decision
x</td></tr>
<tr><td>Route to this meeting</td><td colspan="4">The ICS Digital Strategy has been developed by system partners and has been approved by each ICS partner organisation board</td></tr>
<tr><td></td><td>ICB Internal</td><td>Date</td><td>System Partner</td><td>Date</td></tr>
<tr><td></td><td>Strategic Executive</td><td>18/5/23</td><td>GHFT
GHC
GCC</td><td></td></tr>
<tr><td>Executive Summary</td><td colspan="4">The ICS Digital Strategy outlines our key digital priorities from 2022 to 2025, with benefits for the citizens and our staff. It is a strategy which we have developed together as a system. Our vision is to:

“Design, develop and deliver simple and sustainable digital, data and technology services with our citizens, and our staff, to meet their current and future needs”

Gloucestershire has a number of health and care priorities as a county that this digital strategy supports. Meeting the needs of our frail and elderly citizens is combined with support for clinical priorities such as respiratory care, diabetes and mental health.Those priorities span our health and social care colleagues and much of the strategy is about strengthening our integration to better support citizens in their homes as well as in our care facilities.It is not just about technology, our goal is to deliver quality services for the people of Gloucestershire, our success will be measured on how we all will be able to manage our population’s health.

This digital strategy provides simplicity for every citizen when connecting to health and care services across the county. Our strategy is underpinned by our data and digital transformation plan delivering platforms that are secure and trusted by our people and our care professionals.

The strategy support our net zero ambitions across the county as well as providing a digital environment that encourages research and life long learning.</td></tr>
</table>

<table>
<tr><td>Key Issues to note</td><td colspan="4">The last 2 years has introduced us all to greater use of technology than ever before in health and care, and we are determined to harness its potential to improve and join up care for our population. Our teams have embraced new technologies faster, and adapted to provide support and care in different ways to meet the needs of local people.

This strategy defines a level of ambition for the system which is pragmatic and achievable. There is some funding expected but not yet confirmed for 2324 but for 24/25 there are a number of unfunded schemes. The availability of plans will enable us to take advantage of any opportunities that may arise for digital funding.</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">There is a risk of not being able to fully achieve the ambition set out in the strategy due to lack of resourcing.

Add a risk rating, even if low:
(4x3) 12
(4x2) 8 (residual meaning accepted risk)

This risk will be mitigated by taking advantage of any opportunities which arise for digital funding.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">Answer the following questions:
• There are no known conflicts of interest</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td>x</td><td>Information Management & Technology</td><td>x</td></tr>
<tr><td>Human Resource</td><td>x</td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">This strategy had a costed plan to complement it.
Years 22/23 and 23/24 the digital plans are included in the system financial plans which are agreed. There is some funding expected but not yet confirmed for 23/24 but for 24/25 there are a number of unfunded schemes. The availability of plans will enable us to take advantage of any opportunities that may arise for digital funding.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">This is a high level strategy which sets out priorities for digital programmes. Detailed plans will be developed which will consider any regulatory and legal issues. There are no known regulatory or legal issues at this time.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">The strategy will develop a detailed digital inclusion strategy which will outline any areas of health inequality arising from the implementation of a digital initiative with plans of how to address these.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">EIAs will be completed within each project.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">An outline of the actions which contribute to Gloucestershire’s green plan are in appendix 1</td></tr>
</table>

Patient and Public Involvement	A detailed patient and public involvement plan will be developed as part of the delivery plan for the strategy		
Recommendation	The Committee/Board (delete as appropriate) is requested to: • Approval of the ICS Digital Strategy		
Author	**Dr P Atkinson**	**Role Title**	**CCIO**
Sponsoring Director (if not author)	**Dr P Atkinson**		

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

Digital Health and Care Gloucestershire

2022 - 2025

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Contents

- Welcome to Our Digital Strategy
- One Gloucestershire
- Our Digital Vision, Priorities & Person Journeys
- Digital Themes – current state, where we want to be, how we are going to get there
- Our Outline Plan for Delivery
- Investment Plan
- Appendices

Chapter 1: Welcome to Our Digital Strategy

Our Vision

Design, develop and deliver simple and sustainable digital, data and technology services with our citizens, and our staff, to meet their current and future needs.

Introduction from the ICB CEO

The last 2 years has introduced us all to greater use of technology than ever before in health and care, and we are determined to harness its potential to improve and join up care for our population. Our teams have embraced new technologies faster, and adapted to provide support and care in different ways to meet the needs of local people.

This digital strategy provides simplicity for every citizen when connecting to health and care services across the county. Our strategy is underpinned by our data and digital transformation plan delivering platforms that are secure and trusted by our people and our care professionals.

The strategy support our net zero ambitions across the county as well as providing a digital environment that encourages research and life long learning.

Introduction from our CCIO

Gloucestershire has a number of health and care priorities as a county that this digital strategy supports. Meeting the needs of our frail and elderly citizens is combined with support for clinical priorities such as respiratory care, diabetes and mental health.

Those priorities span our health and social care colleagues and much of the strategy is about strengthening our integration to better support citizens in their homes as well as in our care facilities.

It is not just about technology, our goal is to deliver quality services for the people of Gloucestershire, our success will be measured on how we all will be able to manage our population's health.

Chapter 2: One Gloucestershire

- Gloucestershire has been working in a ‘structured’ partnership across health and social care (known as an Integrated Care System or ICS) since 2018
- This partnership is known as ‘One Gloucestershire’
- It’s made up of local health and care partners including:
  - Gloucestershire Integrated Care Board (ICB), that plans for and commissions health and care services to meet local needs
  - Primary Care (GP) providers
  - Gloucestershire Health and Care NHS Trust that provides community physical, mental health and learning disability services
  - Gloucestershire Hospitals NHS Foundation Trust that provides specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital
  - South West Ambulance Services NHS Foundation Trust
  - Gloucestershire County Council that jointly commissions a range of services with the NHS, is responsible for social care and public health
  - and wider partners such as the City Council, Districts and the Voluntary and Community Sector (VCS)

One Gloucestershire

Working as an Integrated Care System means:

- greater focus on supporting people across the county to be healthy, independent and involved in developing active communities
- more joined up care and support for people whether in their own home, at their GP surgery, receiving community or social care support or in hospital
- easier for staff to work across organisations to support shared health and care priorities
- greater freedom and control to make local decisions about how services are organised and delivered that make best use of the Gloucestershire pound
- more opportunities to make the best use of scarce resources and support a net-zero NHS

Chapter 3: Our digital vision and priorities

Simplicity for the citizen

- Making the best use of technology
- Preventative and assistive technology

Support for health and care colleagues

- Establishing a digital working culture

Levelling up maturity and harmonising pace

- Partnership working

Joining up care across the county

- Shared care record

Simplicity for the citizen

Delivering digital for the population of Gloucestershire

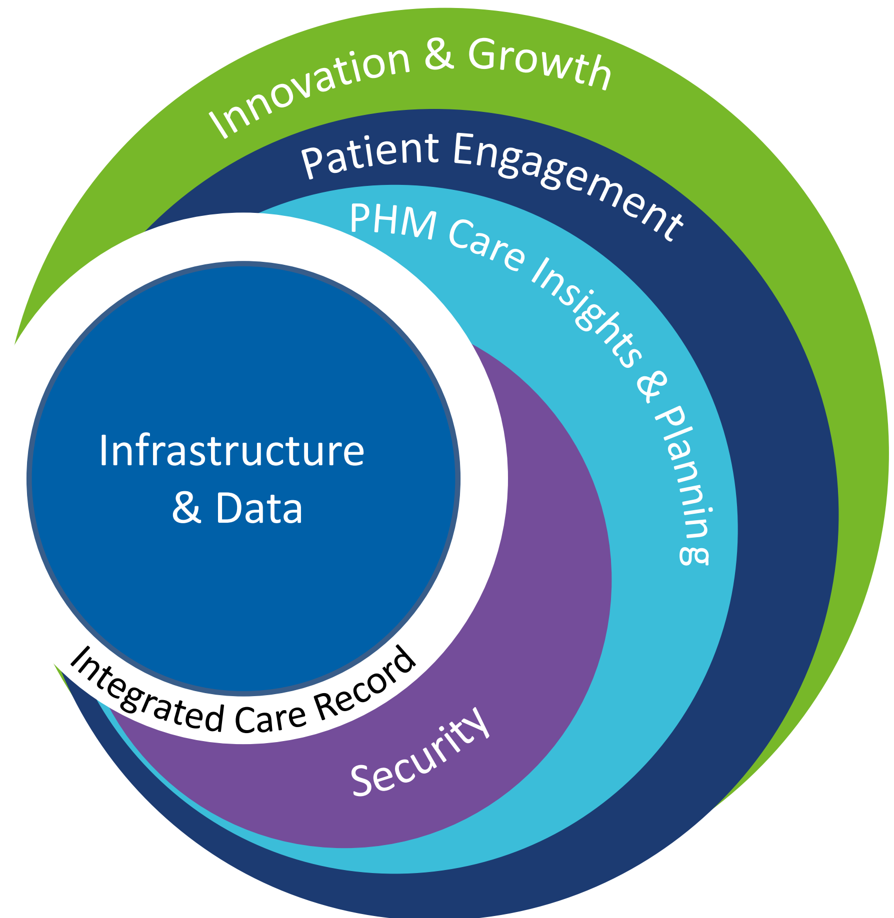
The Gloucestershire population will have available to them digital services they value which are **simple**, **trusted** and **engaging**.

Our citizens will only have to tell their story once as all health and care professionals understand their needs, medication etc, through their shared care record.

People will have the support they need to gain the skills to access our health and care services digitally. We will address **digital exclusion** across the county, enabling our citizens to develop digital skills, not only for health and care assistance but to improve modern social/digital inclusion, especially with our most vulnerable groups. Facilitating independence of care to citizens through digital services will provide greater personal choice and control over the way the ICS will meet their needs.

The public will be involved as stakeholders in developing, designing and adopting new digital services – from agreeing what information should be shared with whom, through to reviewing how and indeed whether new systems should be introduced.

Simplicity for the citizen - making the best use of technology



Simplicity for the citizen - making the best use of technology (cont..)

Having access to digital and technology solutions will empower the people of Gloucestershire to have more control over their health and care, to be comfortable in using technology and data to manage their health throughout their lives, promoting healthy living and manage long term conditions where required. Where health deteriorates and / or care needs increase, digital and technology solutions will provide an opportunity for our citizens to have choice over their care requirements and with more efficient use of staff time, improve the response of the care provision to match their needs.

Supporting our digital journey we will have in place the necessary infrastructure, robust governance standards, cyber security and services to deliver safe, modern health and care services.

Data capture and linkage will help us plan our resources and support clinical decision making. Through this we will deliver inclusive services, reducing variation and enhancing safety within our ICS.

With an enhanced AI data-driven approach we will gain a deeper understanding of our population (through Population Health Management). We will design new models of care and implement change using data-driven analysis and predictive modelling tools that will focus on the needs of our citizens.

Utilising investments in communication technology over the last few years, we will connect key care applications and harness the continual increase in coverage of social media. Our virtual presence will increase to capture care data from individuals and provide diverse digital ways to interact with our citizens.

Simplicity for the citizen - preventative and assistive technology

Through the use of preventative and assistive technology, both in home and in person, we will improve our citizens self-care services to support more people to remain living independently in their own homes.

Citizens will trust and be motivated by the digital tools available to them and be an active participants in the management of their own health and care. Through this, true personalised care interactions will allow our citizens to have [the] choice and control over the way their care is planned and delivered.

Our goal is to fully integrate technology within the care journey, making technology enabled care a core part of our service delivery models.

However, we do recognise that the use of digital and technology solutions is only one way to access services and for care provision. As such, we will continue to provide our citizens with choice based on their preferences.

Support for health and care colleagues

Delivering digital for our colleagues in health and care

Embedding digital and technological solutions that can improve efficiency of working practice will help to reduce demand for services and provide an alternative to face-to-face service provision where appropriate and beneficial for the citizen. This will also help address significant workforce shortages and enable our staff to focus on their core values of helping people whilst managing their own work / life balance.

We will support colleagues to gain confidence in using digital tools. For some colleagues, digital and data skills of discovery, design and development will be a core part of the evolving culture within teams and roles. We will utilise digital and data to redesign care pathways and establish new 'digital first' services such as remote monitoring, digital triage, and consultations, technology enabled care at scale and data-enabled population health management.

We recognise that implementing digital technology at scale will significantly change how our staff across health and care work, and these changes can create anxiety. As such, we have prioritised investment in engaging our staff in re-designing services, and in building capacity and skills in utilising technology. Our staff being aware, confident and excited about technology as a driver of new offers will be fundamental in delivering a successful strategy, and sustainable health and care system.

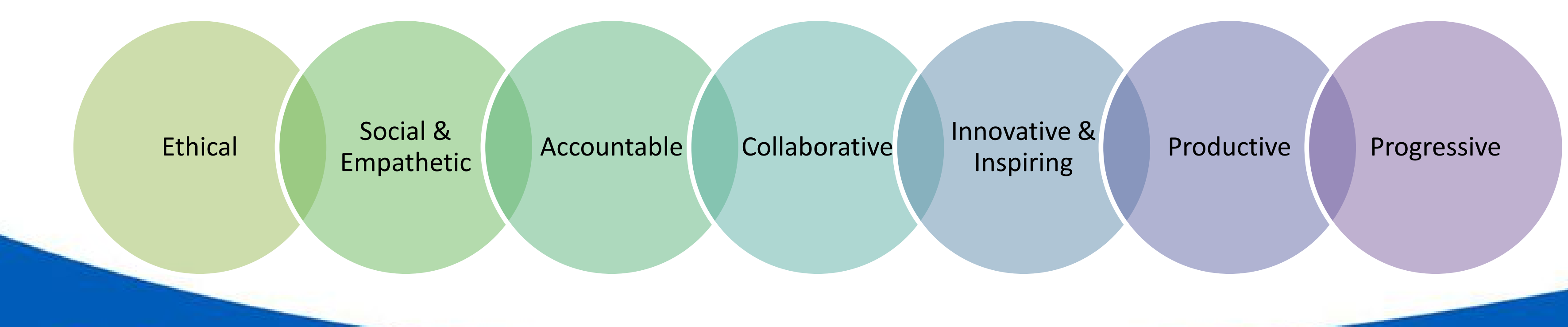
All partners across health and care will be both contributing to, and benefiting from, real time information, images and insights flowing between organisations and supporting alerting clinicians, practitioners, patients and carers to make safe decisions in support of the health services delivery to and care of individuals in the Gloucestershire population. This will help us to develop a reputation as a digital leader will act as an 'attractor' for people to want to work in Gloucestershire.

Support for health and care colleagues - establishing a digital working culture

How our colleagues work as individuals and how they interact with each other, in care teams and more broadly, is shaped by physical and digital interactions – and is enabled by technology. Our desired core digital behaviours apply to all of us; no matter who we are, what we do or where we provide our care services. The technology we adopt, how we manage it technology and how we use our data use therefore influences the way we work.

Our digital strategy highlights how we plan to establish a 'digital working culture' to enable us to effectively work together for the benefit of the Gloucestershire population. In so doing, we develop trust in our services and consistency from our colleagues.

Desired digital behaviours



Levelling up maturity and harmonising pace

Delivering digital for all the partner organisations in the ICS

A Gloucestershire-wide digital operating model will be fully established – with digitally mature foundations in each partner organisation, a digitally aware ICS leadership team and a data-led decision making culture.

The digital operating model for the ICS will be delivered through financially sustainable partnership digital services, workforce models and skills development – all underpinned by a comprehensive shared care record. The ICS will use improved data in relation to performance to understand where the care system requires intervention, leading to improved decision making and use of scarce resources.

Digitally enabled care will transform the way in which our services are delivered, and therefore will improve the patient experience whilst systematically reducing waste, resources and carbon emissions.

Gloucestershire will have embedded an adaptive learning approach* across the ICS, supported by core linked data services. It will ensure that staff and the public are confidently and consistently using quality data for operational and clinical decision making, innovative commissioning, understanding and addressing inequality and supporting open public deliberation about care provision across the county. That will extend to academic partners including the University of Gloucestershire, the West of England AHSN and The ARC.

All partners will move forward in digital maturity with no partner left behind and that all will share in digital maturity increases and digital skills uplift.

**adaptive learning in this context means using artificial intelligence to continually develop and refine insights about a population*

Joining up care across the county

Delivering digital for all the partner organisations in the ICS

Each part of our health and care system needs to be excellent in designing and unifying the digital information on which we rely. We will commit to innovation, transformation and doing things differently to ensure our digital services are in line with peoples every day use whilst maintaining NHS Digital standards.

Utilising the power of joined-up digital capabilities, integrated care teams from health and social care can unite effectively to serve our population. Removing the requirement of paper-based processes for collaborative working is enhanced by, not limited by, technology.

A shared care record underpins integrated care for our citizens. Our digital strategy uses this as a foundation to bring systems, new and old, together for the benefits of all.

Digital capabilities support **fluidity** of health and care staff – enabling colleagues to work in multiple care settings and ensuring practitioners can work in any health or care location.

Joined up care extends beyond clinical colleagues and social care practitioners to key support services that enable frontline practitioners within health and care.

Chapter 4: Our Delivery Approach - Digital Strategy Themes

We have identified **five key themes** to articulate our approach to delivering the digital strategy. These have formed the basis of the development of the activities to deliver the vision. These are summarised below and in further detail in subsequent pages

1. Delivery Framework

- Our digital strategy is integral in driving our health and care future, demonstrates our commitment to change through citizen and staff engagement, robust planning and prioritisation
- We will invest in a people-first, needs-led change management approach to ensure successful delivery

2. Levelling Up

- All partners will move forward in digital maturity as one, ensuring no partner is left behind and all partners share in digital maturity increases and digital skills uplift.
- We will invest in a digitally inclusive community, ensuring equal access and connectivity to digital solutions

3. Data & Information Sharing

- We will build the infrastructure, systems and digital tools to enable appropriate information to be shared in real-time to enable collaborative working and decision making, whilst improving planning and evaluation of services.

4. Innovation & Growth

- We will maximise the implementation of digital tools, products and services by changing our models of care, workforce and citizen engagement to continue to meet our citizens needs.

5. Population Health Management

- PHM tools will give us insights into our population that will support clinical decision making and inform interventions.

Chapter 4: Our Delivery Approach – measuring success

The approach and activities set out in subsequent slides are a strategic view of our existing priorities based on the current environment we are operating within. It is important that the digital strategy has a clear method of ensuring it is focused on delivering evolving priorities, as we will no doubt witness, as well as providing a clear method of evidencing impact against a defined set of measures. As such, the system Digital Executive Group have agreed the following:

1. **Ambition and reference framework:**
   a) The national framework for assessing digital maturity at a system level is HIMSS Continuity of Care Maturity Model (CCMM) – the system has been assessed against this model and were assessed between stages 1 and 2 for the different stakeholder components – clinical, information technology and governance. The ambition, as reflected in the strategy, is to move the system up to HIMSS CCMM Level 5.
2. **Measurement of success:**
   a) It is important to have clear success measures and approach to evaluation to demonstrate progress, evaluate priorities, and justify ongoing investment
   b) Whilst CCMM above will be key to measuring success, there will be others that will need to be reflected upon e.g. return on investment – a priority within the digital strategy is to agree / enhance the delivery mechanism behind the strategy. The success measures and evaluation approach will be delivered as part of this work.
3. **Review process**
   a) There will be a regular review of the digital strategy to ensure it is delivering against the plan, value for money and is focused on the right priorities for the system. This will be agreed as part of the delivery framework

Delivery Framework

Digital strategy themes – delivery framework

Where are we now?

- A good understanding of our level of maturity in each organisation, our delivery approaches and individual organisational strategies which was baselined as part of the CCMM evaluation.
- A clear joint ambition aiming to meet CCMM level 5.
- An ICS wide governance structure is in place with accountability at Executive level in each organisation. The governance structure is evolving as the ICS becomes more mature
- A recognition that resources are constrained but a commitment to work collaboratively to ensure that no one organisation is left behind

Where do we want to be?

