Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 26th July 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** *Apologies: Mark Walkingshaw, Dr Jo Bayley, Dr Olesya Atkinson*	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 31 May 2023** **Minutes of the meeting held on 28th June 2023**	Approval	**Chair**
4.	2.04 – 2.05pm	**Action Log & Matters Arising**	Discussion	**Chair**
		Business Items		
5.	2.05 – 2.10pm	**Questions from members of the public**	Discussion	**Chair**
6.	2.10 – 2.25pm	**Patient Story** – 'Let's Cook with Josie' (VCSE).	Discussion	**Josie Houghton** **Will Chapman**
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	**Christian Hamilton** **Tracey Cox** **Marion Andrews- Evans** **Cath Leech**
		Decision items		
10.	3.05 – 3.20pm	**Gloucestershire Health and Social Care Framework Agreement 2024 onwards**	Approval	**Benedict Leigh**
		Discussion items		
11.	3.20pm – 3.30pm	**ICB Governance Report**	Discussion	**Tracey Cox**
12.	3.30 – 3.55pm	**Overview of NHS Workforce plan and implications for the ICB**	Discussion	**Tracey Cox**
13	3.55 – 4.10pm	**Hewitt Report – implications for Gloucestershire ICB**	Discussion	**Mary Hutton**
		Information items		
14.1	4:10 – 4:20pm	**Chair's verbal report on the Audit Committee** meeting held on 27 June 2023; minutes of the Audit Committee held on 16 March 2023	Information	**Julie Soutter**

14.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 1 June 2023 and minutes of 17th April 2023**.**	Information	**Colin Greaves**
14.3		**Chair's verbal report on the Quality Workshop** held on 20th July 2023**.**		**Prof Jane Cummings**
14.4		**Verbal report on the People Committee** meeting held on 20th July 2023.		**Tracey Cox**
14.5		**Chair's verbal report on the Resources Committee** meeting held on 4th May and minutes of the meeting**.**		**Prof Jo Coast**
15.	4.20 – 4.25pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on 27th September 2023 at

Churchdown Community Centre

Parton Rd, Churchdown, Gloucestershire, GL3 2JH

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.

(for reasons of commercial in confidence discussions)

Gloucestershire Integrated Care Board Meeting, Part 1 in Public

Wednesday 31st May 2023, 14:00 – 16:35pm

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

Members Present:		
Dame Gill Morgan	**GM**	Chair, NHS Gloucestershire ICB
Mary Hutton	**MH**	Chief Executive, NHS Gloucestershire ICB
Ellen Rule	**ER**	Deputy CEO/Director of Strategy and Transformation, NHS Gloucestershire
Dr Andy Seymour	**AS**	Chief Medical Officer, NHS Gloucestershire ICB
Colin Greaves	**CG**	Non-Executive Director, NHS Gloucestershire ICB
Cath Leech	**CL**	Chief Finance Officer, NHS Gloucestershire ICB
Douglas Blair	**DB**	Chief Executive, Gloucestershire Health and Care NHS Foundation Trust
Deborah Lee	**DL**	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Emily White (*Deputising for Sarah Scott)*	**EW**	Director of Quality, Performance & Strategy, Gloucestershire County Council (GCC)
Prof Jane Cummings	**JC**	Non-Executive Director, NHS Gloucestershire ICB
Prof Jo Coast	**JCo**	Non-Executive Director, NHS Gloucestershire, ICB
Julie Soutter	**JSo**	Non-Executive Director, NHS Gloucestershire ICB
Dr Marion Andrews-Evans	**MAE**	Chief Nursing Officer, NHS Gloucestershire ICB
Siobhan Farmer	**SF**	Director of Public Health, Gloucestershire County Council
Tracey Cox	**TC**	Director of People, Culture and Engagement, NHS Gloucestershire ICB
Participants Present:		
Benedict Leigh	**BL**	Director of Integration, GCC and NHS Gloucestershire ICB
Councillor Carole Allaway-Martin	**CAM**	Cabinet Member, Gloucestershire County Council
Deborah Evans	**DE**	Chair, Gloucestershire Hospitals NHS Foundation Trust
Helen Ainsley	**HA**	Gloucestershire Hospitals NHS Foundation Trust
Helen Goodey	**HG**	Director of Primary Care & Place, NHS Gloucestershire ICB
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Mark Walkingshaw	**MW**	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Dr Olesya Atkinson	**OA**	GP, Primary Care Network Representative
Dr Paul Atkinson	**PA**	Chief Clinical Information Officer, NHS Gloucestershire ICB
Stephen Otter	**SO**	Trust Chair, SWAST
Ayesha Janjua	**AJ**	Associate Non-Executive Director, NHS Gloucestershire ICB
In attendance:		
Becky Parish	**BP**	Associate Director, Patient & Public Engagement
Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire ICB
Lucy White	**LW**	Healthwatch Gloucestershire Manager
Rachel Carter	**RC**	Governance Co-ordinator, NHS Gloucestershire ICB

The Chair spoke about the recent sad death of one of the Board's Non-Executive Directors, Clive Lewis. Clive was very well loved and respected and was an extremely humble and inspiring man. A minute's silence was held in respect for Clive who will be most sadly missed and fondly remembered by all his colleagues.

The Chair welcomed and introduced two new colleagues, Stephen Otter Trust Chair, SWAST and Douglas Blair, Chief Executive, Gloucestershire Health and Care NHS Foundation Trust to the Board members.

Announcements from the Chair

There was notification last week that Gloucestershire would have a joint inspection on Children's Services which will be conducted across a three week period with multi-agency involvement. A letter will be written after the end of the inspection rather than a full report. Ann James will be leading a vast amount of work in preparation for this inspection. The Chair recognised the responsibility and valuable work of all those concerned in providing good services for the young people in our county.

There will be a further Junior Doctor's strike in a fortnight and the Chair gave assurance that everything was being done to ensure that plans were coherent and were able to deal with any negative impacts the strike may have.

The Chair spoke about the forthcoming stepping down of Deborah Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust (GHFT). The Chair acknowledged how important Deborah's leadership had been and that she will be a big loss to her colleagues and to the system. The Chair commended Deborah Lee on her Leadership of the Trust. The recruitment process for the Chief Executive post was underway.

1. Apologies for Absence

1.1 Apologies were noted from Ryan Brunsdon, Christina Gradowski, Sarah Scott, Martin Holloway, Mark Cooke, Pete Bungard and Dr Jo Bayley.

1.2 The meeting was confirmed to be quorate.

1.3 There were seven members of the public present during the meeting, three in the meeting and four attending online.

2. Declarations of Interest

2.1 The Chair asked that all members declare any relevant interests at every ICB Board meeting. The Chair stated that this was in line with best practice to consider any potential conflict of interests at each meeting. 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 Declarations of declared during this meeting.

3. Minutes of the Previous Meeting

3.1 There were a few errors in the minutes of the previous meeting held on 29th March 2023, namely concerning the acronym POD which stood for *Pharmacy*, Optometry and Dentistry and not Podiatry. Also the stroke unit was going to move from Gloucester to Cheltenham rather than the reverse. These corrections have now been made. Subject to those amendments the minutes of the meeting held on 29th March 2023 were agreed to be a true and accurate record of the meeting and were therefore approved by the Board.

4. **Action Log & Matters Arising**

4.1 The Chair noted that none of the actions were significant, but she would like the log examined after the meeting just to close off some of the items.

4.2 The Chair referred to the practice of vaping, and the need for distinguishing the difference between vapes being an aid to ceasing tobacco intake and vapes being taken up by those who had never smoked before. SF will produce a Statement on this, which will come back to the Board.

5. **Questions from Members of the Public**

5.1 There had been no questions received formally from members of the public since the last meeting on 29th March 2023.

6. **Patient Story – Healthwatch**

6.1 Lucy White from Healthwatch spoke about a couple who had come into contact with many parts of the system and their story highlighted both positive and negative interactions for both Bob, the person in need of care at home, and Sandra who cared for him. Sandra wanted to share her story to help others who may meet such barriers.

6.2 Rapid Response services had been very helpful and the home that Bob stayed in had delivered quality care during his last few days. However, Sandra felt that health and care services could have been more joined up with better communication, information sharing and more collaborative working. Support to complete paperwork for allowances, funded care, blue badges etc could have been far simpler.

6.3 Sandra felt that one dedicated and consistent point of contact, appointed to helping people navigate the care system would have been better with a central, local information site to offer support, signpost to appropriate care providers, and advise on eligibility for funded care/allowance.

6.4 The Chair stated that Healthwatch had compiled a much longer report on communication, with the intention that they present it in future, to the whole Integrated Care Board (ICB) to examine how working more effectively would enable people going through our services, to feel genuinely supported. The story will also be presented to the Ageing Well Steering Group to try to resolve some of the aforementioned issues, inviting them back in order to follow up the story. It was also agreed that from a quality aspect, that there were issues that the ICB would be addressing.