- **Drives strategy:** Digital strategy integral in driving the system's health and care strategies, co-produced and aligned but challenges organisational digital strategies to be consistent; digital strategy aims to stretch ambition as benchmarked against other systems but also reflects a pragmatic approach to delivery
- **Framework for improvement:** Provides a framework that drives improvement across health and care
- **Costed plans:** Supported by a clear, costed roadmap that accounts for and co-ordinates each individual organisational ambition, shifting resources across the system to deliver as one; recognises the investment in digital leadership and digital change capacity
- **Implementation is critical:** Plan recognises conditions to deliver successful change – leadership, co-production and engagement with frontline to practically deliver change, build evidence and deliver impact, change capacity and capability, agile change approach. Ability to describe, capture and monitor benefits. Change approach will provide a framework for communication and engagement, including fostering, encouraging and guiding innovators within our workforce to lead and contribute to change.
- **Ability to scale:** The system will have a clear approach to evaluation and ability to scale digital interventions that improve outcomes and costs across the system

How are we going to get there?

- Develop system-wide digital strategy with a costed roadmap
- Development of enterprise architecture as a framework for technical strategies including data strategy, systems architecture, cyber security
- Clear governance to provide framework for investment and decision making
- Clear implementation approach – priorities, people-first, ability to scale, agile delivery, continual assessment of conditions for successful change
- By engaging with patients / citizens in co-producing solutions

Levelling Up

Digital strategy themes – levelling up

Where are we now?

- Significant investment over the past 5 years in digital infrastructure and maturity has put in place the foundations for an ambitious vision to become digitally advanced when benchmarked against similar ICS's
- A joint network infrastructure is in place across the ICS has improved connectivity and access for staff and is the beginning of improving ways of working across the organisations
- A commitment to improving the digital literacy of our staff There have been a number of new or upgraded clinical and social care systems being implemented increasing functionality which has enabled more clinical and social care information to be available to clinicians across the system

Where do we want to be?

- **Digital foundations:** All system organisations have the basic digital foundations to support innovation and growth, prioritising the whole system to progress in the medium term towards HIMSS digital maturity index level 5 or equivalent in social care
- **Invest in workforce:** Equip our staff and organisations with the digital tools, infrastructure, hardware and technology enabled care to work as effectively as possible in enabling improved outcomes.
- **Connectivity and access:** Enhance connectivity and access to wifi networks, systems for our staff, providers and citizens so frustrations become a thing of the past
- **Digitally enabling workforce / organisations:** invest in training and embedding a digitally enabled workforce, digital culture and enhance new ways of working
- **Digital inclusive communities:** improving connectivity, access, digital literacy and digital skills of our communities to enable people to have choice and control over their lives; we will engage and support more vulnerable, diverse, seldom heard groups through digital solutions; support families and carers help those they care for engage digitally

How are we going to get there?

- Prioritised investment in digital foundations as basics for innovation and growth
- Clear workforce strategy to first baseline, then plan to embed the digital skills – building first awareness then understanding and finally digital confidence across health and care
- Developing "digital skills for digital people" and support technology-enabled learning for all elements of the workforce
- Investing in digital projects that positively impact the workforce such as rostering, staff passports and AI / RPA to manage frequent and repetitive tasks and to support decision making
- Investment in connectivity and access to basic infrastructure for our citizens across the county, engage with communities in improving digital skills

Data & Information Sharing

Digital strategy themes – data & information sharing

Where are we now?

- Gloucestershire was one of the first areas in the country to implement a shared care record system which has a rich source of data from multiple organisations. The contract is ending and the shared care record system is being reprocured
- There is a commitment from all organisations to maximise the benefits of the new shared care record system adding richer clinical and social care datasets as they become available
- Use of the NHS app and online digital tools, particularly in primary care saw a significant increase during Covid. Usage was largely for transactional services such as appointment booking which saved administration time.

Where do we want to be?

- **Shared intelligence:** Build a digital and data offer that enables sharing of real-time, timely information across systems to support multi-agency operational and strategic decision making, ultimately improving the care and support to citizens. We will embed a new shared care record as one vehicle in enabling this to be achieved.
- **Collaborative working:** The offer will enable collaborative working across organisations, supporting shared expertise, knowledge and technology
- **Online platforms, digital tools and technology:** Systems are easy to access for our workforce and organisations with increased use of digital tools and technology to support decision making, efficiency and promote the fluid use of scarce resources across the county e.g. RPA, AI / machine learning. Online platforms, digital tools and technologies are easy to access for our citizens to support improved advice and guidance, communication and self-care e.g. unified app, digital front door, etc.
- **Digitally enabling workforce / organisations:** Information used will provide a single version of the truth, support integrated decision making, planning and commissioning, with the ability to analyse to increase proactive and preventative care across the system

How are we going to get there?

- Prioritise procurement and implementation of a new shared care record building on the progress made within the existing system
- Invest in digital service transformation to maximise the impact of sharing of information and use AI and RPA to address workforce challenges
- Develop a plan and implement improving health and care information and services for citizens, including personal health records
- Establish a system wide digital dashboard to maximise system-wide access to intelligence

Innovation & Growth

Digital strategy themes – innovation & growth

Where are we now?

- Closer links with universities and medical schools have been developed to help alleviate workforce shortages
- Digital solutions such as online consultations and virtual wards have increased capacity and made some efficiencies in clinical services
- Service transformation leads are reviewing more digital solutions to improve patient care across the patient pathway

Where do we want to be?

- **Improved access to technology solutions:** Develop patient-facing technology that provides people with a less intrusive and alternative approach to managing their health and care needs. The technology will be simple to use and access e.g. through single sign-on and will be thoroughly tested for data security and clinical safety.
- Fundamental shift in workforce: Develop a digital offer to ensure that the workforce has the best digital tools to work as effectively as possible, provides opportunities for career progression and development, the ability to work collaboratively across organisations and roles in sharing expertise, systems, services and technology. This includes support functions as well as the frontline. Develops a digital workforce to respond to changing environment, improving the recruitment and retention of our workforce across all disciplines.
- **Transformation and continuous improvement:** Invest in service transformation to maximise the impact of developing technologies in shifting the model of care, enabling personalised health and care and improving outcomes. Keeping on top of technological advances in improving outcomes for people through partnership networks. Utilising technology to reduce our carbon footprint.

How are we going to get there?

- Develop and implement technology enabled care (TEC) strategy and plan
- Develop and implement One Gloucestershire community wide data analytics strategy and plan
- Continuous assessment of market / supplier developments through partnership networks
- Plan and embed at scale active citizen self-care / health management plan
- Working with partners in the regional UX lab to embed user-centred design (e.g. joint R&D project with BNSSG ICS around Autism)

Population Health Management

Digital strategy themes – population health management

Where are we now?

- Gloucestershire ICS has a successful programme of work implementing PHM in primary with clinical champions driving this forward within PCNs. A PHM roadmap is in place and the governance structure and priorities are being reviewed
- The development of a data strategy has begun which will incorporate a review of the ways of working, capability and infrastructure required for a PHM programme

Where do we want to be?

- **Insights driving population wide decisions:** Tools providing the insights into population behaviours and health & well being to enable targeted decision making and inform interventions that take into account wider determinants of health and the potential impact
- **High quality predictive analytics:** Develop utilisation of co-ordinated intelligence and predictive analytics to support population planning and long term service planning. The ability to utilise a range of data sources to undertake longitudinal analysis to plan at population level across the system whilst driving prevention at scale
- **Research:** Work with academia to enhance quality improvements, research and audit opportunities; promote the use of trusted research environments in supporting long term planning
- **Citizen engagement** Improved working with citizens and patients in strengthening their skills, knowledge, decision making and control through improved access to evidence, in addition to behavioural interventions

How are we going to get there?

Working alongside system-wide PHM infrastructure in developing the analytics capabilities in:

- Development and embedding of population health management approach including data warehousing capabilities
- Develop PHM techniques, identifying initial priority cohorts
- Provide the digital foundations / intelligence to support the delivery of targeted interventions at scale; re-design services, develop digital twin capability (scenario planning) based around PHM analytics
- Provide intelligence to support the implementation of population health management academic / research studies to support long term planning, working with PHM system infrastructure / workstreams
- Digital and technology solutions to support and enable the drive for personalised care (linked to ShCR)

Bringing the strategy to life – people journeys

Jill is 20 and has been living with a complex learning disability that impacts on her confidence interacting socially. She also has physical health conditions that requires her to take regular medication otherwise her health deteriorates which can cause serious implications.
She has spent her childhood being cared for by parents and within a special school for her education. She has limited independent living skills and has struggled to gain employment since leaving education at the age of 18. She has recently moved out of the family home into an independent living environment. She has a low level support plan with social care and has regular appointments with a community nurse to manage her health conditions.

Themes

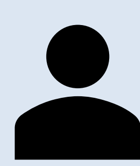
A smart home and access to applications tailored for Jill
Jill will have access to a tablet that will include applications that provide practical videos to support independent living, such as cooking and cleaning. She will have worked with a charity to tailor these applications to her living environment. Jill will be remotely assessed by a practitioner in her place of living to prevent anxiety in having to visit a busy GP practice. Jill can also use the tablet to engage socially with friends and family to prevent her being isolated – this improves her mental well-being and assures her parents that she is coping living independently.

Jill uses a range of online platforms to link in and access local services, providing opportunities for social interaction.

Access to Jills shared care record through her personal health record
Health and social care practitioners will have access to Jill's shared care record to have a full view on her health and care needs. The shared care record will include information from a range of health, care and voluntary sector organisations that Jill engages with. This will provide more context and help tailor the care and support plans to support her to live independently.

Utilising technology-enabled care solutions to reduce care support
Jill has access to a range of TEC solutions to support independent living and reduce the number of care workers having to help with care needs. This includes help such as medication dispensers, digital diaries, meal plans that act as guidance and prompts to live independently whilst managing health and care conditions. This also reduces the cost of paying for care workers in her home.

Bringing the strategy to life – people journeys



Frank is 85, lives with his 83 year old wife and has been living with progressive dementia for 3 years
He has a number of health conditions of which restricts his mobility and requires him to take medication daily. His wife helps with basic care needs but is also frail. They live 75 miles away from their daughter who visits monthly. They receive twice weekly visits from domiciliary care to support with personal hygiene. Frank has started to change his behaviours, getting up in the middle of the night, letting himself out and wandering the streets and leaving the gas on the cooker. He has also had a recent hospital visit due to a mild fall.

Themes

Technology enabled remote monitoring in Frank's home will allow him and his wife to be as independent as long as possible
Sensor technology, linked to emergency remote monitoring dashboards will enable care support to monitor behaviours and intervene if needed. This includes front-door sensors, cooker sensors

Frank will wear a wrist watch sensor
This will be used for vital signs monitoring and to detect potential falls. Information collected in Franks watch will be captured in his personal health record with care plans created automatically and updated by her trusted set of carers. Use of artificial intelligence / machine learning will drive alerts to carers and the GP relating to Franks condition.

A population health management service
Will be able to identify more people like Frank across the system and enable early, targeted care to prevent escalation of need within the health and care system. Cohort identification and risk stratification tools of the population will look to reduce inequalities in the system and enable individuals to be partners in their own care.

A digitally enabled workforce across Gloucestershire
Will be able to work remotely and effectively to care for Frank and his wife. Information relating to his condition can be shared effectively across care settings and will provide more co-ordinated and joined up care for Frank. Staff will be confident in identifying technology solutions alongside face to face care to ensure Frank remains living independently as long as possible as his health condition deteriorates.

Bringing the strategy to life – people journeys

Michelle is 41, 4 months pregnant with her first child and lives with her husband
The couple have struggled with their fertility and this is the first time they have been able to conceive. Michelle was diagnosed with polycystic ovary syndrome (PCOS) in her 20s and has managed the hormone imbalance with daily medication. She also has type 1 diabetes and must maintain stable blood glucose levels as her hormones change.

Themes

Access to apps linked to Michelle's Patient Held Record
This will allow her to follow her progress. Appointments, results and birthing plans online. This will be a single source of information that can be accessed via a mobile or PC device and can be taken to any of her appointments with her GP, midwife or diabetes team.

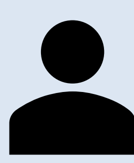
Access to Michelle's longitudinal health and care record
This will allow midwives, gynaecologists, nurses, her GP and diabetes team to have a single source of information relating to Michelle's pregnancy and diabetes. This will enable more personalised care for Michelle.

Robust cloud-based infrastructure across the ICS
This will allow midwives, gynaecologists, nurses, her GP and diabetes team to input information seamlessly form any care setting or hospital and will be updated in real time.

A digitally enabled workforce across Gloucestershire
Will be able to work remotely and effectively to care for Michelle during her pregnancy. Information relating to her health history and current conditions can be shared effectively across care settings and will provide more co-ordinated and joined up care.

Condition monitoring apps relating to Michelle's diabetes and PCOS
This can be accessed via her mobile. She is able to track her symptoms throughout the pregnancy, deal with multi co-morbidities which will be monitored remotely and integrate automatically into her PHR. Michelle and her practitioners will be alerted via the app if her condition is noticed to be abnormal through AI / ML

Bringing the strategy to life – people journeys



Ahmed is 45, is dyslexic and has been living with chronic depression since separating from his wife 15 years ago
He is on medication to support his depression having attempted suicide 12 years ago. His dyslexia and depression has prevented him from gaining employment. He attends interviews every 2 years which causes severe anxiety and worsening health conditions. He likes socialising but has found it difficult because he is on benefits and struggles to afford to go out but also his depression impacts on confidence to meet new people – he has tried to search on the internet but his local wifi connection is very poor. He is a religious man and used to be a very active part of his local mosque but rarely visits now due to the stigma of his mental health issues. He visits his GP weekly.

Themes

Access to applications tailored to Ahmed
Ahmed will have access to applications via a mobile device or tablet that provide practical video guidance to support communication and enable him to prepare for interviews in the comfort of his own home. He also utilises the apps to connect to local community activities, accessed through a local directory of services. He undertakes self assessment questionnaires online that then link him to local services that are free to use.

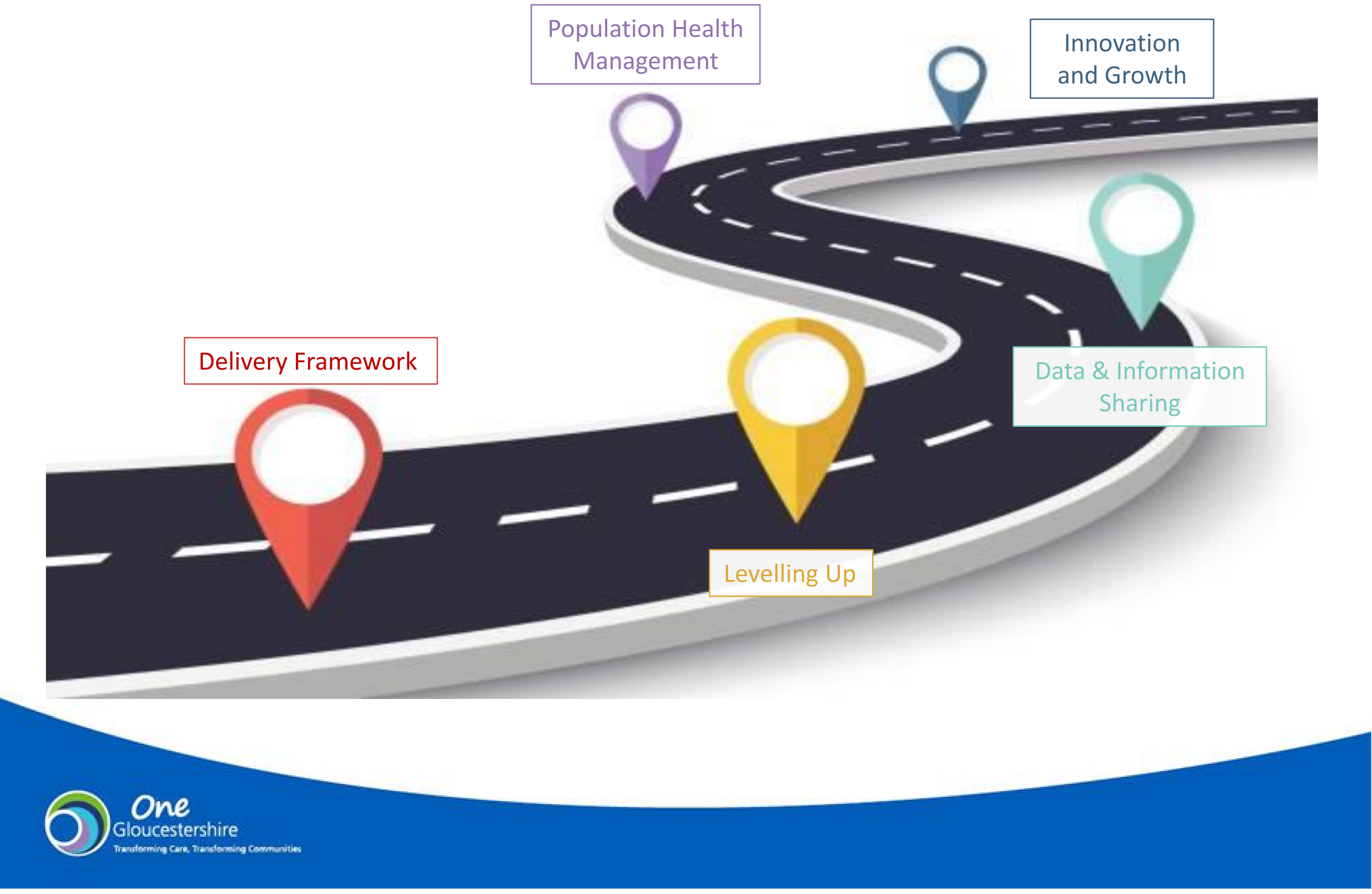
Improved connectivity
Investment in local connectivity and wifi means Ahmed can now utilise web services to explore local services to connect with the community and improve his mental well-being.

Access to Ahmed's longitudinal health and care record
Health and social care practitioners will have access to Ahmed's shared care record to have a full view on his health and care needs. The shared care record will include information from a range of health, care, and voluntary sector organisations that Ahmed engages with. Ahmed is able to self report on his mood weekly and this is accessible to his GP to intervene where necessary.

4 5

Communication with local services
Local social prescribing / care co-ordinators have been able to work with Ahmed, his GP, with consented access to Ahmed's personal health records, communicate through online platforms in supporting Ahmed to engage with his local mosque. Care co-ordinators have used virtual tools to communicate with the local Imam and explain the situation and sensitivity with Ahmed's situation prior to the Imam reaching out and contacting Ahmed.

Chapter 5: Our Outline Plan for Delivery – the next three years



Our Outline Plan for Delivery – Key Deliverables & Outcomes Year 1

KEY PRIORITIES

- Establish delivery framework – strategies, plan and governance
- Establish requirements and procure new Shared Care Record
- Implementation / design priority digital foundations: unified network, system convergence in MH, acute, community and Council
- Design and implement hospital discharge dashboard
- Develop and pilot technology enabled care strategy in care homes, develop detailed TEC implementation plans and implement early prevention priorities

WHAT DOES THIS MEAN FOR.......

The people of Gloucestershire .....

- More people will have access to a broader range of technology enabled care to support living independently at home and in care homes
- People spend less time delayed in hospital, improved experience during discharge and increased independence

The staff in Gloucestershire............

- Staff are able to access networks at any time, in any place, reducing frustration of sourcing information
- Improved confidence in commissioning TEC as part of care packages for priority cohorts
- Help shape the new shared care record capability to support care co-ordination and shared planning

A sustainable health and care system.........