RESOLUTION: ***The ICB Board noted the Patient Story from Healthwatch and asked that this be brought back in six months' time for follow up at the ICB Board meeting.***

7. **Board Assurance Framework (BAF)**

7.1 TC explained that BAF showed an assessment of the key strategic risks facing or impacting on the delivery of the ICBs strategic objectives. Descriptors of those risks from last year had been carried forward into this year with workforce, Urgent and Emergency Care (UEC) and the financial position still rated as high risk.

7.2 After examination by all Committees, some adjustments were made to the scoring in relation to workforce which was still one of the greatest challenges. There was also a reduced risk assessment score in relation to urgent and emergency care linked to the work around securing our delivery partner to help us with the transformation programme. The risk around Integrated Care System (ICS) transition had also been adjusted down.

7.3 The Chair commented that at the next ICB Board meeting a summary of the Governance Review undertaken by the Internal Auditors BDO will be presented.

7.4 JSo responded that the work that had been conducted on the Board Assurance Framework was coming along well and she, as Chair of the Audit Committee, valued the very helpful Executive Directors update. Any gaps in controls and assurance were regularly examined at the Audit Committee but overall, JSo was very pleased with progress.

7.5 **RESOLUTION:** ***The ICB Board noted the content of the Board Assurance Framework.***

8. <u>Chief Executive Officer Report</u>

8.1 MH informed the Board:

- The Dental Strategy Group was being supported by many providers and organisations who had given valuable time to this. Three areas of challenge were access, workforce and oral health.
- There were plans in place to increase urgent appointments across the county, developing a Primary Care Access Centre in Gloucester City and plans to increase the local offers for training. A model to increase access and deliver improved oral health was being offered to care homes. A large number of groups were interested and keen to receive updates on dental access around the county.
- The money given to Primary Care Networks for their Quality Improvement Initiative projects had made a huge difference to local communities, people were grateful for the help that they received.
- The West Cheltenham Health Equalities Project Group promotes health and wellbeing in the Cheltenham community. The group was looking to increase opportunities to build on the strengths that already exist and increase uptake of local health and wellbeing offers.
- Creative Health Programme – the ICB had now agreed with voluntary sector colleagues that they will collect the NHS numbers which will be added to the data warehouse, to examine the impact for individuals and giving the ICB confidence to work and invest in the necessary areas.
- NHS Gloucestershire ICB and the Gloucestershire Voluntary Care Sector (VCS) Alliance were planning to connect the work of the Clinical Programme Groups to the wide ranging work of VCS Organisations and to collaborate to better improve the health and wellbeing of the population.
- Operational Planning 2023/24 - this year the planning round was extended to the beginning of May with focus on three areas; activity performance, finance and workforce numerical submissions. There were financial and delivery risks and therefore updates on the Operational Plan will be provided through performance monitoring at this Board.
- The national team came to Bristol and met the ICB to talk about the Gloucestershire Plan. They were very interested in some of the innovative work around our strategic housing programmes, inequalities, prevention and the work on UEC. The Board noted that the national team had been pleased with and had commended the "partnership demonstration in action" evidenced at that meeting.

8.2 **RESOLUTION:** ***The ICB Board noted the contents of the Chief Executive Officer Report.***

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

9.1 This is still a work in progress and the Report will be reviewed and refined on behalf of the ICB by MW in the autumn 2023.

9.2 MW updated on the Performance reporting, up to the end of March 2023.

- Inroads had been made into elective and emergency care services.

- Mental health and community services have also seen improvements.
- Frontline staff had delivered improved performance during very difficult times.
- The system was rated as Amber for the majority of the performance standards.
- Additional capacity had delivered inroads in diagnostic waits.
- The 78 week waits had been eliminated at the end of March 2023.
- Backlogs in cancer services were being cleared and GHFT was meeting the 2023/24 targets.
- Improved performance was being seen in services for those with serious mental health problems.
- Primary Care in Gloucestershire continued to perform well against all the national metrics, despite increased demand. The challenges of this continued demand together with the level of funding in 23/24 is causing real pressure across the County.

9.3 TC updated on the Workforce element of the Report:

- Despite challenges around recruitment and retention, some benefits were being realised.
- The intended deep dive had now been carried out on recent Staff Survey results.
- The National Workforce Plan and confirmation of transformation monies were awaited from the national team to help with upskilling and testing new ways of working.
- Good progress was being made in apprenticeships and increased utilisation of our levy transfer spend, together with some of the initiatives to support wider participation of health and social care, which will support strong alignment with the Integrated Care Partnership (ICP) Strategy.
- Workforce Priorities will be the focus for the Board Development session next week.

9.4 MAE updated on Quality and was pleased to report that:

- The System Mortality Group had met and the GHFT mortality rate had reduced and was now within standard limits.
- GHFT was fortunately no longer having to board patients in corridors.
- Gloucestershire was a pilot site for Black Maternity Matters and were part of the Academic Health Science Network Programme, which had been keenly embraced by midwives.
- There were plans to develop a Quality Assurance Management Plan for Adult Social Care thus widening the Quality remit and assisting this Board with quality.
- Interim guidance had been received from the Care Quality Commission (CQC) around ICS inspections and the lead inspector will visit to give an information briefing for the Board.
- A National Audit of End of Life Care revealed that GHC was a high performer and the trust was commended for their good quality care for end of life patients. More patients were also able to die in their place of choice, countywide.
- DL explained that at GHFT's most recent Board meeting, the last audit showed that 70% of patients wishing to die at home had not been able to be discharged quickly enough for that to happen. DL stated that pathways at the front door needed to change in order to avoid admitting these patients in the first instance. MAE was looking at the whole system figures and agreed that these patients did need swifter discharge.
- The three-year action plan for Maternity was being worked on, enabling easier future implementation and monitoring of the service.
- A recent system-wide workshop was held around the new Patient Safety Incident Reporting Framework (PSIRF). A further workshop will examine implementation processes throughout the county.
- In GHFT the satisfaction with the emergency department services has now gone up to 80% - a pleasing result. Satisfaction of our mental health patients has gone up to 87% and community services are the top at 93%.
- DL updated the Board that since the last meeting the CQC had revisited GHFT and had reinspected both the maternity service and the surgical service regarding Section 29A

notices issued last year. A formal report was still awaited but verbal feedback and a letter was positive. This will not result in a re-rating of the services but will pave the way for the ratings to be adjusted upwards when the full inspection takes place.

9.5 CL provided an update on finance to the Board:

- Each organisation had made a very small surplus in 2022/23 despite managing a number of pressures, being workforce, medicines and Urgent Care. The recurrent impact of both cost pressures, underspends and non-delivery of savings had been brought into the 2023/24 financial plan for the system and within the organisational financial plans.
- There was an agreed overspend against the system's Capital Departmental Expenditure Limit (CDEL) with the Regional Team and others offsetting underspends. This meant that capital had been fully maximised as a system throughout the year.
- Capital had been underspent against the national budget held for leases. Better Payment Policies had been achieved, meaning that our suppliers were paid on time. Balanced plans had been set as a system, for the new year. There will be some challenges to achieve delivery, so the focus will be on productivity and transformation.
- Emerging pressures have resulted in savings starting to slip such as strikes, which bring their own costs, and other programmes of work have also slipped. There has been an announcement about the pay award which was being implemented. There were ongoing questions about the funding of that payment and there was likely to be a reasonable shortfall which was being examined.
- Conversations continue with the regional/national team about the mobile Computerised Tomography (CT) Unit which was part of the Community Diagnostic Centres (CDC) Programme where approval has not yet been received. This will be a key part of transformation delivery.

9.6 The Chair noted that due to the delay of setting up the ICB from March to June 2023, there had been two sets of accounts to close down simultaneously. The Chair thanked CL and her Finance team for the huge amount of work undertaken to achieve this result.

9.7 DB informed the Board that there had been some legal attention around Wotton Lawn Hospital last week with which he was disappointed, and he expressed apologies to anyone who had received a poor experience there. The incidences took place from 2016 to 2023 and had either been fully investigated or were in the process of being investigated. All changes and associated learning had been made throughout that period. Any allegations involving staff were always taken seriously and investigated. The Hospital was also participating in a Rapid Quality Review this week.

9.8 SO spoke about ambulance handover delays having improved across the South West but in some places they were still problematic. The uplift in resources was starting to show results and enabling demand to be met in those areas where it was required.

9.9 SO had visited the Staverton crew and spoke about their positivity overall; but did think that for some areas in the South West it would probably be a long time before the service reached the level that it had been previously. The Chair recognised that demographics and boundaries definitely had an impact in transforming care and suggested that Ellen Rule could visit and talk about those issues if it would prove helpful. SO was also keen to undertake some work on alternative pathways and looking to team up with the Academic Healthcare Science Networks and stated that partnerships with other areas would also be very welcome.