- Clear delivery framework and detailed plans agreed cross system to enable rapid and successful implementation of digital strategy focussing on early prevention priorities
- Reduced delayed discharges and improved system flow, freeing up beds in hospital
- TEC targeted at key cohorts of need (such as care homes), reducing costs, workforce constraints and/or demand

Our Outline Plan for Delivery - Year 1 key activities

Delivery Framework

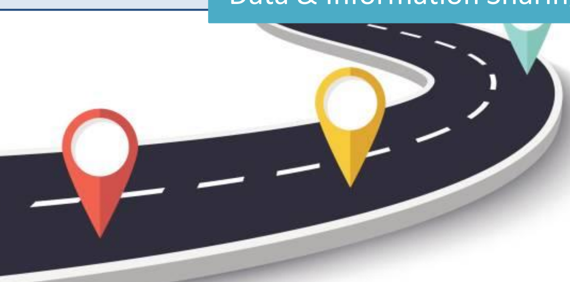
First 6 months
- Develop system-wide **digital strategy**
- Develop and agree system-wide **data strategy** – systems of record; consistent data utilisation; data interop; data sharing approach; information governance / security
- Develop and agree system-wide **governance structure** to deliver digital strategy – roll out local / national policy; investment approach; structure & decision making approach – agile, delegated limits, system v local
- **Cyber security**: develop and implement system-wide remediation plan
- Develop system-wide **operating plan / enterprise architecture** – technology, processes, people to deliver strategy

Second 6 months
- Review and develop existing system-wide **change management approach** aligned to ICS approach and resource plan to deliver digital strategy
- **Cyber security: upgrade** in line with evolving digital environment e.g. hardware / information sharing
- **Change management resource** – capacity / capability sourcing, recruitment, training
- Develop and pilot **citizen / patient engagement approach** to deliver digital strategy
- **Implement system-wide governance** structure to deliver digital strategy

Data & Information Sharing

First 6 months
- Establish requirements and procure **shared care record** (JUYI v2)
- Develop strategy and plan to improve **health and care information and services for citizens**
- Develop **plan for increased use of digital tools and platforms** – implementation of priorities e.g. MH apps, text services, BP monitoring
- Progress implementation of digital social care records with care homes / homecare providers

Second 6 months
- Develop system **hospital discharge dashboards**
- Implement virtual wards



Innovation & Growth

Second 6 months
- Develop and pilot a **technology enabled care strategy**, supporting care homes to implement a care system
- Establish **data analytics strategy**, plan and implementation approach

Levelling up

First 6 months
- **Digitally enabled workforce** – develop digital workforce plan, assess system capabilities / digital skills assessment; training needs and gap analysis
- **Digital foundations** – execute strategy including system-wide unified network (any user, access any network, any site), converged MS environment, simplified technology estate, end user devices, enabling connectivity for staff and citizens; plan for updating, converging, rationalise health and social care record systems (e.g. EPRs), implement paperless plan
- Draft / approve **digital inclusion strategy and plan**

Second 6 months
- **Digitally enabled workforce –** implementation of digital skills programme; establish digital roles
- Implement **digital inclusion hubs** and innovation fund
- **Digitally enabled workforce:** Identify and implement priority digital tools / online platform

Population Health Management

Second 6 months
- Establish data warehouse capability and repository aligned to **PHM workstream**

Our Outline Plan for Delivery – Key Deliverables & Outcomes Year 2

KEY PRIORITIES

- Undertake training and embed digital skills to priority frontline staff
- Transition to Shared Care Record, embedding shared care planning; care co-ordination
- Scale TEC opportunities for priority cohorts
- Develop and embed digital front door and increase digital tools for citizens to self-care and access digital care solutions
- Implement data analytics plan and pilot for priority cohorts

WHAT DOES THIS MEAN FOR.......

The people of Gloucestershire .....

- Technology enabled care and digital solutions will be a more integral part of care packages, improving choice, control and less intrusive care support
- Easier access and more choice of digital tools and solutions to support self care and management of long term conditions improving independence
- Less time spent repeating their story to staff

The staff in Gloucestershire...........

- Improved awareness, confidence and incidence of commissioning technology / digital solutions
- Improvements in shared care planning and care co-ordination through access to information in ShCR
- Reduced case loads as TEC / digital provides alternative to F2F

A sustainable health and care system.........

- Digital / technology solutions embedded sustainably at scale in care plans reducing reliance on staff as a scarce resource
- Shared care planning, care co-ordination improves decision making, reduces duplication, improves efficiency and costs and reduces our carbon footprint
- Evidence-led analytics supports more informed approach to embedding prevention at scale, improving outcomes and reducing costs for priority cohorts

Our Outline Plan for Delivery - Year 2 key activities

Delivery Framework

First 6 months
- **Implement operating plan / enterprise architecture** (aspects of which are covered below)
- **Implement system-wide data strategy** – confirm guardianship; establish data governance; mini operating model to resolve data quality / contention issues
- Enhance **ICS system-wide change management approach** to include digital transformation requirements
- Work with ICS **citizen / patient engagement** teams to test priority digital plans
- **Digital strategy alignment between organisations –** joint implementation, procurements, contracts, service planning, etc.

Levelling Up

First 6 months
- Digitally enabled workforce – phased implementation of prioritised **digital workforce plan through digital development programme**
- Deliver **digital leadership programme**
- **Digital foundations** – continued execution – simplification, rationalisation, investment
- Progress implementation of **digital inclusion plan,** including implementing digital inclusion hubs

Data & Information Sharing

First 6 months
- Transition to and implement new **shared care record**
- **Implement plan to improve health and care information and services for citizens** – pilot access to information; online digital tools / directories / apps (incl. digital front door)
- Develop plan and implementation approach for **digital operating model** – system dashboard, real-time feeds, design op model
- Establish plan for **personal health record**
- **Implement plan for priority digital tools and platforms –** pilot and scale

Second 6 months
- Plan, design and deliver priority quick wins of **digital service transformation** – operating model, workforce changes, data analytics, culture / behaviours
- Identify priority tools and implement plan for **personal health record –** pilot and scale

Innovation & Growth

First 6 months
- **Implement priority TEC initiatives** – priority care home needs, supplier market review, implement at scale.
- **Implement data analytics plan** – establish priority needs, source data, pilot and implement at scale e.g. risk stratification tools & case finding, ML/AI
- Ongoing assessment of **technology / supplier market developments**

Population Health Management

Second 6 months
- Develop intelligence to support **implementation of PHM techniques / priorities** including – frequent flyers, establish cohorts/ segmentation, risk scoring / stratification

Our Outline Plan for Delivery – Key Deliverables & Outcomes Year 3

KEY PRIORITIES

- Embed digital skills training / support for staff across all care settings
- Plan and implement operating / workforce model changes to maximise increased use of digital tools / TEC and shared information
- Improve connectivity and access to wifi for Gloucestershire citizens and for hard to reach groups
- Implement system wide digital operating model to include system dashboard & real time feeds
- Enhance data analytics capabilities, predictive analytics and AI to drive targeted population wide prevention

WHAT DOES THIS MEAN FOR…….

The people of Gloucestershire …..

- Improved access and confidence in using digital tools enhancing ability to be an active participant in managing their own health
- TEC, digital tools and more innovative care plans enables people to have more choice and control over care delivery
- People are living more independently, connected socially with better access to health and care options

The staff in Gloucestershire………..

- Access to relevant information, digital tools and TEC for key services across health and care enhancing care planning
- Confidence and skills in providing innovative advice, guidance and care plans that improve outcomes for people
- Improved opportunities for career progression through new workforce models
- Improved satisfaction and well-being as more manageable workload as less reliance on face to face care / reduced crises

A sustainable health and care system………

- Mixed digital, technology and people led operating and workforce model for priority areas that reduces reliance on scare people resource and is more economically viable
- Evidence led and timely approach to managing system wide demand and capacity challenges through live dashboards
- Implementation of priority population health prevention improving outcomes and reducing costs of escalating health and care conditions

Our Outline Plan for Delivery - Year 3 key activities

First 6 months
- **Cyber security: strengthen security** across the system in line with evolving digital environment
- Embed sustainable approach to **citizen / patient engagement** in co-producing digital / technology plans

Delivery Framework

First 6 months
- Digitally enabled workforce – continued phased implementation of prioritised **digital workforce plan**

Levelling up

First 6 months
- Optimise **shared care record**
- Ongoing implementation of **digital service transformation** – operating model, workforce changes, data analytics, culture / behaviours
- **Implement plan at scale to improve health and care information and services for citizens** – including possible digital front door
- Implement system **digital operating model** (dependent on data strategy / feeds)
- Implementation of plan for **personal health record –** pilot and scale

Second 6 months
- Work with PHM workstream in scoping and providing intelligence into **PHM enabled research / academic study** plan

Data & information sharing

First 6 months
- Develop intelligence to support **implementation of PHM techniques / priorities** including – frequent flyers, establish cohorts/ segmentation, risk scoring / stratification
- Digital and technology solutions to support and enable the drive for **personalised care** (linked to ShCR)

Second 6 months
- Provide intelligence to enable delivery of **whole system targeted interventions at scale**– re-design services, digital twin capability (scenario planning) based around PHM analytics (recognise already happens in Public Health)

Population health management

First 6 months
- **Continue to implement TEC plan** in care homes and hospices
- Continue to **implement data analytics plan**
- Ongoing assessment of technology / supplier market developments - partnership network, needs v market
- **Activate citizens to self-care / manage health** – consolidate pilots; priority cohorts from PHM; identify digital tools; develop plan and implement; track benefits

Innovation & growth

Financial Summary

- This strategy had a costed plan to complement it
- Yr 22/23 and 23/24 the digital plans are included in the system financial plans which are agreed
- For 23/24 there is still £5.4M of funding which is expected but not yet confirmed, there is a high degree of confidence that this monies will be received
- For 24/25 there are a number of unfunded schemes. The availability of plans will enable us to take advantage of any opportunities that may arise for digital funding.

Conclusion

- This is a strategy all partner organisations have developed together as a system
- It defines a level of ambition for the system that is pragmatic and achievable
- But it recognises that meeting the needs of our citizens across the county requires investment
- An investment case is being developed to underpin funding discussions with NHS England
- There is a gap in funding which will be sought through those discussions and through prioritisation agreed as a system

Appendices

- Appendix 1 – Delivering on Gloucestershire’s green plan aspirations

Appendix 1 : Delivering on Gloucestershire's green plan aspirations

Digitally enabled care will transform the way in which our services are delivered, and therefore will improve the patient experience whilst systematically reducing waste, resources and carbon emissions.

The coronavirus pandemic acted as a catalyst for NHS organisations to implement a number of digital initiatives at speed, in particular remote consultations, our digital strategy, which is in development is building on this work.

Digital support is embedded in a number of ICS transformation programmes supporting new care pathways where there has been a secondary benefit of supporting sustainability (e.g. covid virtual ward, children's mental health pathway).

Organisation	Goals	Objectives and actions
Gloucestershire Health and Care NHS FT Gloucestershire Hospitals NHS FT Primary Care	Conduct outpatient & other appointments remotely where clinically appropriate, taking account of patient preferences, aiming for 25% to be delivered remotely overall	Develop a digitalised pathway to become paperless organisations where clinically possible Embed digital technology to reduce face-to-face appointments for clinical activities in line with NHS Targets. Introduce digitalised meal ordering system to reduce hospital food waste
ICS	New models of care to include digital solutions where there is proven benefit.	Collaborate to ensure identification, design and delivery of transformation programmes and clinical networks that have a positive impact on sustainability are identified as potential options in the overall solution design by March 2024 Digital literacy programme jointly with GCC to enable better access to digital services by a wider range of the population
Virtual Wards	Enable a greater number of individuals to receive care at home with remote monitoring	Virtual ward programme of work to identify areas of greatest benefit to patients and the NHS through care at home with virtual monitoring

Appendix 1 : Delivering on Gloucestershire's green plan aspirations

Date	Measures of success
Year 1	Where attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation
March 2024	Reduce paper use to absolute minimum
March 2024	Develop a plan and start implementation of digital meal ordering systems
March 2023	Digital literacy programme jointly with GCC to enable better access to digital services by a wider range of the population
March 2024	Ensure identification, design and delivery of transformation programmes and clinical networks that have a positive impact on sustainability are identified as potential options in the overall solution design by March 2024
March 2025	Further rollout virtual wards in line with planning guidance

Appendix 1 : A framework for an ICS-wide sustainable digital strategy

The ICS has a fundamental role in incentivising green behaviours through system levers and incentives to change culture. Some things can be done at system level to ensure that environmental impact has been fully considered.

Rethink

- Develop guidelines for digital business case development that address the green agenda
- Investment objectives to support the net zero agenda
- Options under consideration to have a clear dimension associated with sustainability
- Options appraisal criteria to include consideration of climate change
- Procure only with suppliers committed to/ in the process of setting science-based targets for sustainability outcomes
- Management cases and business as usual service delivery models for digital services to be designed with embedded sustainability

Reduce

- Implement electronic patient records in line with national digital maturity guidelines to reduce paper usage including:
    - Reduce paper use for communication with care professionals/ patients/ residents.
    - Reduce paper use within organisations across all back-office functions.
- Reduce printers on-site to only areas where they are absolutely needed and put software in place to minimise printing and ink usage.
- Provide hardware (sensors, monitoring devices etc.) and software for patients to receive care in their usual place of residence rather than a hospital or other healthcare facility.
- Utilise e-learning to reduce travel required to attend training courses.
- Provide hardware, software, and other relevant infrastructure to ensure staff can work from alternative locations to reduce travel.
- Review and assure digital maturity and investment plans to ensure commitment to ‘cloud first’ and virtual machine approaches for existing infrastructure.
- Develop/ review/ update power management policies and protocols and embed solutions to implement the policies and report on power usage.

Re-use

- Refurbish and re-use old equipment for other purposes (for schools, charities, or UK/ overseas projects) as part of an organisation’s corporate social responsibility.
- Share learning on digital initiatives to support sustainability with other organisations across Gloucestershire.

Recycle

- Recycle digital consumables wherever possible.
- Dispose or recycle digital equipment safely, securely and in line with relevant regulations.

Further information

Our Digital Strategy can be found at:

PLACEHOLDER

The One Gloucestershire website has a dedicated page for all resources relating to ICS Development:

https://www.onegloucestershire.net/ics-development/

You can register with the GIG on-line platform to find out how to get involved in shaping the ICS in Gloucestershire: https://getinvolved.glos.nhs.uk/

Agenda Item 13

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

Report Title	**System Quality Committee – updated Terms of Reference** **Primary Care and Direct Commissioning Committee – updated Terms of Reference**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	The Chairs of the System Quality Committee and PC&DC Committee met with the executive leads at the end of March to discuss and agree the process for quality assuring primary care and pharmacy, optometry and dental services (POD). The Terms of Reference were updated to reflect the changes made to the ToR and submitted to each committee virtually for agreement. Once agreed the ToRs were included in the ICB Board papers for May 2023 for approval.				
Executive Summary and Key Issues	System Quality Committee ToR changes are highlighted in Green and cover the quality assurance of primary care and POD services, the inclusion of social care which is referenced at appropriate points within the ToR. It should be noted that System Quality Committee reports its meeting to the Board on a bi-monthly basis via its minutes and a verbal update by its Chair Prof. Jane Cummings. PC&DC Committee ToR have been updated with changes to the quality assurance of primary care and POD services highlighted in yellow and information included in the ToR on the delegation of the commissioning and contracting of POD services highlighted in green. It should be note that PC&DC meeting had held meetings in public but in line with other ICB Committee and other ICBs PC&DC will follow a similar method of reporting via its minutes to the ICB Board, along with a verbal update given by its Chair, Colin Greaves.				
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without ToR ICB Board sub-committees would be unclear under what terms the committee operates, its jurisdiction and powers would not be defined and could lead to committees assuming powers they do not have and making inappropriate decisions. Add a risk rating, even if low: (4x1) 4 (4x1) 1 (residual meaning accepted risk)				
Management of Conflicts of Interest	The changes have been considered by members of each relevant committee and supported. It is the Board's decision whether to approve the changes to the ToR. No conflicts of interests have been declared or identified.				
Resource Impact (X)	**Financial**		**Information Management & Technology**		

	Human Resource		Buildings	
Financial Impact	PC&DC operates within the financial delegation afforded to the Committee through its ToR.			
Regulatory and Legal Issues (including NHS Constitution)	The Full Delegation Agreement for Primary Medical Care and POD Services is referenced in this document; the annexes have been lifted from the delegation agreement and inserted into the ToR for PC&DC			
Impact on Health Inequalities	As detailed in the ToR			
Impact on Equality and Diversity	Not referenced in the ToR			
Impact on Sustainable Development	Not referenced in the ToR			
Patient and Public Involvement	Healthwatch attend PC&DC Committee meetings			
Recommendation	The Board is requested to: • Approve the updated System Quality ToRs • Approve the updated PC&DC Committee ToRs			
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**	
Sponsoring Director (if not author)	**Marion Andrews Evans, Chief Nursing Officer** **Helen Goodey Director of Primary Care and Place**			

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

QUALITY COMMITTEE

TERMS OF REFERENCE

Version	Author	Approved by	Review	Type of changes
V0.1	Name / Title			Creation of ToR
V0.2	Robert Mauler			
V0.3	NHSEI			Model ToR integrated
V0.4	Christina Gradowski			Alignment with other committee ToR
V0.5	Robert Mauler			Augmentation to system focus
V0.6	Robert Mauler			Updates on membership and partnership
V0.7	Dan Corfield			Consistency changes in line with other Committee ToRs Formatting.
V0.8	Dan Corfield			Final reconciliation of membership
V1.0	Dan Corfield	Board of ICB 01/07/2022	Annually	Final version for ICB start date
V2.0	Marion Andrews Evans	Board of the ICB 31/05/2023		Amendments made regarding inclusion of social care and clarification of primary care quality.

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One
Gloucestershire
Transforming Care, Transforming Communities

1. Introduction

1.1 The Quality Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. Purpose of the Committee

2.1 The Quality Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

2.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

2.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. Delegated Authority

3.1 The Quality Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

3.2 The Quality Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.3 The Quality Committee is authorised by the Integrated Care Board to:

3.3.1 Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.3.2 Commission any reports it deems necessary to help fulfil its obligations;

3.3.3 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.3.4 The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be.

- Independent Non-Executive Director of the ICB with the remit and responsibility for Quality (Chair);
- Independent Non-Executive Director of the ICB (Vice-chair);
- ICB Chief Nursing Officer or their nominated Deputy;
- ICB Chief Medical Officer;
- One main Acute Partner executive representative;
- One main Community and Mental Health Partner executive representative;
- One Primary Care representative who shall not be the ICB Chief Medical Officer;
- One or more Local Authority representatives (Director of Public Health, Director for Adult Social Services).

4.3 Members will possess between them knowledge, skills and experience in: clinical quality and governance and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5 <u>Chair and vice chair</u>

4.5.1 The Chair of the Committee shall be an Independent Non-Executive Member of the ICB.

4.5.2 Committee members may appoint a Vice Chair who shall be an Independent Non-Executive Member of the ICB.

4.5.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR in consultation with the Executive Lead - Chief Nursing Officer.

4.6 Attendees and other Participants

4.6.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- One Independent Non-Executive Director of each main system Provider partner (Community & Mental Health; Acute), who chairs their equivalent committee responsible for quality.
- ICB Deputy Director of Nursing;
- ICB Associate Director of Nursing (Commissioning);
- ICB Patient Safety Specialist;
- ICS Health and Care professional leads;
- ICS Designated Nurse Safeguarding Children and Safeguarding Adults Manager;
- ICB Quality Leads;
- ICB Quality and Nursing Business Manager;
- ICB Associate Director of Corporate Affairs.

4.6.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.6.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Primary Care, Secondary and Community Providers.

4.6.4 The Chief Executive should be invited to attend the meeting at least annually.

4.7 Attendance

4.7.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Quoracy

5.1 Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy, and the Chief Nursing Officer or Chief Medical Officer (or deputy).

5.2 Where partner members are included in the core membership of the Committee, business planners for meetings will be designed to make optimal use of partner time, meaning that they may not be required for all of every meeting. Where this is the case, their absence will not affect the quoracy of the meeting.

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

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

6. Voting and decision-making

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

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

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

7. Frequency and notice of meetings

7.1 The Quality Committee shall meet six times a year (every other month). The Chair of the Committee may convene additional meetings as required.

7.2 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

8. Committee secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least 5 working days before the meeting, having been agreed by the Chair with the support of the relevant executive lead – Chief Nursing Officer;

8.1.2 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.1.3 Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

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

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

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

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

8.2 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the committee

9.1 The Quality Committee has been constituted in terms of its scope, responsibilities and membership to facilitate the ICB meeting its four fundamental purposes to:

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

9.2 Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility. First, the Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. Second, it will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3 The committee will have a strong focus on the partnership agenda and will work with the System Quality Group to support the ICS to bring partners together on approaches that can't be achieved by a single organisation alone.

9.4 The responsibilities of the Quality Committee will be authorised by the ICB Board. It is expected that the Quality Committee will:

9.4.1 Be assured that there are robust processes in place for the effective management of quality across health and social care;

9.4.2 Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern across health and social care;

9.4.3 Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan;

9.4.4 Oversee and monitor delivery of the ICB key statutory requirements;

9.4.5 Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

9.4.6 Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

9.4.7 Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation affecting health and social care and assure the ICB that these are disseminated and implemented across all sites;

9.4.8 Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

9.4.9 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers including primary care;

9.4.10 Receive assurance that the ICB with contracted service providers, identify lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

9.4.11 Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

9.4.12 To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

9.4.13 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

9.4.14 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

9.4.15 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;

9.4.16 Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety;

9.4.17 Approval of policies and standard operating procedures (SOPs) as relevant to the committee's business.

10. Relationship with the ICB and other groups / committees / boards

10.1 The Quality Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

10.2 The Committee has responsibility for assuring the Board of the quality of services across health and care including primary care. The Primary Care & Direct Commissioning Committee shall receive reports on the quality of primary care services at its meetings.

10.3 The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Infection Prevention and Control, Safeguarding Boards / Hubs etc).

10.4 The Committee will periodically receive updates from the Primary Care and Direct Commissioning Committee regarding the quality and safety of primary care services commissioned by the ICB, as well as sharing with the committee innovations in practice. This is to enable the Committee to discharge its duty to scrutinise the robustness of, and gain assurance regarding systems for monitoring the quality of these services.

10.5 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

11. Policy and best practice

11.1 The Committee shall have regard to current good practice, policies and guidance issued by the NHS England, NICE, Royal Colleges and other relevant bodies.

12. Monitoring and Reporting

12.1 The Chair of the Committee shall report the outcome and any recommendations of the committee to the Board of the ICB, and provide a report on assurances received, escalating any concerns where necessary.

12.2 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICB.

12.3 The Committee shall submit to the Board of the ICB an Annual Report of its work.

12.4 The Committee shall agree an annual schedule of reports and their frequency for the Quality Committee meetings.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending the Committee shall be have in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4 Conflicts of interests

13.4.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

13.4.2 All potential conflicts of interest must be declared and recorded at the start of each meeting.

13.4.3 A register of interests must be maintained by the Governance Team, submitted with the Quality Committee papers and annually to the Board.

13.4.4 If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

14.2 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD

PRIMARY CARE & DIRECT COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Version	Author	Approved by	Review	Type of changes
V01	Helen Edwards			Creation of ToR
V02	Christina Gradowski			Content
V03	Jo White			Content
V04	Dan Corfield			Consistency changes in line with other committee ToRs. Formatting.
V0.5	Dan Corfield			Final reconciliation of membership
V0.6	Dan Corfield			Incorporating feedback from Committee Chair Designate
V1.0	Dan Corfield	Board of ICB 01/07/2022	Annually	Final version for ICB start date
V1.1	Christina Gradowski	Board of the ICB 31/08/22	Annually	Amendments to the ToR i.e., membership and PCOG ToR
V 2.0	Marion Andrews Evans and Christina Gradowski	Board of the ICB 31/05/2023		Amendment to the ToR i.e., clarification of quality assurance; inclusion of the POD requirements

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1. Introduction

1.1 The Primary Care & Direct Commissioning Committee, PC&DC (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and with Delegations made under section 65Z5 of the 2006 NHS Act. The Committee has specific responsibilities with regard to primary care medical services, which are long established and for Pharmaceutical, Ophthalmic and Dental (POD) services delegated by NHS England to NHS Gloucestershire ICB on 1 April 2023.

1.2 NHS England has delegated authority to the ICB for the commissioning of primary care and POD services. Part 1 of Schedule 2A, 2B, 2C and 2D (Primary Medical, Dental, Ophthalmic and Pharmaceutical Services) Delegation Agreement (see here) sets provision regarding the carrying out of those Delegated Functions relating to Primary Medical Care & POD Services, being in summary:

- decisions in relation to the commissioning and management of primary medical care services, primary dental services and prescribed dental services, primary ophthalmic services and pharmaceutical services and local pharmaceutical services:
- planning the provision of services, including carrying out needs assessments.
- undertaking reviews of services.
- management of the Delegated Funds with respect to services.
- seek assurance in respect of the delivery of high quality, safe and effective primary care and POD services as part of the management of the contracts with primary care and POD service providers.
- co-ordinating a common approach to the commissioning and delivery of Primary Medical and POD Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.3 The committee acknowledges that, in addition to the statutory duties set out in Schedules 2A, 2B, 2C and 2D, it must comply with the following as regards primary medical care and POD services:

1.3.1 duty to consult with Local Medical Committees and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act.

1.4 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.5 Committee members including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

2.1 The purpose of the Committee is to manage the delivery of those elements of the primary medical care and POD services delegated by NHS England to the ICB. The aim will be to deliver to the people of Gloucestershire, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness and transparency, supported by sound governance arrangements.

3. Delegated Authority

3.1 The PC&DC Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.2 The PC&DC Committee is authorised by the Integrated Care Board to:

- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference.
- Commission any reports it deems necessary to help fulfil its obligations.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.3 The PC&DC Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint the seven committee members:

- Committee Chair: shall be a Non-Executive Director of the ICB who is not the Chair of the Audit Committee;
- Committee Vice-Chair: Independent Non-Executive Director of the ICB with a remit for Quality.
- Associate Non-Executive Director *(Non-Voting)*
- Chief Executive Officer or Deputy CEO of the ICB

- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Chief Financial Officer

4.3 Members will possess between them knowledge, skills and experience in Primary Care and POD development and contracting, patient safety and quality and technical or specialist issues pertinent to the ICB's business (such as dentistry, optometry, and pharmacy). When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4 Membership will be reviewed, and other individuals may be invited to become members of the Committee as and when appropriate to meet the needs of the agenda.

4.5 **Attendees and other Participants**

4.5.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Primary Care & Place
- Deputy Director of Primary Care and Place (Primary Care Development).
- Healthwatch
- Primary Care ICB Board participant
- Head of Primary Care Contracting
- Councillor, Gloucestershire County Council.

4.5.2 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter, including representatives from the primary care estates, workforce developments and the Training Hub.

4.5.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5.4 If the membership of the Committee includes the Deputy CEO rather than the CEO, then the Chief Executive should be invited to attend the meeting at least annually.

4.6 **Attendance**

4.6.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Quoracy

5.1 For a meeting to be quorate a minimum of four members must be present at the meeting, including:

- One Independent Non-Executive Director of the ICB.
- Chief Financial Officer or their nominated deputy

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

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

6. Voting and Decision-Making

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

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

6.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

7. Frequency and Notice of Meetings

7.1 The Committee shall meet up to six times a year. The Chair of the Committee may convene additional meetings as required.

7.2 The Committee shall conduct its business in accordance with the Standing Orders and the Scheme of Reservation and Delegation, in addition to other relevant ICB policies. The Committee may meet virtually when necessary, and members attending using electronic means such as telephone or videoconferencing shall be counted towards the quorum.

8. Committee Secretariat

8.1 The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.2 The agenda and papers are prepared and distributed in accordance with the Standing Orders at least five (5) working days before the meeting, having been agreed by the Chair with the support of the relevant Executive Lead – Director of Primary Care & Place.

8.3 Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report).

8.4 Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary.

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

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

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

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

8.9 An annual review of the effectiveness of the Committee shall be undertaken and the findings along with action plan will be reported to the Committee.

8.10 All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the Committee

9.1 In accordance with its statutory powers under section 65Z5 of the NHS Act NHS England has delegated the exercise of the Delegated Functions to the ICB to empower it to commission Primary Care and POD Services for the people of Gloucestershire.

9.2 NHS Gloucestershire Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility.

9.3 The Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. It will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness

9.4 The role of the Primary Care and Direct Commissioning Committee shall be to carry out delegated functions that are related to the commissioning of primary medical care and POD services from NHS England to the ICB as set out below:

- Appendix A – Schedule 1 2A – list of delegated functions for Primary Medical Care Services

- Appendix B – Schedule 1 2B – list of delegated functions for Primary Dental Services
- Appendix C – Schedule 1 2C – list of delegated functions for Primary Ophthalmic Services
- Appendix D – Schedule 1 2D – list of delegated functions for Primary Pharmaceutical Services

9.5 The Committee shall also have oversight of the landscape, development plans and performance/usage of digital information system (notably clinical/patient information systems) and other technology, uptake of and compliance with local and national digital transformation and integration programmes, and the adoption of innovative medical technology

9.6 **Primary Care Networks (PCNs)**

9.6.1 PCNs shall be accountable to the PC&DC Committee including contractual responsibilities.

9.6.2 The Committee shall review the ICB plans for the management of the Network Contract Directed Enhanced Services, including plans for re-commissioning these services annually, where appropriate.

9.6.3 The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and mandated guidance including:

- Maintain or establish identified Network Areas to support the local population.
- Review any waived PCN list size requirements wherever possible and appropriate to best support the local population;.
- Ensure that each PCN has at all times an accountable Clinical Director.
- Align each PCN with an ICB that would best support delivery of services to the local population.
- Collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN

9.6.4 The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and guidance including maintaining or establishing identified Network Areas to support the local population in the area.

9.6.5 The Committee shall receive highlight reports regarding the activities of Primary Care Networks, including PCN transformation and improvement plan progress, shared risks and issues, and interaction with individual member practices and Integrated Locality Partnerships (ILPs).

9.7 Financial Accountability

9.7.1 The Committee's authority for procuring services is covered in the ICB Scheme of Reservation and Delegation and Standing Financial Instructions.

9.7.2 The Committee shall refresh the Primary Care Strategy and include POD services for Gloucestershire and report on and make recommendations to the ICB on the following:

- Primary Medical Care & POD Strategy for Gloucestershire
- Planning primary medical care & POD services in Gloucestershire (including needs assessment)
- Performance management of primary care services and contracts.

9.7.3 The Committee may delegate some tasks to such individuals, sub-committees, or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. The Committee may not delegate the procurement of services to any individual or sub-committee.

9.7.4 The Committee shall be structured to address two core parts: statutory functions, and the transformational agenda which will link with the Clinical Programmes Approach and interface with, but not oversee, ILPs.

9.7.5 The Committee shall receive information regarding the allocation of operational and transformation funding provided to individual practices and PCNs, both capital and revenue, and similarly shall receive information on the use of those funds relative to the achievement of agreed objectives. The Committee shall hold practices and PCNs to account for value for money and other pertinent metrics regarding any such funding. Such monitoring and accountability notably includes, but may not be limited to, all items listed under sections 9.3 and 9.4 of these Terms of Reference

10. Relationship with the ICB and other Groups/Committees/Boards

10.1 The Committee has delegated authority for the commissioning of some primary medical care and POD services as outlined in the Delegation Agreement (appendices 1-4.)

10.2 The Committee shall make recommendations to the ICB for the primary medical care and POD services and functions listed in the Delegation Agreement (appendices 1-4.)

10.3 The Committee will periodically provide to the ICB Quality Committee updates regarding the quality and safety of primary medical care and POD services commissioned by the ICB, as well as sharing innovations in practice.

10.4 The ICB Primary Care Operational Group (PCOG) shall undertake the operational management, implementation and oversight of the nationally defined primary medical care and POD contracts and the primary medical care and POD workstreams. In addition, the PCOG will also monitor complaints and quality.

10.5 The Primary Care Operational Group will act as a sub-committee and shall report to the Committee and submit the minutes of their meetings to the Committee for review. The Terms of Referenced for PCOG will be approved by the PC&DC including any revision or amendments.

10.6 The Primary Care Operational Group shall provide a timely summary highlight report of primary care planning, performance (operational and financial), quality and transformation activities for review by the PC&DC Committee.

11. Policy and Best Practice

11.1 The Committee has delegated authority for the commissioning of some primary medical care and POD services as outlined Delegation Agreement (appendices 1-4.)

11.2 When considering matters, the Committee should take into account the following:

- All statutory requirements applicable to the ICB.
- NHS England requirements and standards.
- Best professional practice and standards, e.g., CIPD.
- Emerging risks and issues.
- Relevant Business Information and Data analyses.

11.3 In exercising the Delegated Functions, the Committee must have due regard to the Guidance set out at Schedule 9 and such other guidance as may be issued by NHS England from time to time, including on the Primary Care & POD Guidance web pages.

11.4 The Committee shall have regard to current good practice, policies and guidance from NHSE&I, the ICS, and other relevant bodies.

12. Monitoring and Reporting

12.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

12.2 The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICB.

12.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

12.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

12.5 The Committee will undertake an annual committee effectiveness review using the existing template model.

13. Conduct of the Committee

13.1 Members will be expected to conduct business in line with the ICB values and objectives.

13.2 Members of, and those attending the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

13.3 Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

13.4 Conflicts of interests: In discharging duties transparently, conflicts of interest must be considered, recorded, and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team and submitted to the PC&DC Committee at each meeting and to the Board annually. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of the ToR

14.1 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

APPENDIX 1

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause **Error! Reference source not found.** (*Finance*) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause **Error! Reference source not found.** (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on

the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in **Error! Reference source not found.** (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

APPENDIX 2

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2B: Primary Dental Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause **Error! Reference source not found.** *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause **Error! Reference source not found.** *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 10 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, **Error! Reference source not found.** (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in

accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental

Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 12 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph **Error! Reference source not found.** above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

APPENDIX 3

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph **Error! Reference source not found.**);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause **Error! Reference source not found.** *(Finance)* or paragraph **Error! Reference source not found.** above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause **Error! Reference source not found.** (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in **Error! Reference source not found.** (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

APPENDIX 4

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph **Error! Reference source not found.** of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph **Error! Reference source not found.** of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph **Error! Reference source not found.** of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;

LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph **Error! Reference source not found.**. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs **Error! Reference source not found.**, **Error! Reference source not found.**, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the “Delegated Pharmaceutical Functions”), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

 2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[1], specifically:

  2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

  2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

  2.1.3 lists of persons participating in the Electronic Prescription Service[2]

[1] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations

collectively referred to in this Schedule as the “Pharmaceutical Lists”. In doing so, it is sufficient for the lists referred to at paragraphs **Error! Reference source not found.** and **Error! Reference source not found.** to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph **Error! Reference source not found.**.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[3];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[4];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[5];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter (“the Fitness to Practise Functions”);

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[6];

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[2] Regulation 10 of the Pharmaceutical Regulations
[3] Schedule 2 of the Pharmaceutical Regulations
[4] Part 10 of the Pharmaceutical Regulations
[5] Regulation 11(3) of the Pharmaceutical Regulations
[6] Part 11 of the Pharmaceutical Regulations

2.1.16 making LPS Schemes[7], subject to the requirements of paragraph 5;

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[8] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[9];

2.1.21 determining Dispensing Doctor Decisions[10];

2.1.22 preparing and maintaining Dispensing Doctor Lists[11];

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[12];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[13];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

[7] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[8] Part 13 of the Pharmaceutical Regulations
[9] Part 7 of the Pharmaceutical Regulations
[10] Part 8 of the Pharmaceutical Regulations
[11] Regulation 46 of the Pharmaceutical Regulations
[12] Schedule 3 of the Pharmaceutical Regulations
[13] Regulation 94 of the Pharmaceutical Regulations

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[14]; and

2.2.1.3 a Dispensing Doctor List (together the “Relevant Lists”); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the “Relevant Health and Wellbeing Board”):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph **Error! Reference source not found.** of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board (“the Designated Commissioner”);

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board’s area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph **Error! Reference source not found.** of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

[14] Regulation 114 of the Pharmaceutical Regulations

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

9.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

9.3 work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

One
Gloucestershire
Transforming Care, Transforming Communities

Agenda Item 14

NHS Gloucestershire ICB Board (Public Session)

Wednesday 31st May 2023

<table>
<tr><td>Report Title</td><td colspan="4">Joint Forward Plan – Progress Briefing</td></tr>
<tr><td>Purpose (X)</td><td colspan="4">For Information: X | For Discussion: | For Decision:</td></tr>
<tr><td rowspan="3">Route to this meeting</td><td colspan="4">Describe the prior engagement pathways this paper has been through, including outcomes/decisions:</td></tr>
<tr><td>ICB Internal</td><td>Date</td><td>System Partner</td><td>Date</td></tr>
<tr><td>Board Update
Strategic Executive</td><td>29/03//2023
18/05/2023</td><td>Range of partner engagements/governance</td><td>Various</td></tr>
<tr><td>Executive Summary</td><td colspan="4">The Joint Forward Plan (JFP) is the NHS five-year delivery plan in response to the Integrated Care Strategy. It describes how the ICS will meet its 17 statutory duties, with supporting information regarding key enablers. Summary narrative supporting how we meet our 17 legislative requirements is appended in the JFP, noting that Gloucestershire was the only system in the region at Draft stage to have satisfactorily met this requirement:
• Describing the health services for which the ICB proposes to make arrangements
• Duty to promote integration
• Duty to have regard to wider effect of decisions
• Financial duties
• Implementing any Joint Local Health and Wellbeing Strategies
• Duty to improve quality of services
• Duty to reduce inequalities
• Duty to promote involvement of each patient
• Duty to involve the public
• Duty to patient choice
• Duty to obtain appropriate advice
• Duty to promote innovation
• Duty in respect of research
• Duty to promote education and training
• Duty as to climate change, etc.
• Addressing the particular needs of children and young persons
• Addressing the particular needs of victims of abuse

The three strategic pillars of the strategy are directly referenced in both the content and the structure of the JFP. The operational plan 2023-24 heavily informs parts of the JFP, which will be annually refreshed.</td></tr>
</table>

	Following the Board meeting, final updates will be made and the JFP taken through the design team for presentation and the Healthwatch Gloucestershire reading group to improve language before final approval across system partners and publication on 30th June.
Key Issues to note	The Draft was well received and the only submission in the SW to address all 17 Statutory Duties. The Draft was also noted for its conciseness and accessibility. The One Gloucestershire approach to the Joint Forward Plan is to provide a very high-level summary of a wide range of detailed plans. In this way it can be thought of as a 'gateway' strategic delivery plan that signposts stakeholders and readers to more specific content, groups and leads There will be format and content changes from the version presented here to the final published version, however these will be primarily presentational and refinement with no anticipated material changes to the narrative. The final version will also have high-level metrics ("markers of success") completed. Based on further feedback from Strategic Executive, the Joint Forward Plan has been enhanced with clearer content regarding our strategic objectives and financial context, and our approach to quality assurance and improvement. Through April and May the Programme Management Office (PMO) team have engaged extensively across the system, including Integrated Locality Partnerships (ILPs), partner forums and senior management and clinical groups, and transformation programme boards. The annual refresh of the JFP will enable improvement to the coordination and planning of this solid foundation of engagement, and increasingly align with transformation programme reporting and annual operational planning. It is recommended that the Joint Forward Plan foreword is signed by Gill Morgan on behalf of all ICS partners for simplicity.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There is a risk that despite significant engagement, some stakeholders and staff groups may feel they have not been heard. This has been mitigated as much as possible through this first ever JFP process and will be managed through the annual refresh process and ongoing improvement. This does not present a material risk to JFP completion and publication, or to the ICB or system.
Management of Conflicts of Interest	No conflicts of interest became apparent through development of the Joint Forward Plan
Resource Impact (X)	**Financial**: X; **Information Management & Technology**: X; **Human Resource**: X; **Buildings**: X
Financial Impact	The Joint Forward Plan is interdependent with the developing medium-term financial plan, and the final version will need to align with the financial impact as included in the 2023/24 system operational and financial plans.