9.10 EW considered that the themes discussed such as communication, had been mirrored in the self-assessment work currently being conducted by the Local Authority in preparation for their Quality Assurance Framework, bringing weight to some of the issues that could be responded to.

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

10. Scheme Investments

10.1 As part of the operational and financial planning approach, work had been undertaken to coordinate the process for scheme investments for 2023/24. For schemes that either do not have access to national funding or require additional investment a priorities process had been completed. The aim was to agree how to allocate the Demand and Capacity Fund as the primary funding source for the remaining schemes.

10.2 ER reflected that there had been some really positive system discussions about the allocation of this investment with colleagues coming together to work through the detail on the schemes. It was proposed that the System Resources Committee of the Board would have the ability to track the impact of the schemes. There had been increased focus on the importance of benefits realisation detailing the proposed benefits. Delivery benefits needed to be monitored bearing in mind the current financial position, where a number of these schemes were allocated funding on a non-recurrent basis. Robust evidence of delivery will need to be provided should the schemes wish to move to a recurrent basis for funding in future years.

10.3 CG stated that he would like some assurance around careful monitoring to obtain the benefits realisation and it would be good if the Board could see some progress during this financial year. Delivery had to be seen to be working.

10.4 ER responded that over this year's winter, over 90% of what had been intended had been implemented whereas in the past this figure had been lower. This was due to having signed up to fewer schemes and having a more collaborative process . ER confirmed that she would be happy to report back to the Board on progress.

10.5 CL explained that assumptions had been made about the funding being recurrent and the ICB would not be over-committing against recurrent funding and that would be part of the evaluation in terms of benefits.

10.6 JSo asked whether a scheme would be able to be stopped where benefits were not going to be realised but where there were permanent staff recruited to that scheme, and whether they would be moved to other projects/programmes if that particular scheme were ceased.

10.7 ER explained that assessment of the risks on a scheme-by-scheme basis would be recorded in a framework which was being developed. A number of people were working together on this – DB had contributed as well as Finance Directors to this process. The new schemes would be non-recurrent but recruitment would be permanent to facilitate recruitment, and where the skills would be of value to Gloucestershire they would be retained and staff redeployed in a slightly different way. The People Committee would be involved on a case-by-case basis of the risk against the context of the overall vacancies. TC stated that it would be important to choose the right areas in which to take this approach. This will help progress some of the innovations being planned, so that the system could deliver, make progress and see the benefits.

10.8 **RESOLUTION:** ***The ICB Board noted the update in the Scheme Investment paper.***

11 **Neurodiversity Future Plans**

11.1 MH reported that this decision had been brought to the Board today because the scheme was over £1,000,000 pounds of investment and that decision was reserved to the Board. Work had continued over a number of years on the neurodiversity pathway and some changes had been put in in place. But there were a number of factors which were highlighted in the paper that had accelerated the need for the Board to examine the neurodiversity pathway more urgently.

11.2 Neurodiversity was an umbrella term which encompassed Attention Deficit Hyperactivity Disorder (ADHD), Autism and other conditions relating to how the brain functions.

- Gloucestershire had experienced a significant increase in the number of referrals for ADHD and Autism assessment services, and the number continues to grow.
- There had been an increase of 200% in referrals in four years and also issues around staffing shortfalls and specialist staffing, and insufficient information on referrals resulting in delays in helping individuals and their families.
- The plans included work to bring about two neurodiversity assessment pathways – under 18 and over 18. This work included front-door support through better signposting and work with partners to improve the effectiveness of the pathway. This would be built into the service redesign being taken forward.
- The Board was asked to consider the issues raised in the paper and whether these would be supported in the forward plan for the neurodiversity pathway.
- The Board was also asked to give delegated authority to the Chair, Chief Executive Officer and the Chief Finance Officer of NHS Gloucestershire ICB to enable decisions to be made swiftly once the review of the impact modelling had been completed.
- DL stated that the system would need the team working on this to think creatively and offer incentives to encourage people to want to come and work in the Gloucestershire system. The Chair commented that the Executive would address this and that conversations with Gloucestershire University could take place to make this an exemplary service which benefits local people.