Regulatory and Legal Issues (including NHS Constitution)	Producing the Joint Forward Plan is a statutory requirement for ICS's. There are no potential legal issues that could arise from it.		
Impact on Health Inequalities	The Joint Forward Plan articulates and summarises our overall strategic direction and programmes of work that will contribute to tackling health inequalities in the coming years.		
Impact on Equality and Diversity	No outcomes to report.		
Impact on Sustainable Development	No direct impact beyond those already recorded in component transformation programmes.		
Patient and Public Involvement	The public were engaged through the development of the integrated care strategy. Since then, public engagement has been via existing public membership (e.g. experts by experience) on transformation programme boards, CPGs and ILPs.		
Recommendation	The Board (delete as appropriate) is requested to: • Note the progress of the One Gloucestershire Joint Forward Plan since Draft submission in March, including the ongoing engagement programme. • Support the proposal that the Joint Forward Plan foreword is signed by Gill Morgan on behalf of system partners. • Support and confirm the proposed governance and formal approval routes.		
Author	**Dan Corfield**	**Role Title**	**Associate Director ICS Programmes**
Sponsoring Director (if not author)	**Ellen Rule, Deputy CEO and Director of Strategy and Transformation.**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
GCC	Gloucestershire County Council
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ILP	Integrated Locality Partnership
JFP	Joint Forward Plan
PMO	Programme Management Office
VCSE	Voluntary, Community and Social Enterprise

2023-28 Joint Forward Plan Update

ICB Board

31st May 2023

@One_Glos
www.onegloucestershire.net

1. What is the Joint Forward Plan?

- The Joint Forward Plan (JFP) describes how we as Gloucestershire Integrated Care Board (GICB) will contribute to the delivery of the Gloucestershire Health and Wellbeing Partnership's integrated care strategy, published in December 2022

- The JFP is a 5-year delivery plan setting out clear priorities, milestones and trajectories for our key areas of work and transformation. It is aligned to the delivery of universal NHS commitments, notably the Long Term Plan, Operational Planning guidance and other identified NHS priorities.

- The content of the JFP is therefore primarily constructed from elements of the annual Operational Plan to inform the year 1 priorities, and from existing system transformation plans to inform longer-term ambitions and plan delivery.

- In addition the JFP sets out how as and ICB we will meet our legislative requirements.

- We are required to publish the JFP by 30th June 2023.

- The JFP is refreshed annually; this enables the update to the immediate year delivery priorities and ambitions, and moves the longer-term transformational horizon on a year.

- A draft version of our JFP has been co-produced with colleagues across the ICS and shared with partners including NHS England (NHSE).

Context – strategy and planning alignment

	2023/24	2024/25	2025/26	2026/27	2027/28
5yr	Integrated Care Strategy				
5yr	Joint Forward Plan				
2yr	Operational Plan				
1yr	Detailed Transformation Plans	Transformation Delivery Plans and ambitions			

2. What is in our Joint Forward Plan?

Context	• **Foreword** on behalf of ICS (proposed signature by Gill Morgan on behalf of ICS partners) • **Statement** from Gloucestershire Health and Wellbeing Board • **About this plan** – context and structure of the *Integrated Care Strategy* and our approach to engagement • **About Gloucestershire**	
Our contribution to: Improving health and care services today (Pillar 3) & Transforming what we do (Pillar 2)	**Strategic Theme 1: Improving care for the people we serve** 1a. Better care at every age 1b. Better care for major health conditions 1c. Better care for different groups of people **Strategic Theme 3: Working together in an integrated way for all** 3a. Accessible and timely planned care 3b. A sustainable urgent and emergency care 3c. Better population health in localities	**Strategic Theme 2: Supporting our people across the ICS and beyond** 2a. An empowered and valued workforce 2b. A data and digital health and care 2c. An effective and efficient use of our estate **Strategic Theme 4: Improving access and quality in the services we deliver** 4a. Efficient and accessible diagnostics 4b. A resilient and integrated primary care 4c. Safe and efficient use of medications
Our contribution to: Making Gloucestershire a better place for the future (Pillar 1)	**Improving health outcomes & achieving health equity over the longer-term** • Resilient communities and a healthy Gloucestershire • Achieving health equity in Gloucestershire • A sustainable and green NHS	
Delivering this Joint Forward Plan	• **Delivery** via ICS Transformation programmes • **Oversight** via Executive-led Boards • **Accountability** via NHS Gloucestershire ICB Board	
Appendices	A. Delivering our **legislative requirements**	B. **Measures** of success

3. Legislative Requirements

- The Health and Social Care Act 2022 bestowed 17 overarching legislative requirements on Integrated Care Systems (in addition to the detailed responsibilities inherited from CCGs).
- The Joint Forward Plan is a mechanism we can use to convey how we plan to achieve those requirements.
- The NHSE Southwest (SW) regional team provided a 'critical friend' review of a draft version of our JFP in March, and felt assured we are providing suitable content that articulates how we will meet all 17 requirements.

Duty to enable patient choice	Duty to improve quality of services	Duty to reduce inequalities	Duty to promote involvement of each patient
Duty to promote education and training	Duty to obtain appropriate advice	Duty to promote innovation	Duty in respect of research
Duty to involve the public	Duty to promote integration	Duty to have regard to wider effect of decisions	Duty as to regard to climate change and adaptation to impacts
Addressing particular needs of children and young people	Addressing particular needs of victims of abuse	Financial duties	Describe health services the ICB proposes to arrange to meet needs
Implement joint local health and wellbeing strategy			

4. Progress Update

- A draft version of the JFP was developed collaboratively between January 2023 and March 2023.
- Since 30th March 2023 continued development of our draft Joint Forward Plan has been carried out through:
  - A series of engagement opportunities across the Integrated Care System (ICS) – *see table to the right.*
  - Working collaboratively with all Transformation Programmes for ongoing review and refinement of their content.
  - Continued alignment to the operational plan requirements and submission, ensuring clarity on the measures for success.
- The JFP is a high level strategic plan setting out how we will deliver the Integrated Care Strategy from an ICS perspective, covering the breadth of responsibilities across the health agenda.
- Updates and changes are being recorded, actioned and tracked; this tracker has been shared with internal auditors as requested to provide assurance.

Integrated Locality Partnerships x6
Primary Care Network Clinical Directors
ICB internal • Programme Development Group (PDG) • Strategic Executive • Senior Managers • Statutory Duties leads
ICS Transformation Programme Boards: • Children and Young People's Mental Health • Local Maternity & Neonatal System (LMNS) • Planned Care Delivery Board • Diagnostics • Medicines Optimisation Committee • Quality • Urgent and Emergency Care CPG • Clinical Programme Board
Gloucestershire Health and Care NHS Foundation Trust • Strategic Oversight Group • Senior Leadership Network • Board (via CEO update)
Gloucestershire Hospitals NHS Foundation Trust • Nursing, AHP and Midwifery Delivery Group • Divisional Board x4
Health and Wellbeing Board (January and March presentations; virtual review)

5. Next steps through to publication

- The final draft of the JFP will be produced by the 31st May for final review by:
  - the Communications team for adaptation into a public-facing, production design version.
  - The Healthwatch Gloucestershire Reading Group, to provide feedback recommendations regarding the clarity and accessibility of language; subsequently they will review the 'look and feel' of the production version from the Communications team.
- The final version of the JFP will be completed by mid-June.
- The JFP will then go through governance routes (see right) for support, endorsement and final approval.
- The Joint Forward Plan will be shared with the board and on 30th June with the aim to publish on this date as per guidance; it will be refreshed for publication at the end of each financial year.
- Inclusion Gloucestershire will help us produce an 'easy read' version to ensure inclusion.
- *Some further post-publication engagement is planned where meeting dates did not align with the development timeline.*

Endorsement and Approval Routes
Gloucestershire Health and Care NHS Foundation Trust • 29th June - Resources Committee (delegated authority)
Gloucestershire Hospitals NHS Foundation Trust • Directors Operational and Assurance Group and Trust Leadership Team • 30th June – Extraordinary Board meeting
NHS Gloucestershire Integrated Care Board • Strategic Executive • 30th June – Extraordinary Board meeting

7. Recommendations

The Board is asked to:

- Note the progress of the One Gloucestershire Joint Forward Plan since Draft submission in March, including the ongoing engagement programme.
- Support the proposal that the Joint Forward Plan foreword is signed by Gill Morgan on behalf of system partners.
- Support and confirm the proposed governance and formal approval routes.

Gloucestershire Integrated Care Board

Primary Care & Direct Commissioning Committee

Part 1 Minutes of the Hybrid Meeting Held at 2:00pm on 2nd February 2023

Members Present:		
Colin Greaves	CG	Chair, NED
Ellen Rule	ER	Deputy Chief Executive Officer
Dr Andy Seymour	AS	Chief Medical Officer
Professor Jane Cummings	JC	Member, NED
Dr Marion Andrews-Evans	MAE	Executive Chief Nurse
Shofiqur Rahman *(Deputising for Cath Leech)*	SR	Deputy Chief Financial Executive Officer
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Gerald Nyamhondoro	GN	Corporate Governance Officer (taking minutes)
Jo White	JW	Deputy Director of Primary Care & Place
Helen Goodey	HG	Director of Primary Care & Place
Declan McLaughlin	DM	Senior Primary Care Project Manager
Dr Olesya Atkinson	OA	Primary Medical Services (Primary Care Network Perspective)
Lauren Peachey	LP	Governance Manager
Becky Parish	BP	Associate Director of Engagement and Experience
Zainab Fatima Qazi	ZFQ	Post Graduate Student
Cllr Carol Allaway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning
Jeannette Giles	JG	Head of Primary Care Contracting
Bronwyn Barnes	BB	Head of Locality Development
Julie Zatman-Symonds	JZS	Deputy Chief Nursing Officer

1.	**Introduction and Welcome**
2.	**Apologies**
2.1	Apologies were received from Cath Leech and Mary Hutton.
2.2	The meeting was confirmed as quorate.
3.	**Declarations of Interests**
3.1	No interests were declared.
4.	**Minutes of the Last Committee Meeting**
4.1	Minutes of the meeting held on 1st December 2022 were approved as a correct record of the

Approved

	proceedings.
5.	**Matters Arising**
5.1	**04.08.22, Item 10.6** Primary Care Delegated Commissioning – Pharmacy, Optometry, Dentistry Highlight Report. CG requested that a more detailed report on Pharmacy, Optometry and Dentistry be brought before members for further discussion. **Item closed.**
5.2	**06.10.22, Item 9.9** Primary Care and PCN Performance Report. Members requested HG and JW to provide further detail and analysis on the Respiratory Quality Improvement project. **Item closed.**
5.3	**06.10.22, Item 9.11** Primary Care and PCN Performance Report. Members requested CGi to arrange a meeting, which includes JC, MAE, HG, CG and CGi, to discuss the overlap between PC&DC and Quality as regards reporting processes (incl. POD). **Item closed.**
5.4	In addition to the above items, members discussed the previously agreed position to expand membership by bringing on board an additional member. It was agreed that the new member would be an Associate (Non-Executive Director (NED) and MH was charged with the responsibility of supporting implementation. **Item closed.**
6.	**Questions from the Public**
6.1	There were no questions from the public.
7.	**The Primary Care & PCN Highlight Report**
7.1	JW presented and stated that Primary Care models were designed to connect patients to sources of community support and ensure that users received joined-up out of hospital care. JW added that the models promoted health and wellbeing by way of: • increasing access to health at scale; • improving integration; • allowing greater use of technology; • improving shelter through improved estate development; • developing and investing in workforce.
7.2	JW cautioned that workforce pressures remained a material system-wide risk, but PCN models mitigated by incorporating an element of significant investment in workforce through the 'Additional Roles Reimbursement' (ARR) scheme. JW emphasised that workforce models required an element of flexibility which would enable staff to move around to areas with more need, throughout the PCNs.
7.3	MAE commended the improvements made in workforce planning within the PCNs. CG enquired as to the progress made regarding the securing of visas for overseas health workers

Approved

	aimed at reversing workforce shortages. AS responded that initial work on recruiting from overseas was in progress. Members discussed the report and investment made in Primary Care hubs within PCNs, including ways of reversing workforce pressures.
7.4	**RESOLUTION: The Committee noted contents of the Primary Care & PCN Highlight report**
8.	**Primary Care Quality Report**
8.1	JZS presented the report and stated that Dr Michelle Sharma had joined the Quality team as the new Safeguarding Doctor. MAE added that Dr Sharma was not new to the county or to its health needs. JZS reported one case of serious incident relating to a missing sample. JZS reassured members that there was no harm to the patient and the incident posed no danger or risk to anyone.
8.2	JC commended the hospital and ambulance incident reporting platforms and culture but wondered why such platforms and tools did not seem to extend to Primary Care. MAE explained that legal dictates did not extend to General Practices in the same way; there were dissimilarities in incident reporting platforms and tools between General Practices and hospitals. OA concurred that there was no obligation for General Practices to share the same reporting platform with Secondary Care, or to report incidents to the ICB.
8.3	OA reassured members that in terms of outcomes there was no evidence of disparities in the quality of Safeguarding and Patient Safety between Primary Care and Secondary Care. Members suggested that system partners could, in the long term, need to create a bespoke common incident reporting platform for the benefit of Gloucestershire public.
8.4	Regarding the Patient Advice and Liaison Service (PALS), JZS highlighted that the number of contacts received in Quarter (Q3) of year 2022/23 had fallen compared to the previous quarter, with fewer concerns raised. JZS highlighted that Twigworth area had a new housing development and some of the new patients were finding it difficult to register with the local Practices; JZS commended that PALS liaised with the Primary Care Team, and this was resolved.
8.5	JC stated that liaising and sharing of information at the level of partners would enhance system-wide health delivery. JZS outlined the ICB's involvement in supporting the settling of immigrants in the county. JZS described the provision of shelter to the immigrant community and summarised vulnerabilities of the immigrants regarding issues of health needs and social welfare. JZS added that Covid-19 infections were amongst the worrying health challenges in the immigrant community.
8.6	BP reassured members that the Engagement Team were committed to running successful engagement programmes. BP also stated that the Team provided support to local Practices which were implementing structural changes such as mergers or branch closures. BP added that the Engagement Team supported public events and meetings involving patient groups.

Approved

<table>
<tr><td>8.7</td><td><u>RESOLUTION</u>: The Committee noted contents of the Primary Care Quality report.</td></tr>
<tr><td>9.</td><td>Primary Care Delegated Commissioning Pharmacy, Optometry, Dentistry (POD) Progress Report</td></tr>
<tr><td>9.1</td><td>JW presented and reiterated that from 1st April 2023 the ICB would be expected to take on delegated responsibility for Pharmacy, Optometry and Dental services (POD) across the county. JW presented a timeline for the delegation process and added that NHS England had been engaging in ongoing fortnight meetings with the ICB Finance Team to discuss financial arrangements for delegation. JW stated that NHS England continued to provide monthly information packs outlining latest contractual data on POD services.</td></tr>
<tr><td>9.2</td><td>JW emphasised that the POD Project Team would continue to work through the following in the period leading to 1st April 2023:

• attend Project Team meetings to work through requirements of Self Delegation Checklist (SDC) in readiness to operate;
• review the current contracts for Pharmacy, Optometry and Dentistry to identify risks and issues;
• review Corporate Risks;
• implement recommendations from BDO LLP;
• identify resources and where necessary, recruit and train new staff to fulfil needs of delegation in readiness for April 2023.</td></tr>
<tr><td>9.3</td><td>JW presented before members minutes of the POD Delegation Project Team meeting held on 13th December 2022. Members discussed the risks associated with the delegation exercise and brainstormed on ways of mitigating the risks.</td></tr>
<tr><td>9.4</td><td><u>RESOLUTION</u>: The Committee noted contents of the Primary Care delegated commissioning Pharmacy, Optometry, Dentistry (POD) progress report.</td></tr>
<tr><td>10.</td><td>Acute Respiratory Hubs</td></tr>
<tr><td>10.1</td><td>JW presented and stated that Acute Respiratory Tract Infections (ARIs) formed a significant proportion of General Practice attendances and hospital admissions. This contributed significantly to pressures in the health delivery pathways. Thus, more actions were required to respond to the pressures. JW outlined the steps taken in setting up local Acute Respiratory Hubs in response to the pressures.</td></tr>
<tr><td>10.2</td><td>JW explained that the modelling of Acute Respiratory Hubs was informed by a need to:

• capitalise on infrastructure and models such as 'hot hubs' established during Covid-19;
• provide same day face to face access to appointments.</td></tr>
<tr><td>10.3</td><td>JW explained that the Acute Respiratory Hubs, which stood to benefit from national funding, extended to paediatrics. JW added that proposed pathways for the hubs which aimed to deliver</td></tr>
</table>

Approved

	through flexible staffing would be tested through PDSA cycles. JW added that Primary Care Teams were working toward integrating Primary and Secondary health delivery pathways and linking existing services with virtual wards. HG stated that the development and utilisation of Acute Respiratory Hubs model could induce spinoffs and the development of a wider spectrum of hub development and pathways across the county's health delivery system.
10.4	**RESOLUTION: The Committee noted contents of the Acute Respiratory Hubs report.**
11.	**Delegated Primary Care Financial Report**
11.1	SR presented the report and stated that as of January 2023 the ICB's delegated Primary Care co-commissioning budget position was £1,132,000 overspend, and he clarified that such overspend incorporated a figure of $984,000 Additional Roles Reimbursement (ARR) scheme which could be reclaimed in due course. SR explained that the overall overspend forecast for the year was £224,000. Members discussed budget risks mitigation.
11.5	**RESOLUTION: The Committee noted contents of the delegated Primary Care financial report**
12.	**Gloucestershire Dental Strategy Group Update Report**
12.1	HG presented the report and stated that although the performance of children's dental care compared well with other regions, access rate of adults receiving dental treatment in Gloucestershire was below national average. HG explained that a shortage of dentists in the county prejudiced high street Practices' capacity to deliver optimal service. HG stated that it was expected that delegation of dental services to the county, starting from 1st April 2023 would reverse current slippage.
12.2	HG highlighted that Gloucestershire Dental Strategy Group was established in January 2023 in response to delegated commissioning of Primary, Community and Acute Dental services. HG added that Gloucestershire Dental Strategy Group had a wider membership which included NHS England, Gloucestershire Health and Care (GHC), Gloucestershire Hospitals Foundation Trust (GHFT), Gloucestershire County Council and the ICB.
12.3	HG explained that Gloucestershire Dental Strategy Group aimed to: • drive the improvement of standards and outcomes in dental services; • ensure that dental commissioning would be patient focused and clinically led; • understand barriers to delivery of project; • make best use of available resources. HG expressed a need to incorporate patient voices, such as Health Watch, into the Dental Strategy Group.
12.4	HG suggested that it could be helpful to come up with various strategy sub-groups to assist

Approved

	commissioning POD services. Members discussed contents of the report and agreed that the early stages of dental commissioning could bring challenges but should not be allowed to derail planned outcomes. Members commended MAE for setting up programmes with local training institutions and university to support targeted oral dental health.
12.5	**RESOLUTION: The Committee noted contents of the Gloucestershire Dental Strategy Group Update report.**
13.	**Gloucestershire Neighbourhood Transformation Group Update Report**
13.1	HG and JC presented and briefly navigated the complex structure constituting One ICS and drilled down to its 6 ILPs, 15 PCNs to the 69 GP Practices. HG highlighted the challenge to developing a person-centred service in a complex set of system driven workstreams. HG explained that Gloucerstershire Neighbourhood Transformation Group was established in January 2023 and charged with facilitating the role of neighbourhoods in supporting pathways leading to joined-up services. JC emphasised on need to fulfil recommendations of the Fuller report.
13.2	**RESOLUTION: The Committee noted contents of the Gloucestershire Neighbourhood Transformation Group Update report.**
14.	**ILPs Highlight Report**
14.1	BB presented the report and provided an update on progress made in delivering the work of the Integrated Locality Partnerships (ILPs) across the county. BB explained health priorities which span across localities and neighbourhoods. HG described various teams and programmes driving outcomes across the ILPs. JC added that multi-disciplinary teamwork and community engagement was a critical factor in developing both short-term and long-term outcomes which cut across all sectors of health, including the voluntary sector. Members emphasised on the value of joined-up services.
14.2	**RESOLUTION: The Committee noted contents of the ILPs Highlight report.**
15.	**Any Other Business**
15.1	There was no other business to conduct.

The meeting ended at 3:45pm

Date and Time of Next Meeting: 17th April 2023 at 09:00am (Hybrid).

Signed (Chair):____________________ Date:_____________

Approved

NHS Gloucestershire System Quality Committee

Thursday 16th February 2023, 14.00 – 17.00

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

Members Present:		
Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Dr Marion Andrews-Evans	MAE	Chief Nursing Officer, GICB
Matt Holdaway	MH	Chief Nurse and Director of Quality, GHFT
Sarah Scott	SS	Executive Director of Adult Social Care, Wellbeing and Communities, GCC
In attendance:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning Team
Alison Moon	AM	Non-Executive Director and Chair of Quality Committee, GHFT
Christina Gradowski	CGi	Associate Director of Corporate Affairs, GICB
Hannah Williams	HW	Deputy Director of Nursing, Therapies and Quality, GHC
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Julie Zatman-Symonds	JZS	Deputy Chief Nursing Officer, GICB
Melanie Munday (Agenda Item 6 & 7)	MM	Associate Director of Integrated Safeguarding, GICB
Ryan Brunsdon	RB	Board Secretary, GICB
Rachel Carter	RC	Governance Coordinator, GICB
Robert Mauler	RM	Assistant Director, Quality Development and Patient Safety, GICB
Trudi Pigott	TP	Deputy Clinical Quality Director, GICB
Noor Al-Koky (Agenda Item 6)	NA	Commissioning Officer, GICB
Karl Gluck (Agenda Item 6)	KG	Head of Integrated Commissioning (Adult Mental Health, Advocacy and Autism)
Zoe Riley (Agenda Item 13)	ZR	Senior Commissioning Manager, Children and Families
Kim Forey (Agenda Item 13)	KF	Director of Integration

1 Apologies for Absence

1.1 JCu welcomed members to this System Quality Committee meeting.

2 Apologies

2.1 Apologies were noted from Andy Seymour, Sarah Morton, Becky Parish, Emily White and John Trevains.

2.2 It was confirmed that the meeting was quorate.

3 Declarations of Interest

Approved

3.1 There were no declarations of interest received.

4 Minutes Of the Last Meeting On 12th December 2022

4.1 11.18 - JSo **was** present for this part of the meeting (the notes stated she was not there).

8.14 - Alison Moon noted that JCu had requested some more metrics and details around Primary Care - this should have been an action with a timescale and was not in the Action Log. This has since been rectified by DC on the Action Log for today's meeting.

It was agreed by the Committee members that the Confidential section of the minutes should always be split away from the regular minutes from now on.

Otherwise, the minutes of the previous meeting, subject to agreed changes, were deemed to accurately reflect the meeting held.

5 Matters Arising

5.1 Actions

Revised ToR were required to reflect where Primary Care Quality should sit. JCu, AS and MAE had met prior to the last GICB Board meeting to discuss this. CGi was not present at that meeting and explained that she will catch up with MAE. JCu said that upon receipt of the revised ToR, which are due shortly, these will be taken to the PC&DC and Quality Committees for approval - MH said this action is now closed (see Action Log).

There were four outstanding actions and JCu stated that she would prefer to have timescales around these and for which meetings they would be coming back to reflect a clear plan.

JSo commented that MAE had asked if the Action Log could be circulated prior to meetings, this would enable Execs to provide an update in the comment column so that if actions were still open, they could at least reflect any progress.

Action 3 for Matt Holdaway - Transfer of Services and issues around Information Governance. MH informed that the team were due to meet on Friday 17th February 2023, having approved relevant changes. The meeting will just clarify things and the transfer will take place as soon as possible before 31st March 2023. **Action: To be closed with MH to provide the Committee with a further update when the transfer had taken place.**

6 Policies for Approval

6.1 S117 Policy

6.1.1. KG summarised the use and purpose of the s117 policy and explained that it was the responsibility of the GICB and the local authority to have a joint policy. KG explained that they were in the process of reviewing the pre-existing policy which was in place before the pandemic.

6.1.2 KG informed the committee that a financial analysis had been carried out, and alternative models were explored. The policy went to the Joint Commissioning

Approved

Partnership and the favoured model included a 50/50 funding split. KG explained that regular financial monitoring would be in place.

6.1.3 KG said that the development of a training programme would raise awareness of how pathways operate and would provide a clearer process on Personal Health Budgets. SS said one of the key aims of the policy would be to achieve greater financial clarity and ensure appropriate use. SS added that a having a clear policy would support the provision of a better service for the people that come under this policy. KG agreed and explained that it was a complex area which would continue to evolve and develop. This was being supported by Community Practice colleagues within the team.

6.1.4 In terms of commissioning specialist training sessions from Bevan Brittan, CGi advised that they may not allow further sharing of training materials. KG replied that a pilot session had been done with Bevan Brittan; however, they have paused progress to seek further professional legal advice from a King's Counsel (KC). NA added that Bevan Brittan sent information that established that training could be delegated to other colleagues in the system, which could be a part of a longer-term training programme.

6.1.5 JSo asked whether any benchmarking had been done to establish if other ICB's were in a similar position. KG informed that as there was no national guidance, benchmarking was conducted only to see what other policies and procedures entailed. It was acknowledged that insight into the community of practices within other regions could be further developed. CGi reminded the committee that KG is an Approved Mental Health Professional (AHMP) and was therefore able to develop this policy with an experienced view.

6.1.6 JCu asked if the finance teams from the different constituent organisations had signed this off as an approach. KG responded that this approach had been signed off by the Finance team at Gloucestershire County Council. KG said there would be an impact across the system which would be monitored. KG said the policy was about partnership working to meet the needs of the people this policy applied to. KG explained that the policy did not prescribe a "one size fits all" approach and advocated a more tailored approach.

6.1.7 KG confirmed that the fifty-fifty split was weekly. MAE asked how the policy will be further communicated to patients and families, particularly information on their entitlements. KG replied that this communication and explanation of s117 should already be within the Code of Practice. In the event that there are no family members an advocate is used, s117 explained, and then documented.

6.1.8 <u>Recommendation</u>: The Committee approved the s117 policy.

6.2 <u>Safeguarding Adults Policy</u>

6.2.1 MM said that the policy had been updated and was at the Committee for approval. MM highlighted some key changes which were made within the policy, which included further information around domestic abuse and the Mental Capacity Act.

6.2.2 AM asked whether the Committee members were comfortable that the importance of transition from children to adulthood is adequately covered solely within the Children's Safeguarding policy. MAE replied that there was programme that focused on integrated safeguarding arrangements across the ICS, and on improving the quality of safeguarding for children and adults. TP suggested editing the quoted guidance from the Home Office to use neutral pronouns.

Approved

6.2.3 Actions:

JM/SS to clarify how the GCC/ICB Quality Assurance team feed into the diagram on page 80 of the Safeguarding Adults policy. Due: 12/04/23. **JM/SS**

MM to review Safeguarding Children's and Adult's policies for information on transition and learning/development support. Due: 12/04/23 **MM**

6.2.4 ***<u>Recommendation</u>: The Committee approved the Safeguarding Adults policy subject to changes that reflect transition, and on the terms that the EIA is completed. These changes will need to be reviewed and the updated policy returned to the Committee in April.***

7 Staff Safeguarding Training Compliance

7.1 JCu welcomed MM who presented this item. MM advised that ConsultOD does not capture Safeguarding training compliance above level 2, despite many staff completing safeguarding training at levels 3+. MM wanted to assure the Committee that work is being done with CSU to resolve this issue. A training needs analysis has been done for the ICB. Staff required to take training above level 2 will be informed how they can capture/record multi-disciplinary Safeguarding training on ConsultOD as a part of their appraisal process.

7.2 CG clarified that the current ConsultOD is base model that is purchased from CSU, and the default system for all ICBs. To add this feature for levels 3+ requires commissioning and funding. CG said that the Safeguarding team would need to compile a list of names that need to be approved as levels 3+.

7.3 ***<u>Recommendation</u>: The Committee support the work to go ahead with CSU to enable the compliance/record feature for Safeguarding training levels 3+.***

8. Primary Care Quality Report

8.1 JZS brought the Committee's attention to Serious Incident reporting. JZS said the team were trying to capture the number of adverse system incidents within Primary Care on the new dashboard. Dermatology is a particular concern due to recent changes in their 6-month follow up criteria.

8.2 JZS explained that an investigation had been completed into the April 2022 lost cytology samples which had failed to reach the Bristol laboratory. Seventy-five follow ups have been completed and no harm had been found to those patients. Work on a new tracking system is underway.

8.3 JZS said that student nurses, supported by general practice nurses and supervisors, had been out on the ICB bus and had made over 150 patient contacts. In March they will travel to Lydney to see a further 50 patients. There were hopes to follow up with the student nurses in 6-months. JZS informed the committee that Legacy Mentor roles would be advertised at the end of February 2023.

8.4 JZS said that in terms of migrant health, a new hotel was now being used. The average stay for migrants in most hotels is around an average of 316 days. 324 asylum seekers had moved out of Gloucestershire. JZS said due to the Migrant Health team's particular focus on GP registrations and general health checks, migrant emergency department attendances had decreased considerably. Mental Health remained a concern for this cohort.

Approved

8.5 JM suggested a focus on Primary Care dentistry in the next Primary Care report. JSo said that there should also be a focus on associated quality and system-wide risks. AM added that it would be useful to see metrics that NHS England currently use for quality and performance.

8.6 AM raised a topic on NHS England six metric priorities set out by NHS England on ambulance and emergency department waits. AM queried if there were any visual aids to establish postcodes where unplanned attendances are attending from, and whether there was support work ongoing for these six indicators. JZS responded that business intelligence colleagues were doing work on A&E attendances and this information will be included in the next Primary Care Quality Report.

8.7 ***Recommendation**: The Committee noted the Primary Care Quality Report.*

9. System Assurance Discussion - Provider Organisations

9.1 **Gloucestershire Hospitals NHS Foundation Trust (GHFT)**

MH summarised the high-level themes from the GHFT report submitted. MH said that the last inspection for Well-Led was in July 2022 with a Requires Improvement rating. Core services inspections for Maternity and Surgery had overall Inadequate ratings. Improvement work for these areas were in place and progressing with regular oversight from the ICB and CQC.

Overcrowding in the Emergency Department had necessitated further work to prevent boarding patients in corridors and wards. A suite of metrics are presented to the GHFT Quality and Performance Committee on a monthly basis.

Cancer performance: robust plans were being developed. Elective Care was performing well. The Quality Improvement team are focused on simple discharges, taking a similar approach with boarding and corridor care, and ensuring the new discharge lounge is being well utilised. This is beginning to have a good impact and will be fed through into this Committee.

9.2 **Gloucestershire Health and Care NHS Foundation Trust (GHC)**

HW said that GHC's Quality Dashboard was produced on monthly basis and presented bi-monthly to their Quality Committee and Board. HW highlighted that this month was the quarterly Non-Executive Directors Audit of Complaints, and that full assurance was achieved across the Board on how complaints were managed and responded to.

HW said colleagues were feeling the benefits from improvements in health care support vacancies. There was good progress within a QI project which stemmed from a complaint on frequent mental health observations. HW summarised that onboarding beds and escalation beds were now open and that there was a continuing demand for mental health inpatient space for working-aged people with specialist dementia.

9.3 ***Recommendation**: The Committee noted the verbal updates on System Assurance from Provider Organisations.*

10 Update on Out of Hours Assurance

10.1 JZS reminded the committee of the Section 29 letter was issued by Care Quality Commission (CQC) in early December, which outlined main concerns and areas needed

Approved

for improvement on Out of Hours. Meetings had taken place with the Patient Participation Group (PPG). Initial investigations had highlighted clear performance issues. JZS said there were no immediate issues from a quality perspective and most concerns lay with medicines management. A robust action plan had been drawn out and will be with CQC by the 17th March 2023.

10.2 JZS said that PPG were now aware of the Orange Folder Initiative and had been invited to the Patient Experience Group with Urgent and Emergency Care. Next steps would be around the CQC action plan and encouraging increased Primary Care Network (PCN) involvement.

10.3 JSo was not familiar with the Orange Folder in terms of what it contained and how long it had been in operation. This started off around End of Life so that people had everything in one place, and this is gradually being rolled out to Mental Health and Urgent Care and as JS-Z said, there are many initiatives here, so it would be useful for them to be part of the Clinical Programme Group.

10.4 JSo raised assurance. The CQC letter with the outcome of their review was being published today and would also be available on the CGC website. Their action plan will be monitored from which assurance can be gained. JSo said that this was a long-term change and was concerned that should certain areas be addressed, then resources being placed into this would mean the slippage in other areas. JSo asked if they had been able to maintain improvement across all the various areas in the past that had been brought to their attention.

10.5 RM explained that the CQC had replaced people, but it was taking time to implement changes. The business model along with assurance is being addressed at the moment and JS-Z and her team will help embed these changes across the whole system. The performance aspects were raised, and RM said that these would go to Ellen Rule and the Urgent Care team. MAE said that there is a Clinical Programme Board, and anything raised would be picked up via the Performance Report that would come to the ICB. Future contracts and contract renewal would be examined to demonstrate what the CQC would be doing.

10.6 JZS agreed to take Governance back to Ellen Rule for clarity around any performance issues**.** **JZS**

10.7 ***Recommendation*****: *The Committee noted the verbal update on Out of Hours Assurance.***

11. Social Care Quality – Provider Organisations

11.1 EW said from September 2023 onwards there will be 20 CQC adult social care assessments across the country. From April to September 2023, there will be a data review and intelligence gathering review of local authorities. GCC had been gathering evidence and undertaking a detailed self-assessment in preparation. However, there were difficulties as local authority adult social care did not have a recognised Assurance Standard.

11.2 EW said that GCC will be holding a serious of small-group workshops for senior leads which will approach the view of having a first draft SEF completed by the end of March. SS mentioned that there had been significant moral injury across staff working in adult social care who are unable to give the quality of care they wished to, and this should also be acknowledged.

Approved

11.3 JSo mentioned that we needed to know about the quality of what was provided through those voluntary and community sector organisations that received grants.

11.4 KF said that we give money to the voluntary sector in two very different ways, the first being in grants for organisations to do good things for us out in the communities. This type of grant (as directed by National Guidance) would require the least amount of quality assurance because the organisation had the autonomy to be able to arrange things for the good of the community, and they would be supported with a contribution.

11.5 There were significant contracts with the voluntary sector which were all under Service Level Agreements (SLAs) which contained detailed Key Performance Indicators (KPIs), targets and dashboards feeding into regular quarterly meetings. The voluntary sector comprises different things and there is a form following function in terms of how quality assurance is addressed. There is always more that could be done but KF felt we should not put unnecessary obstacles in the way of those things we loved the most.

11.6 JSo asked how the information from all the SLAs came through, which was both a governance and quality question.

11.7 KF said the people who managed the contracts managed the quality of those contracts and felt that this was a larger question being asked and how would we assure ourselves of the quality across the Board.

11.8 MAE said that she and her team were cited on quality as any issues going to KF’s team would be discussed with MAE and she and the team would correct any particular issues. There was however nothing in the papers today to give that assurance, and MAE will follow this up.

11.9 MAE agreed to follow up on how quality is assured with SLAs and inform the next meeting on 12th April 2023. **MAE**

11.10 ***<u>Recommendation</u>*: The Committee noted the verbal Social Care Quality update.**

12. <u>Maternity Assurance</u>

12.1 MH said that Maternity had received a CQC Inadequate rating, summarised with four ‘must-dos and eight ‘should-do’ actions. Progress is monitored monthly by the Maternity Delivery Group and GHFT Quality & Performance Committee. The three main areas of concern within the section 29A related to midwifery staffing. MH said that they are working closely with a Maternity Improvement Advisor to continue to monitor and develop an action plan. There are some challenges around the Maternity Incentive Scheme; however, there are now three new Maternity Safety Champions with a shared governance focus.

12.2 TP added that improvements had been evidenced with the CQC maternity user survey, with service users reporting that access to midwifes and services were good. This feedback had helped raised staff morale amidst the current challenges in Maternity.

12.3 JSo questioned the new birthing unit being developed in Cheltenham amidst midwifery staffing issues. MH said there is a commitment to continue midwifery care in Cheltenham and there had been an improvement in midwifery staffing.

12.4 ***<u>Recommendation</u>*: The Committee noted the verbal Maternity Assurance Update.**

Approved

13. **SEND (Special Educational Needs and/or Disabilities) Area Inspection Framework**

13.1 ZR shared a presentation on SEND which summarised the contents and background of the project, as well as what the main areas of focus for inspections will be. ZR highlighted areas for improvement and assured the committee that work is ongoing for all areas. A full inspection under the updated SEND Inspection Framework is expected in the near future.

13.2 KF added that a significant increase in Emergency Health Care Plans (EHCPs) was also affecting current community services. JM said that in preparation for assessment, all areas of concern should be flagged and that plans for improvements were clear and in place. ZR said with investment the SEND team would like to work with providers to develop more detailed and formal plans for the future.

13.3 MAE said that there was a national requirement to review every special needs child in a residential placement in county. This was undertaken and no particular issues were found, but there is an opportunity to discuss this alongside SEND work.

13.4 ***Recommendation**: The Committee noted the SEND Area Inspection Framework and upcoming inspection and advised that the Operational Executive Group should have oversight over the SEF and future documentation.*

Date and Time of next meeting: **12th April 2023 at 2pm in the Board Room at Sanger House.**

Approved

People Committee
Minutes from 12th January 2023
9:00 am – 12:00

APPROVED

Members present		
Clive Lewis (f2f)	CL	Non-Executive Director, Committee Chair, ICB
Jane Cummings (f2f)	JC	Non-Executive Director, Committee Vice-Chair, ICB
Tracey Cox (v)	TC	Interim Executive Director of People, Culture and Engagement, ICB
Mary Hutton (v)	MH	Chief Executive Officer, ICB
Marion Andrews-Evans (v)	MAE	Chief Nursing Officer, ICB
Andy Seymour (v)	AS	Chief Medical Director, ICB
Sarah Scott (v)	SS	Director of Adult Social Care, GCC
In Attendance		
Lauren Peachey (f2f)	LP	Governance Manager, ICB (minutes)
Christina Gradowski (f2f)	CG	Associate Director of Corporate Affairs, ICB
Ryan Brunsdon (f2f)	RB	Board Secretary, ICB
Neil Savage (v)	NS	Director of HR & OD, GHC
Ruth Thomas (v)	RT	Associate Director: OD, Learning and Development, GHC
Sophie Atkins (v)	AS	ICS People Programme Manager, GHC
Claire Hines (v)	CH	ICS - Workforce and OD Project Lead, GHC
Ruth Thomas (v)	RT	Associate Director: OD, Learning and Development, GHC
Abi Hopewell (v)	AH	
Anis Ghanti (v)	AG	
Zack Pandor (f2f)	ZP	OD Programme Manager, People Solutions NHS South, Central and West, CSU

1. Apologies and Introduction

1.1 Apologies were received from Claire Radley and Deb Evans

1.2 CL welcomed the members and attendees to the third People Committee of the Integrated Care Board (ICB). It was confirmed the meeting was quorate.

2. Declarations of Interest

2.1 The Chair asked if any members or attendees in the meeting held any interest in any items on the agenda. No interests were declared.

3. Minutes of the meeting held on the 6th of October 2022

3.1 Resolution: The minutes of the meeting held on the 6th of October were agreed as an accurate record of the meeting.

4. Actions Log

4.1 There were no open actions to discuss.

4.2 CL asked colleagues if there was any feedback following the strike action event on the 11th of January. MH responded that data from the 11th of January showed only 100 ambulance handover hours, which was a reduction in comparison to the previous week. Category 2 ambulance performance was strong. There was a low ambulance stack enabling more people to be seen in the system. MH said that there had been concern that the industrial action would result in increased demand in the following days.

4.3 CL observed that there had been an open call for support and asked whether anyone had come forward. MH replied that following the call for support there was now a structured programme to support discharge, end-of-life and the flow through Discharge to Assess (D2A) beds. There was an understanding that the industrial action would have an impact on planning so prioritisation would be needed, particularly for hospital discharge.

4.4 NS added that a rota of voluntary support for Healthcare Assistants and Registered Nurses within Gloucestershire Health and Care (GHC) had been put into place. There are some critically important roles included on the rota that will be beneficial in terms of flow and giving extra support in key cohort areas for winter.