11.3 **RESOLUTION:**
The ICB Board agreed:
- ***That the current neurodiversity pathways needed clarification and simplification.***
- ***That the plan for two pathways with proper investment will allow improvement and sustain the quality of services for individuals.***
- ***Delegated financial approval for the investment schemes to be authorised by the Chair, Chief Executive Officer and Chief Finance Officer of NHS Gloucestershire ICB once the review of impact modelling had been completed.***

12. Digital Strategy

12.1 PA explained that engagement for the Strategy started in February 2022 and now had the agreement of all the partners in the ICS and was taken to each of their Executive Meetings before being brought to the Board today. There were five themes to the Strategy, Infrastructure and Data, Security, Population Health Management Care Insights and Planning, and Innovation and Growth.

12.2 The ICS Digital Strategy outlined key digital priorities from 2022 to 2025, with benefits for citizens and staff. It was a strategy that had been developed by system partners. PA read out the vision which was 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."

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

12.4 This digital Strategy provided simplicity for every citizen when connecting to health and care services across the county. The strategy was underpinned by data and digital transformation plan delivering platforms that were secure and trusted by our people and care professionals.

The Strategy supported the system's Net Zero ambitions across the county as well as providing a digital environment that encouraged research and lifelong learning.

12.5 This Strategy defined a level of ambition for the system which was pragmatic and achievable. There was some funding expected but not yet confirmed for 2023/23 but for 2024/25 there were a number of unfunded schemes. The availability of plans would enable the Digital team to take advantage of any opportunities that may arise for digital funding.

12.6 A detailed Patient and Public Involvement plan will be developed as part of the delivery plan for the Strategy.

12.7 MH stated that there was a significant amount of work to agree the 2024/25 plan and to some extent that would help to shape the road ahead for 2024/25; as some of these schemes had considerable revenue attached to them. Thought needed to be given as to how many schemes should be prioritised in 2024/25. It was envisaged that this work would be shared with the Board in November/December.

12.8 DE commented that it was good to see the Appendix on sustainability. Her understanding was that iCloud storage was very energy intensive and she would appreciate seeing in the Appendix how this issue would be addressed and how the system would be planning for this.

12.9 DL informed the Board that the bid for development of the Patient Portal had been approved so £75,000 would be coming into the system enabling patients to access their letters, view appointments online etc., and GHFT would be able to expedite that project as a result of that funding. There would also be savings on paper and postage.

12.10 DL stated that any investment in digital from GHFT was competing for investments with estates, so there was a provisional sum included. But there would have to be some difficult decisions for GHFT to make as to whether they could commit to levels of digital investment given current constraints.

12.11 The Chair asked whether people could engage with Healthwatch so that any work carried out by them already could be fed into the system, thus avoiding duplication. LW was asked to take this back to ensure that a name was given by Healthwatch enabling a future conversation on communication to take place between Healthwatch and GHFT.

12.12 The Chair was keen to make the working life of staff much easier via technology and recognised that if the baseline was right, then this would help.

12.13 The Chair did not want to lose sight of training and development and this could be something that the People Committee could be involved with, but also tying in with the conversation about Autism and whether there might be an opportunity to make jobs more attractive using digital technologies.

12.14 The Chair requested that PA write a small piece on AI and Healthcare in order that this could be encompassed with this work and thought that some time could be spent reflecting on this so that when the refresh and iteration comes up, this could also be incorporated. **Action: PA**

12.15 RESOLUTION: ***The ICB Board approved the Digital Strategy subject to it taking into account the reality of the Strategy balanced with other schemes and ensuring that the Digital Strategy was tied in with other strategies such as Sustainability. The Board recognised that the Patient Portal project could now gain momentum for patients with the engagement of Healthwatch.***

13. Changes to Committee Terms of Reference

13.1 System Quality Committee

JCu explained the changes that had been made. Social Care had been included following discussions with Gloucestershire County Council representatives. Section 9 now included Health and Social Care. Section 10 confirmed that updates will be received from the Primary Care and Direct Commissioning Committee regarding the quality and safety of Primary Care services that were commissioned by the ICB and that innovations in practice will also be examined by the Quality Committee.

13.2 Primary Care and Direct Commissioning Committee

The changes made to the ToRs were being driven primarily by the Delegation of pharmaceutical, optometry and dental from 1st April 2023. It also needed to be clear where the assurance level for the quality of primary care sat. Membership had changed where there was now an Associate Non-Executive Director which was a non-voting post. These were the major changes other than the fact that CG had reflected on the fact that the PC&DC meetings held in public had never resulted in any views to be raised at the ICB Board. The committee minutes had always been shared with the ICB Board in line with all other ICB board sub-committees.