5. ICS People Function Summary Report

5.1 TC summarised the future strike action proposed by the RCN. TC said the upcoming strike action dates will be across other parts of the country and the were unlikely to affect Gloucestershire. TC said there had been a proposed strike action from the Chartered Society of Physiotherapists who have indicated that their 4200 Members will be taking strike action across 30 trusts on the 26th of January and at another 30 trusts on the 9th of February. Gloucestershire would not be affected by the strike action on the 26th of January, and it was not

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yet known if Gloucestershire would be affected by the strikes on the 9th of February. TC said there was further action anticipated by other professional bodies as well. The system has responded well to the strike action so far.

5.2 NS confirmed there had been a lot of preparation prior to the strike action, however, the Royal College of Nursing (RCN) had underestimated the work associated with agreeing derogations. Both provider trusts spent a lot of time preparing and planning services to maintain safe staffing levels and working with strike committees. A better understanding of the complexity and interrelationship between services was required. NS explained that some Minor Injury Units (MIUs) had to be closed due to lack of staffing cover. AH explained that at GHFT, there were a few areas which experienced some challenges due to limited staffing however, mostly it went relatively well. It was noted this was likely to be a focus for the coming months and there didn't appear to be an appetite nationally to come into negotiations with staff.

5.3 TC said there would be a key area of focus for systems around workforce retention and staff health and wellbeing. There was a particular challenge around the agency cap and pay bill included in the report; the next year's target had been set at 3% of the overall pay bill.

5.4 TC said we continued to wait for the national workforce strategy which was expected to launch in Spring 2023.

5.5 We continued to onboard the candidates from the health and care support worker recruitment event that took place in September 2022. Approximately 25% of the candidates that we recruited at that event had been lost with challenges with visa issues and a long time to follow up references for candidates. SA said 49 people started before Christmas and another 38 were due to start imminently. There were about 40 candidates for social care. SA explained that the applications were made to be short and easy for the applicants however as they did not include references it put additional pressure on the recruitment teams which took additional time and resulted in delays. SA added there may be a small delay on the DBS checks.

5.6 CL asked for the split between GHFT and GHC. SA responded that seven had started in GHC and 37 have started in GHFT. However, there were another 26 ready to start in GHC and another twelve due to start at GHFT on the next induction days.

5.7 JC asked if there were any starting in Social Care. SA responded at least 5 people had started. SA added that there were multiple employers in social care and the data wasn't always readily available.

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5.8 In terms of the dropout rate. TC explained that we weren't clear ta the time what the dropout rate would be for Gloucestershire. TC said some other areas had a dropout rate as high as 50%.

5.9 CGi said that, in November 2022, The Kings Fund reported 165,000 vacancies in Social Care across the country. CGi suggested including Social Care vacancies in the workforce report going forward. SS said this data was available for Domiciliary Care and Nursing Care and could therefore be included in the workforce report.

5.10 ***Action: SS, CGi and CH to include social care vacancies on the workforce report.***

5.11 In terms of Equality Diversity and Inclusion agenda, TC said system partners were continuing to participate in the diversity in health and care partner program run by NHS Employers which provided a series of masterclasses. The ICB joined a National Initiative of the 10,000 black interns project which was providing internships for students and graduates over the summer of 2023. TC said the ICB was offering two internships. CL asked what the target was for internships for the NHS. TC clarified that it was a scheme any employer could sign up to and there was not a target as such.

5.12 Resolution: The committee noted the contents of the ICS People Function Summary Report

6 Workforce Intelligence and Programme Highlight Report – November/December 2022

6.1 CH explained the data included within the report was from September and October 2022. CH summarised that the agency usage had increased by 36 WTE (and a further 4 in November). CH said the bank staffing number was consistently just under 900 per month, although it had dipped during October for both GHFT and GHC.

6.2 CH said the nursing vacancy rate had slightly increased and there had also been an increase in people leaving within a year of starting. CH explained that the people leaving with a year of starting was a key metric to focus on as it had an impact on cost for recruiting and capacity.

6.3 CH said sickness absence rates had increased slightly however this was to be expected for the time of year.

6.4 CH highlighted there had been an increase in Healthcare Support Workers.

6.5 CH highlighted that the report now included some children and as well as adult social care data. Children's social work staff had increased over the period.

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6.6 CH said the diversity across our staffing in the NHS for bands 5 and 6 had improved.

6.7 All staff groups except AHPs have increased over last 12 months. CH explained that AHPs had continually decreased since Oct 2021 following a sudden increase. CH was looking to find out why this is decreasing.

6.8 CH highlighted that the Gloucestershire Integrated Workforce Report had being held up as an exemplar.

6.9 MAE explained that she had been to the Gloucestershire Graduation Ceremony and had observed a notable mix of ethnic backgrounds and varied ages for the nursing graduates. However, the physiotherapists were less diverse. It was noted many physiotherapist graduates often went to work in private sports therapy rather than the NHS.

6.10 RT explained research suggested that for people who leave within the first six to twelve months it is their induction process that wasn't right in a lot of cases. RT emphasised the influence line managers can have on the way that people settle into their roles.

6.11 CL asked whether we captured where colleagues were going to when they were leaving their jobs and whether they were moving to another NHS organisation or into the private sector. CH responded this exit data was available, however, it was limited and dependent on the HR department's capacity to obtain this information. NS said at GHC there was a standard national minimum data set for a destination on leaving which must be completed by either the manager or the workforce information team to be able to process somebody's final pay. CL suggested that exit data may provide additional understanding of the agency spend. CGi explained that much of the exit data was high-level and did not offer detail. Many leavers did not participate in exit interviews.

ACTION: NS and CH to liaise around including additional exit data in the Integrated Workforce Report.

6.12 AS observed that the data showed a significant number of GPs leaving in one month. CH clarified that eleven GPs had left during the months and this included Registrars. CL asked if there was a link between the GP leavers and areas of deprivation. CH responded that Primary Care Teams may have this data.

ACTION: CH to split the data between GPs and Registrars and GP leavers and areas of deprivation.

6.13 TC explained that the aim to work with the Business Intelligence Team to develop a visually engaging report which shows the long terms workforce trends. CH highlighted that a data analyst, who was familiar with Power BI, had recently been recruited to and would support this work.

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6.14 TC highlighted that a Workforce Retention Lead had recently been recruited and will start in March. In addition, an Apprenticeship and Widening Participation Lead role had also been recruited into.

6.15 TC said there were three areas of focus across the system. These were health and well-being, international recruitment, and agency expenditure. TC explained there had been work underway to map the range of health and wellbeing functions and activities that each organisation currently has in place. In terms of international recruitment, there had been a mapping exercise to better understand the approaches and processes that each of our organisations, including our social care partners, currently use. A similar process was underway in terms of understanding agency expenditure.

6.16 NS explained that national funding for the Wellbeing Line had been discontinued. Gloucestershire had sought alternative funding for the Wellbeing Line which was a positive move considering the focus on staff health and wellbeing.

7. Leadership Development and System Capability Update

7.1 TC provided an overview of the work taking place around Leadership development across Gloucestershire.

7.2 In terms of Leadership Development, AH explained the One Gloucestershire Leadership Development Programme, which was targeted at those in a band 7 and above, has been running since 2018 and had trained 240 people across the system since it began. AH highlighted that the programme consistently evaluated well and was developed to support participants to make connections and bring people together.

7.3 AG summarised the One Gloucestershire System Thinking and Leadership Masterclass programme targeted at those in a band 8 and above. AG said this was about a more focused emphasis on what systems thinking is about and how leadership plays a part within that. AG highlighted that, despite the significant time commitment, there had been no participant drop off. Feedback from the masterclasses had been very positive and they provided participants with practical tools they could apply to the system context within which they were working.

7.4 AH summarised the Leadership support for the Equality, Diversity and Inclusion agenda such as the Flourish programme which is a positive action development programme aimed at those in bands 4 to 7 who identify as an ethnic minority in the UK, a member of the LGBTQ+ community, those having a disability, impairment of long-term condition or identify as neurodiverse. AH explained that WRES and WDES data indicated that colleagues in these cohorts are

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overrepresented at more junior levels and underrepresented proportionately at more senior levels in the ICS.

7.5 AH explained that the One Gloucestershire Inclusion Allies Programme was a five-week immersive learning course designed to prepare participants to become inclusion allies. AH highlighted that because it was delivered virtually, it could be offered to a large number of participants.

7.6 We had also provided a One Gloucestershire EDI Network Chair Development programme of four development sessions for colleagues who are chairs of EDI networks.

7.7 AG explained that Gloucestershire was one of the few systems in the country that had signed up for the Reciprocal Mentoring programme. The programme provided an opportunity for senior leaders and decision-makers to access and listen to the lived experience of people from different protected characteristics and positive dialogue between two people to explore different ways of thinking.

7.8 TC summarised the work underway to support Urgent Care Transformation, such as the One Gloucestershire Systems Thinking and Leadership Masterclass programme and the dedicated funds allocated to support Urgent Care to with the recommendations from the Newton work.

7.9 In terms of resourcing, TC explained that many of the programmes outlined had been historically funded through the Leadership Academy or Health Education England. Future funding opportunities were not yet known. It was estimated that approximately £100k would be required to support the continuation of these programmes for 2023/24. TC summarised the options to secure funding.

7.10 TC highlighted that all the programmes combined have benefited over 400 staff and there had been positive feedback and outcomes. The programmes had supported building relationships across the system.

7.11 TC showed the draft plan on a page for 2023/24 and detailed the next steps. TC said work was underway to scope and understand existing line management and training and leadership development offers that are taking place across the partner organisations. TC highlighted we needed to ensure links with Quality Improvement and Clinical Leadership Workstreams were maintained and strengthened.

7.12 MH extended thanks to colleagues who have worked on these programmes. MH highlighted some of the feedback she had been given by participants. RT agreed and emphasised the importance of having leadership development across the system. RT extended support to the approach and highlighted the value of the networking opportunities these programmes enabled.

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7.13 In terms of the Quality Improvement programme, KH highlighted that improvement methodologies enabled people to work together to reach out across organisations and to effect a great change and work with service users and work with patients to create better outcomes. KH said that a Strategic Approach was being developed and will be presented to various executive groups in March.

7.14 KH summarised that Quality Improvement was a professional practice that helps to identify and understand a problem, who to engage with to understand the problem further, and take a scientific and evidence-based approach to setting metrics, aims and treatment. The purpose of the One Gloucestershire Improvement Community was to broaden the collective improvement capability and capacity and to further develop the approach to system improvement.

7.15 KH said a number of stakeholder workshops have been held and key themes have been collated around building a community and developing leadership throughout the system. KH said the approach that we use in Gloucestershire was founded on the model for improvements, and improvement as a practice is something that's flexible and adaptable.

7.16 KH said the Quality Improvement Delivery Plan was split into three key themes around leading improvement, enabling work and energising work. KH highlighted that around 1000 people have completed the Quality Improvement programmes.

7.17 TC asked the committee for feedback on the current approach to leadership development and system capability. JC responded that the range of programmes and length of time they had been running was impressive and it was great to see social care was included as well as the NHS. In terms of multidisciplinary approaches, JC asked if there was a separate clinical leadership programme or if clinical leaders were being asked to join the multidisciplinary programmes. JC asked if there was much information on the impact that these programmes have had. In terms of the development around talent management, JC asked if there was a mechanism of alumni to flag participants who could be suitable for a fast-track programme to further develop their roles or skillset. TC responded that clinical leaders were encouraged to participate in the existing programmes. However, it was recognised that clinical leaders may have some specific training and development requirements and a questionnaire was going to be launched to ascertain what their needs are. TC said there was a register of alumni although this had not yet been developed into a talent management plan however this would be next step. AH added that all programmes had the potential to link into a talent development programme. HLR highlighted that there was value in combining managers and clinicians in the same cohorts.

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7.18 In terms of Social Care attendance at these programmes, KH said that on the QSIR practitioner programme, teams were encouraged to attend with a real problem to work on and progress on their project. Colleagues from public or integrated commissioning had participated. The new deputy director of social care and KH had been discussing how they begin to build that improvement practice within adult social care.

7.19 AS said a different approach for clinical leaders may be required as they were often employed for half a day per week for their clinical leader role and could therefore not commit the same level of time as other groups. Bespoke work may be required. JC added that there was a benefit of clinical leaders sometimes being able to participate in multidisciplinary cohorts and the clinicians were all clinicians and not just doctors.

7.20 SS said that Adult Social Care has not yet used the QI methodology. SS said that Adult Social Care has used the Seven Pillars of Clinical Governance to improve quality and safety in Adult Social Care but there was huge potential of using QI in Adult Social Care.

7.21 NS said the gold standard we should be aspiring to is joining up the talent management approach with succession planning. It's a big task that would need an investment in time. Nationally it had gone quiet on leadership in terms of the implementation and next steps of the Messenger Review of Health and Social Care Leadership. However, there appeared to be support for systems to identify and develop their own talent.

7.22 CL said the work being done for quality improvement was exceptional. CL said that from an agenda for change perspective, aiming the programmes at band 7 and above was appropriate. 50% of the NHS staff report into a band 7 or above therefore there was likely to be a good return on investment here. CL and TC had briefly discussed system-wide succession planning which was a large piece of complex work however there was an appetite to consider how this would be developed.

7.23 TC summarised that the Leadership Development work was a critical enabler to the rest of the work that the system does. TC said more could be done in terms of formalising succession planning and talent management to support future aspirations and ambitions in terms of how we work as a system.

7.24 **RESOLUTION: The Committee noted the contents of the Leadership Development and System Capability Update**

Break 10:55 – 11:05

8. Developing a One Gloucestershire People Strategy – Tracey Cox

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8.1 TC reported the need to develop a comprehensive people strategy for one Gloucestershire. As part of our transition to an ICS in 2022, a high-level position statement was set out against the 10 people functions and TC explained her ambition for Gloucestershire was to evolve and develop our thinking.

8.2 TC said through the operational planning guidance and expectations within the joint forward plan, we will develop detailed narrative against the 10 people functions to describe our intent and our approach, however, we need a process to get us to a workforce strategy for One Gloucestershire and align it with the final requirements around the joint forward plan, which is due at the end of June.

8.3 ZP explained the proposed approach for Developing the One Gloucestershire People Strategy, summarizing the strategy development phases and planned stakeholder engagement over the coming months. NS said in terms of stakeholder engagement, there was likely to be a significant amount of detail that from organisational staff survey results available at the end of March. CGi added that consistent themes were often seen year on year in the staff survey and therefore previous year's themes could be used as a starting point to begin developing the strategy.

8.4 In terms of the national context, ZP explained that the strategy needed to consider the People Promise, the Ten People Function Outcomes, the recently published Planning Guidance and Health Education England Framework 15. The local context would need to consider organisational workforce plans.

8.5 ZP summarised the stakeholders and the engagement approaches for the development of the One Gloucestershire People Strategy and governance and approval timescales.

8.6 TC said she was aware that there were many existing strategies across the ICS however it was important to get clarity for where we were heading in the future and what the ambitions were for this area of work. It was proposed this would be a high-level document which describes the intended approach and our areas of focus. It may not be possible to deliver equitably across all ten people functions, there may be a few areas which may be more important to focus on.

8.7 In terms of engagement with stakeholders, RT said this may be difficult to achieve however it was important and staff should be asked what was important to them so that could feed into the high-level approach.

8.8 JC emphasised that many initiatives and programmes could be put in place to support staff health and wellbeing however if the basics of the role were not right, and if there wasn't enough staff, then the staff would not feel supported. CGi agreed and said we need to get the basics right before moving on the other workforce initiatives. CGi added that relationships in the workplace were an

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important factor to consider in terms of staff happiness and a team with strained relationships would cause additional stress for the staff.

8.9 CH added that the workforce was a risk issue for almost every area of clinical work across our ICS. CH explained that about one-third of the workforce issues were created by having to recruit to temporary posts, sometimes due to financial constraints caused by short-term funding, and sometimes due to organisational appetite to financial risk around the workforce.

8.10 In terms of obtaining additional detail for the strategy, ZP said existing work which was underway as part of the clinical and transformation workstreams may provide the level of detail required to clarify what was required to deliver the strategy.

8.11 TC said the next step was to commence stakeholder engagement. TC summarised that the strategy needed to correlate with the results of the 2022 staff survey and the known workforce risks and issues. Linkages between programmes were critical.

8.12 CL requested that this is a standing item on the agenda until it is launched.

8.13 RESOLUTION: The committee supported the proposed approach for developing the One Gloucestershire People Strategy

9. Workforce Risk Register and Board Assurance Framework Report

9.1 TC explained that a detailed review of the risk registers across all of the People Board subgroups had been undertaken to bring the risk registers up to date. Workforce risks with a score of 15 and above would be reported to the People Committee.

9.2 TC said there were six key areas highlighted in the risk register which had been discussed during the course of the meeting and included in reports circulated to the committee. These risks were around workforce supply, ongoing industrial action, an unresolved issue around band 2/3 pay for health and care support workers. There was an ongoing challenge around the cost of living and impact on staff, placement capacity expansion and finding adequate supervisory arrangements for placements. TC said the final risk was around the ongoing uncertainty for future funding for clinical professional development funding.

9.3 TC said that workforce retention had been discussed during the course of the meetings and we need to also take to the workforce steering group to make sure it was recorded at the right level.

9.4 RESOLUTION: The Committee noted the contents of the Workforce Risk Register and Board Assurance Framework Report

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10. ICB 6-month HR Report

10.1 CGi explained the HR report was produced every six months and there was also a 12-month report produced each year.

10.2 CGi summarised that the ICB headcount had increased by 7.3% over the last 12 months and was at 427. There had been 50 new starters over the last 6 months across 23 teams. CGi explained that the report pulled data from ESR and the cost codes did not easily match to team names.

10.3 In terms of staff turnover in the last six months, CGi explained the rate was at 10.44%. CGi explained that there was a high leavers rate in July due to the transition from a CCG to an ICB and the changes to the Board. CGi explained that in some teams, such as Digital, the turnover was due to labour market factors and higher pay in the private sector. In terms of other teams such as CHC, there had been a high number of retirements. CGi explained that many leave to take a promotion.

10.4 CGI highlighted that over the years, the CCG and ICB had done a significant amount of work around flexible working and wellbeing to support staff.

10.5 In terms of mandatory training, CGi explained that compliance at the end of September 2022 was 78.7% and reminders were being sent to staff to complete their mandatory training.

10.6 CGi said the rolling 12-month absence rate for the six-month period was 3.00% (FTE) which was 0.75% less than the previous reporting period. CGi explained the main reasons for absence was stress/anxiety/depression, and coughs, colds and flu.

10.7 TC said that ICBs had been requested to publish an organogram showing the organisational management and running costs. TC explained that across the Southwest there were organisations that were downsizing in response to cost pressures. MH explained further guidance on management costs was expected. MH clarified the difference between programme costs and management costs and how staff would fit into either category. MH explained that ICB management costs would be saved by moving to a smaller office later in the year.

10.8 CL asked if the total ICB headcount included contractors. CGi responded that there were two figures for the headcount, one which included permanent only staff and the other headcount also included temporary staff.

10.9 RESOLUTION: The Committee noted the contents of the ICB 6-month HR Report

11. AOB

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11.1 **Gloucestershire People Symposium Proposal – Clive Lewis, Tracey Cox**

11.2 CL explained that there was an intention to hold a People and Workforce Symposium in May 2023. The symposium would also focus on how we might be able to work with stakeholders who are also employers in the county, looking at how to attract retain talent in the county and look at wider issues such as infrastructure. CL clarified that two potential dates in May 2023 had been identified. Further details would be provided in due course. TC requested that committee members get in touch if they had suggestions for speakers at the event.

11.3 RT said she had been invited to a Collaborative Leadership Lab which was proposed by Gloucestershire VCS.

There was no other business raised.

Next meeting:

27th April 2023, Prout Room, Sanger House

APPROVED

Gloucestershire Integrated Care Board

Audit Committee

Part I
Minutes of the Hybrid Meeting Held at 9:30am on 26th January 2023

Members Present:		
Colin Greaves	CG	NED, Chairing
Jo Bayley	JB	Member
Claire Feehily	CF	Member
In Attendance:		
Christina Gradowski (*Agenda Item 8)*	CGi	Associate Director of Corporate Affairs
Gerald Nyamhondoro	GN	Corporate Governance Officer (taking minutes)
Cath Leech (*Agenda Item 14)*	CL	Chief Finance Officer
Paul Kerrod (*Agenda Item 6*)	PK	Deputy Head of Local Counter Fraud Service
Andrew Davies (*Agenda Item 7*)	AD	Audit Manager, Grant Thornton LLP
Justine Turner (*Agenda Item 5)*	JT	Audit Manager, BDO LLP
David Porter (*Agenda Items 9 & 10)*	DP	Head of Procurement
Ryan Brunsdon	RB	Board Secretary
Atiya Bashir	AB	Graduate Trainee
Kimberley Magner	KM	Graduate Trainee
Lee Sessions	LS	Local Counter Fraud Service Specialist

1.	**Apologies**
1.1	Apologies were received from Julie Soutter and Marcia Gallagher.
1.2	The Chair confirmed that the Audit Committee meeting was quorate.
2.	**Declarations of Interests**
2.1	Claire Feehily (CF) declared an interest in item 5.4 which covered the case of *Consultant Connect -v- BNSSG, BSW and Gloucestershire ICBs.* CF stated that her professional responsibilities extended to the interests of BSW ICB. The other members present considered the declarations and concluded that the inclusion of CF in the proceedings was consistent with the terms of reference and that her participation with full rights of members was not prejudicial to the proceedings, or to the Gloucestershire Integrated Care Board (thereafter "the ICB").

3.	**Minutes of the Last Audit Committee Meeting Held**
3.1	Minutes of the meeting held on Thursday 17th November 2022 were approved as an accurate record of the meeting.
4.	**Matters Arising**
4.1	**14.07.22, Item 5.2.2** Data Security and Protection Toolkit Follow-Up. JT stated that the Software Asset Register was being reviewed. Members agreed that an update on progress would be made in Quarter 4 (Q4) prior to submission of the next toolkit. **Item remains open.**
4.2	**08.09.22, Items 7.1 & 7.2** HFMA Financial Sustainability Checklist Self-Assessment. Shofiqur Rahman stated that apart from taking the checklist to the ICB Operational Executive, the Finance Team had put in place a plan to meet various budget holders as part of refining and redefining the self-assessment process. Cath Leech and Shofiqur Rahman would update the Audit Committee on progress made by March 2023. **Item remains open.**
4.3	**17.11.22, Item 5.3.3** HFMA Financial Sustainability. AS explained the auditors' role in the assessment of the ICB's utilisation of performance metrics when measuring financial sustainability. **Action: Adam Spires and Justine Turner to provide further update. Item remains open.**
4.4	**17.11.22, Item 10.2** Waiver of Standing Orders. DP stated that on basis of the 71 Waivers reviewed, it was clear that further work needed to be undertaken, particularly for the main Waiver categories, namely 'sole suppliers', and 'service continuity'. **Item closed.**
4.5	**17.11.22, Item 16.1** Cyber Security. FR explained that due diligence focusing on mitigating phishing risks was being concluded and the outcome would be brought before members in January 2023. **Item closed.**
5.	**Internal Audit Report**
5.1	Progress Update
5.1.1	JT outlined the 2022/23 Audit Plan and stated that there was no change made to the current Internal Audit Plan. On financial governance, JT presented and outlined the proposed topics for the Internal Audit Plan for 2023/24 and subsequent years. JT added that the proposal had been presented to the Operational Executive and feedback was being collated.
5.1.2	JT highlighted that as well as taking on commissioning functions of the Clinical Commissioning Group (the CCG), the ICB was to take responsibility for some of NHS England's direct commissioning functions. JT clarified that NHS England would retain overall accountability for the discharge of its delegated functions under the Health and Care Act 2022. JT stated that BDO LLP was providing support to the process of Pharmacy, Ophthalmic and Dental (POD) delegation. JT stated that auditors had started auditing conflicts of interest in the ICB.

5.1.3	JT added that whilst there was some slippage in POD delegation process, work on joint working arrangements was progressing. CG emphasised a need to ensure that management and staff understood their responsibilities and that staff, supported by management, understood the risks associated with the delegation. CG emphasised that members should ensure smooth operation in joint working arrangements with other partner organisations providing Primary Care work.
5.2	Internal Audit Follow-Up Report
5.2.1	AS summarised overdue recommendations including those related to Personal Health Budgets (PHB). JT stated that staffing pressures remained within the team and that part of the input into the PHB pathway came from partner organisations and this element was outside the control of the ICB. Members requested commitment to a deadline of 31st March 2023 for the issue of PHB financial pathway to be concluded. **Action: Kim Forey to work on meeting the deadline requested by members.**
5.3	Key Financial Systems (KFS) Report
5.3.1	JT presented the report and explained that the ICB was required to maintain effective controls over its key financial systems. JT further stated that the auditors found the ICB's KFS to be fit for purpose, both in terms of design and effectiveness. Members commended the Finance Team's hard work.
5.4	Contract and Procurement Pipeline Management
5.4.1	BDO LLP gave the Contract and Procurement Pipeline Management process a substantial rating. JT added that audit work on contracts extended to Lessons Learnt from the *Consultant Connect -v- BNSSG, BSW and Gloucestershire ICBs* case. JT also added that BDO LLP conducted due diligence which extended to the testing of potential conflicts in the contracting environment to the extent it affected the work of the ICB.
5.5	Draft Three Year Strategic Internal Audit Plan for Discussion
5.5.1	JT presented a draft strategic plan covering the next three years. The plan covered areas of assurance and controls and included projection of future assurance. Discussion from members covered the following: • Primary Care Commissioning • Financial Key Systems • Data and cyber security • Environmental sustainability • Business continuity planning • Continuing Healthcare
5.5.2	CG emphasised that the plan should provide more regular assurance on cyber security. JT explained that the cyber audits covered the whole system. There was agreement that cyber audits should be more frequent than in the draft plan.

<table>
<tr><td></td><td></td></tr>
<tr><td>5.6</td><td><u>HFMA Financial Sustainability Benchmarking Report</u></td></tr>
<tr><td>5.6.1</td><td>JT presented the report and stated that the HFMA guidance was published in April 2022 as a self-assessment instrument for Finance Teams designed to support board assurance over the ICB’s financial sustainability.</td></tr>
<tr><td>5.6.2</td><td>JT explained that comparative data covered the following areas:
• business and financial planning
• budget setting
• budget reporting and monitoring
• forecasting
• board reporting
• financial governance framework
• training and development
JT explained that comparative data provided information on areas which required further review by the ICB. JT commended that the ICB also had strong processes which could be shared with others.</td></tr>
<tr><td>5.7</td><td><u>Equality, Diversity and Improvement</u></td></tr>
<tr><td>5.7.1</td><td>JT presented the report and emphasised that understanding and embedding the framework for Equality, Diversity, and Inclusion (EDI) helped organisations to foster a workplace culture and environment that nurtured fulfilment and self-actualisation of staff regardless of their background. JT described the drivers for a cultural shift.</td></tr>
<tr><td>5.8</td><td><u>NHS Audit Committee Handbook Supplement</u></td></tr>
<tr><td>5.8.1</td><td>JT presented the handbook supplement and noted that the Health and Care Act of 2022 had brought about significant changes and the supplement provided an update to key financial and governance changes.</td></tr>
<tr><td>5.8.2</td><td>Members discussed contents of the overall internal audit report and expressed satisfaction with management action and risk mitigation. Both management action and level of Assurance were rated Green.</td></tr>
<tr><td>5.9</td><td><u>RESOLUTION</u>: The Audit Committee noted contents of the Internal Audit report.</td></tr>
<tr><td>6.</td><td>Counter Fraud Report</td></tr>
<tr><td>6.1</td><td>PK presented and stated that the Local Counter Fraud Services (thereafter “Counter Fraud”) had joined a new multi- agency platform to enhance fighting fraud. PK added that the new platform relied on the pooling of information resources from a wider range of stakeholders to use for, amongst other things, carrying out collaborative intelligence led investigations and fraud awareness initiatives.</td></tr>
</table>

6.2	PK highlighted that significant progress had been made in implementing 12 components of the government Functional Standard. PK stated that Counter Fraud was working with the ICB Contracts team in testing processes related to procurement. PK further stated that Counter Fraud had three open cases.
6.3	Members discussed the report and expressed satisfaction with the effort and progress made in countering fraudulent activities. Members stated that the data available was not adequate to conclusively inform a shift in Assurance and management action. Therefore, both Assurance and management action remained Amber.
6.4	**<u>RESOLUTION</u>: The Audit Committee noted contents of the Counter Fraud report.**
7.	**External Audit Report**
7.1	AD presented the report to members and stated that there were no significant emerging issues to bring before the committee. AD added that the value for money audit and work on the three-month Accounts for the period ending 30th June 2022 were in progress. AD explained that work on Mental Health Investment Standard (MHIS) was progressing well, and it was projected that the report would be delivered within time.
7.2	AD stated that arrangements for the nine-month Accounts running from 1st July 2022 - 31st March 2023 were being finalised and the plan would be brought before the Committee. Members assessed the risks identified and considered such risks to be low. Both Assurance and management action were rated Green.
7.3	**<u>RESOLUTION</u>: The Audit Committee noted contents of the External Audit report**
8.	**Risk Management Report**
8.1	CGi presented the report and described the Risk Management Framework. CGi described the Board Assurance Framework (BAF) and the Corporate Risk Register (CCR) of the ICB. CGi emphasised the need to adjust and realign risk metrics with those of partner organisations and she stated that this resulted in the adjusting of the BAF risk scoring from 12 to 15, and that of the CCR from 10. Members discussed contents of the report and were satisfied with the risk management approach. Risk Assurance and management action were both rated Green.
8.2	**<u>RESOLUTIONS</u>: The Audit Committee:** • **Approved the Risk Management Framework and Strategy subject to agreed amendments having taken effect.** • **Noted contents of the Board Assurance Framework.** • **Noted contents of the Corporate Risk Register**.
9.	**Procurement Decisions Report**

9.1	DP presented the report and highlighted the awarding of home oxygen services contract to Air Liquide Healthcare Limited. DP explained that the contract was taken to the Operational Executives on 7th November 2022, and it was approved by the ICB Board on 24th November 2022. DP stated that the Contracts team was reviewing processes to make them more proactive. Members discussed the report and rated Assurance Green and management actions Amber.
9.2	**RESOLUTION: The Audit Committee noted contents of the Procurement Decisions report.**
10.	**Waiver of Standing Orders**
10.1	DP presented the six waivers of Standing Orders requested and approved by the ICB Executive. Members examined the ICB's use of waivers and rated Assurance Green and management actions were rated Amber.
10.2	**RESOLUTION: The Audit Committee noted the Waivers of Standing Orders report.**
11.	**New Procurement Guidance and Legislation**
11.1	DP presented and stated that the new procurement guidance and legislation replaced European Union (EU) public sector regulations. DP added that the guidance aimed to achieve the following outcomes: 1. to create a simpler and more flexible system that better meets the UK's needs while remaining compliant with the Government's international obligations; 2. to open up public procurement to new entrants such as small businesses and social enterprises so that they can compete for and win more public contracts; 3. to embed transparency throughout the contract lifecycle so that the spending of taxpayers' money can be properly scrutinised.
11.2	DP explained that the new procurement legislation would reform and replace the existing procurement rules (known as the Public Contracts Regulations, 2015) which derived from a directive issued by the EU. DP stated that it was expected that the new legislation would bring in significant changes to the contracts and procurement environment. Members discussed the report. Assurance was rated Green and management actions were rated Amber.
11.3	**RESOLUTION: The Audit Committee noted the report on the new Procurement Guidance and Legislation.**
12.	**Primary Care Delegation of Pharmacy, Optometry and Dental (POD) Services**
12.1	Members confirmed that they had read the report before the meeting and the report was thus taken as read. CG stated that the timescale and safe delegation checklist had gone before the ICB Operational Executive. Members discussed contents of the report and noted issues of concern.
12.2	CG added that he was of the view that regarding the POD services being delegated to the ICB,

	dental services appeared to show the highest risk. Members registered optimism that there was capacity to address identified areas of concern before the handover of POD services to the ICB. Members discussed the risks associated with the project and rated Assurance Red and management actions Green
12.3	**RESOLUTION: The Audit Committee noted contents of Primary Care Delegation of Pharmacy, Optometry and Dental (POD) Services report.**
13.	**Cyber Security Report** *Please see Confidential Part II minutes.*
14.	**Aged Debt Report**
14.1	CL presented the outstanding debt as of 10th January 2023. CL explained that the outstanding debt as per the Sales Ledger was £4,284,697 of which £1,597,852 was NHS and £2,686,845 was non-NHS. Members discussed the individual items constituting the outstanding debt and the actions required to recover such debt. Members expressed satisfaction with management action and the low level of risk. Both management action and level of Assurance were therefore rated Green.
14.2	**RESOLUTION: The Audit Committee noted contents of the Aged Debt report.**
15.	**Debts Proposed Write-offs**
15.1	No report was presented on this item.
16.	**Losses and Special Payments Register**
16.1	No report was presented on this item.
17.	**Any Other Business**
17.1	There was no other business to conduct.

The meeting ended at 11:30am.

Date and Time of Next Meeting: 16th March 2023 at 09:30am (Hybrid).

Minutes Approved by the Audit Committee:

Signed (Chair):_____________________ Date:_____________

System Resources Committee

Minutes from the meeting held on
Thursday 12th January 2023; 14:00 – 17:00

Initials	Name	Job Title	Organisation
Present			
JC	Joanna Coast *Chair*	Non-Executive Director; System Resources	ICS
AP	Angela Potter	Director of Strategy and Partnerships	GHC
CaL	Cath Leech	Chief Financial Officer	ICB
ClL	Clive Lewis	Non-Executive Director; Renumeration	ICS
MH	Mary Hutton	Chief Executive	ICB
MW	Mark Walkingshaw	Director of Operational Planning and Performance	ICB
SBr	Steve Brittan	Non-Executive Director	GHC
In attendance			
IQ	Ian Quinnell	Associate Director of Strategic Planning and Transformation	GHFT
JS	Julie Soutter	Non-Executive Director; Audit	ICS
JY	Jess Yeates	ICS PMO Coordinator	ICB
KD	Katharine Doherty	Senior Performance Management Lead	ICB
LH	Louise Holder	Senior Programme Manager	ICB
MG	Mark Golledge	Associate Director, ICS Development	ICB
RB	Ryan Brunsdon	Board Secretary, Corporate Governance	ICB
SA	Stephen Andrews	Deputy Director of Finance	GHC
SE	Stephen Edmonds	Finance Programme Manager	ICB
SR	Shofiqur Rahman	Interim Deputy Chief Finance Officer	ICB
Apologies			
ER	Ellen Rule	Deputy Chief Executive & Director of Strategy and Transformation	ICB
KJ	Karen Johnson	Director of Finance	GHFT
RG	Rob Graves	Non-Executive Director	GHFT
SBe	Sandra Betney	Deputy Chief Executive & Director of Finance	GHC
SL	Simon Lanceley	Director of Strategy and Transformation	GHFT

Item	Details	Owner
	Welcome and Opening	
1.	**Introductions and apologies**	
	JC welcomed the group and noted the apologies, as listed above.	

2.	**Declarations of Interest**	
	No declarations stated, the group were advised to contact JY with any standing declarations to be noted. JC confirmed the attendance met quoracy requirements.	
3.	**Minutes and Action Log from the meeting held on Tuesday 1st November 2022**	
	The minutes were approved as a true reflection of the meeting. The action log was reviewed and updated accordingly.	
4.	**Matters Arising**	
	No matters were raised by the group.	
5.	**Performance including NHS Oversight Framework**	
	MW noted that the Performance report, narrative and metrics, was circulated ahead of the meeting; the full Integrated Performance Report is to be presented at the next Board meeting. It was noted the system remains under significant pressure; with COVID, flu, industrial action and workforce pressures, both retention and recruitment impacting organisations across the system. Key achievements for this period include cancer performance remaining stable, strong primary care performance, the commitment to joint working and joint working with trade unions to help mitigate impact of industrial action. The focus for the next period include: • Pressures on urgent and emergency care • Ambulance handover, in particular category 2 • Gain a better understanding of the drivers behind wait times for overall waiting lists for elective treatment • Maternity, continue to make progress against the action plan. In summary, the challenges remain in urgent and emergency care services, but the focus is on immediate action, moving on to next phase of performance recovery.	

	The group discussed the Discharge Lounge implemented at GHFT, including current and future funding, and GP appointment needs, availability, wait times and benchmarking.	
6.	**M8 Financial Position and next steps**	
	CaL presented the 'Month 8' Finance Report, showing the system in a 'break-even' position. It was noted that GHFT are currently reporting a deficit, as reported in previous months. CaL outlined the ongoing, continuing pressures including workforce, Registered Mental Health nurses and escalation costs from Urgent and Emergency care as a factor in the deficit. It was also noted that fixed term contracts for energy were ending soon, this additional cost has also impacted the financial position for the system. Another additional cost related to prescriptions, rising from £400k to £550k between November and December 2022. It was noted that the cost of placements for children with complex needs is also increasing, discussions are being held within the system to seek a better way to provide their care.	
7.	**Strategic / Operational Planning & Financial Planning Update**	
	It was acknowledged the purpose of this session was to inform the committee on national planning guidance received late last year, detailing how to develop the operational plan. Slides and guidance shared with the members describe the agreed system approach and timeline. The group acknowledged the importance of the need to produce a sound set of plans for the system, alongside how they will be executed, especially as this will be the first occasion as an ICB and ICS. The key principles of the National Planning Guidance were highlighted to group, including key targets. It was noted this is seen as a system plan, triangulating plans across systems with partners. The group were asked to note the separate Finance appendices, included within the slide deck. CaL highlighted the key points, including risk management and specialist commissioning.	

	Draft submission of operational plan is to be submitted by 23rd February, with the final submission date being 30th March. Alongside this is the development of the Joint Forward Plan (JFP), of which a draft is due by 31st March and the final version by the end of June. Discussion held on the approach taken and potentially widening committee to include workforce and quality. **ACTION: CaL to detail Pharmacy, Dental and Ophthalmology new allocations at next meeting.**	**CaL**
8.	**Revenue Prioritisation Process: Next Steps**	
	Slides previously shared with the group were presented and process discussed. MG described and provided an example of the Scoring matrix to be used, exact details of proposed schemes not shared as process is still being worked through. ICS will use the scorings to decide which schemes will be funded, anticipated cost to be approximately £12million. **ACTION: JY to share detail of specific schemes to committee members, when available.**	**JY**
9.	**Capital Plan: Next Steps**	
	Slides previously shared with the group were presented. A notified resource of £34.5million main system allocation; £1.1 million primary care. Draft capital plan across areas and the overall system, with some assumptions and an approach, working towards a strategic approach. Discussions held regarding the maintenance backlog and prioritisation. **ACTION: CaL to provide an update on the next steps at the next meeting.**	**CaL**
10.	**Review of System Resources Committee Risks**	
	MG explained the reason for this agenda item, noting the Board have delegated responsibility to the System Resources Committee to have oversight of a number of identified strategic risks.	

	The importance of ensuring the methodology and approach is applied to each risk was noted. The group discussed risk appetite, risk tolerance and the reasoning for aligning specific risks to committees, to allow deeper dive. **ACTION: A further update on strategic risks, the awareness of these and what is required from the System Resources Committee is to be brought to the next meeting.** **Action: Risk matrix and summary of assigned risks to be sent to members.**	**MG / JY** **MG / JY**
11.	**Any Other Business and Forward Plan**	
	The System Resource committee forward plan details were shared with the group. JY noted work is underway to link up partner organisation 'resources committee' agendas. No further items were raised by the members.	

Future Meeting Dates

Please contact glicb.icbcorpgov@nhs.net if you have not received the diary invites for these.

All System Resources meetings will have the option of meeting face to face, at Sanger House or joining virtually, via Microsoft Teams.

Thursday 4th May 2023; 14:00 – 17:00
Thursday 6th July 2023; 14:00 – 17:00
Thursday 7th September 2023; 14:00 – 17:00
Thursday 2nd November 2023; 14:00 – 17:00

Thursday 11th January 2024; 14:00 – 17:00
Thursday 7th March 2024; 14:00 – 17:00