13.3 The Chair made reference to the issue as to whether the Primary Care and Direct Commissioning Committee (PC&DC) meetings should be held in public and if a decision were to be made not to hold them in public, whether something should be done with the ICB Board to ensure that there was an opportunity to raise concerns directly with the Board in a formal way through our Standing Orders, rather than through the PC&DC.

13.4 HG assured the Board that the Primary Care team worked as closely as possible with the public, parish councils and other stakeholders to ensure that those most impacted with any changes were heard. This would continue as pharmacy, optometry and dental (POD) services continued to be developed going forward. HG stated that it was important that when items come to the PC&DC and the ICB Board it was shown that Primary Care had engaged and understood the views and opinions of the local population as best they could.

13.5 JCu had been involved with the PC&DC Committee since she had joined the ICB and the meetings had never involved members of the public, it was a committee meeting held in public. She stated she would like to have more time with other committee members to think this through. JSo felt it would be helpful to have a wider discussion about meetings in public and like JCu would rather think about it, not being able to make a decision immediately. It did merit wider discussion.

13.6 The Chair considered that discussions around POD could be commercially sensitive and this would fundamentally change the responsibility we had as a statutory organisation. The Board would also need to be cognisant around some of the general practice items because GPs were not employed by the NHS; they were independent contractors.

13.7 The Chair advised that further discussion was needed and that this should be brought back to a future Board meeting having had further reflection and thinking about pragmatic ways through.

13.8 CG stated that attendance by the public at PC&DC could be accommodated in Part 1 of the meeting – Part 2 was confidential and the Committee would think about this and come back to the Chair in due course.

13.9 SF stated that it was worth noting that there were a couple of County Council responsibilities that related to this Committee. It was the Health and Wellbeing Board's responsibility to produce the Pharmaceutical Needs Assessment. The impact of the assessment would have a significant bearing on what was commissioned through pharmacy in the local community. The Council also had a responsibility in health promotion albeit the budget had historically sat with

NHSE and SF was satisfied that HG and she were working very closely on that, but it may be worth a discussion about how this would be linked into the Terms of Reference to ensure transparency around Governance that pertains to the system.

13.10 **RESOLUTION:** ***The ICB Board agreed and approved the changes to the Terms of Reference for the System Quality Committee.***

RESOLUTION*: The ICB Board agreed and approved:*

- ***That the Primary Care and Direct Commissioning Terms of Reference should be changed to reflect that the Committee was taking on the new delegated responsibility for Pharmaceutical, Optometry and Dental (POD) services as from 1st April 2023.***
- ***That the Terms of Reference should reflect the position on Quality.***
- ***That the Associate Non-Executive Director position be added into the Terms of Reference.***

14. **Joint Forward Plan**

14.1 ER updated on the Joint Forward Plan. ER informed the Board that the extraordinary Board would be taking place on 28th June (**not** 30th June as stated on the slide circulated) where delegated approval will be sought for the Annual Accounts and Report. Any final changes may be needed following the GHFT extraordinary Board discussion which would take place on 30th June 2023. Should anyone like a near final draft ahead of the extraordinary meeting then let ER know who would be happy to send it. The Chair stated that the GICB Annual Report and Accounts formed a significant part of the assurance process around how Gloucestershire was performing as an ICB.

RESOLUTION: ***The ICB Board noted the verbal updates provided regarding the Joint Forward Plan.***

15.1 **Chair's report on the Primary Care & Direct Commissioning Committee**

15.1.1 The Committee met on 17th April 2023 and approved the business case for a new surgery on the new site in Tetbury. This will come online in 2025 subject to planning approval by Cotswold District Council. There would be a practice merger between the Acorn Surgery and the Walnut Tree Surgery which was also approved.

The Chair stated that it was good to have both verbal and written reports from the Committee so that these were noted by all.

15.2 **Chair's report on the Audit Committee**

15.2.1 JSo informed the Board that the Audit Committee met on 9th May 2023 and this meeting covered the year end accounts and processes. JSo reiterated thanks to the Finance team for their work as well as to others involved in preparing the draft Annual Report. The draft Accounts were considered, reviewed and noted and will be coming to the Board on 28th June 2023 for final approval.

15.2.2 The Going Concern principle was also reviewed along with the Indicative Head of Internal Opinion from BDO. Progress was noted and this will be finalised along with the external auditor's report for 28th June 2023. Substantial assurance was given on the controls that the ICB operate and also the risk management and governance processes. Reflected also in that Opinion were audits carried out on specific areas and this was also expected to be confirmed on 28th June 2023.

15.2.3 Feedback was given on the draft Annual Report with a number of sections requiring updates pending finalisation of figures applicable to the end of March 2023.

15.3 Chair's report to the System Quality Committee

15.3.1 JCu informed the Board, that the Committee met on 12th April 2023 and the Primary Care Quality Report was reviewed which had also been reported to PC&DC. There was a verbal update on Social Care quality from Emily White. There were assurance updates from providers which included Maternity and End of Life care which were very positive.

15.3.2 There was reflection on the role of the Committee overall and a workshop would take place the following week to consider how the SQC could address the biggest quality issues that affect the system and the population we care for, whilst recognising the individual roles of the constituent organisations and their accountabilities for quality. An update on the workshop will be brought to the next Board meeting.

15.4 Chair's report on the People Committee

15.4.1 TC informed the Board that the previous minutes were awaiting final approval from the meeting held on 27th April 2023. The meeting examined progress on the People Strategy and looked at analysis and actions associated with the recent Staff Survey results which was a useful exercise in comparing and contrasting across the three organisations and to understand various challenges.

15.4.2 A number of ICB policies were approved that were due for renewal including the Menopause and Learning Development policy. The intention with the Menopause policy is to align this with system partners.

15.5 Chair's report on the Resources Committee

15.5.1 JCo informed the Board that the Resources Committee met on the 4th of May and apart from business as usual, the Committee discussed the Health Economics Development session organised for the end of June. In particular what should be covered such as effectively funding prevention for the future whilst addressing the challenges today. The Committee also discussed their approach to evaluation and how this could be strengthened as a system and decided to set up a task and finish group in this area to inform the work on evaluation.

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

16. Any Other Business

16.1 There were no further items of any other business.

The meeting closed at 16.35pm.

Extraordinary meeting to be held 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.

(for reasons of commercial in confidence discussions)

Gloucestershire Integrated Care Board Extraordinary Meeting

To be held 2.00pm to 2.30pm on Wednesday 28th June 2023

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

Members Present:		
Dame Gill Morgan	**GM**	ICB Board Chair
Dr Andy Seymour	**AS**	Chief Medical Officer, NHS Gloucestershire ICB
Colin Greaves	**CG**	Non-Executive Director, NHS Gloucestershire ICB
Cath Leech	**CL**	Chief Finance Officer, NHS Gloucestershire ICB
Douglas Blair	**DB**	Chief Executive, Gloucestershire Health and Care NHS Foundation Trust ICB
Ellen Rule	**ER**	Deputy CEO/Director of Strategy and Transformation, NHS Gloucestershire ICB
Dr Jo Bayley	**JB**	Chief Executive, GDOC
Prof Jane Cummings	**JC**	Non-Executive Director, NHS Gloucestershire ICB
Prof Jo Coast	**JCo**	Non-Executive Director, NHS Gloucestershire ICB
Julie Soutter	**JS**	Non-Executive Director, NHS Gloucestershire ICB
Marion Andrews-Evans	**MAE**	Chief Nursing Officer, NHS Gloucestershire ICB
Siobhan Farmer	**SF**	Director of Public Health, Gloucestershire County Council (GCC)
Prof Sarah Scott	**SS**	Director of Adult Social Care, Wellbeing and Communities, Gloucestershire County Council (GCC)
Tracey Cox	**TC**	Director of People, Culture and Engagement, NHS Gloucestershire ICB
Participants Present:		
Benedict Leigh	**BL**	Director of Integration, NHS Gloucestershire GCC and NHS Gloucestershire ICB
Christina Gradowski	**CGr**	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Mark Walkingshaw	**MW**	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Dr Olesya Atkinson	**OA**	GP, Primary Care Network Representative
Dr Paul Atkinson	**PA**	Chief Clinical Information Officer, NHS Gloucestershire ICB
Ryan Brunsdon	**RB**	Board Secretary, NHS Gloucestershire ICB
In attendance:		
Anthony Dallimore	**AD**	Associate Director, Communications, NHS Gloucestershire ICB
Dan Corfield	**DCo**	Associate Director, ICS Programmes, NHS Gloucestershire ICB
Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 Apologies were received from Mary Hutton (MH), Deborah Lee (DL), Amy Beet (AB), Carole Allaway-Martin (CAM), Deborah Evans (DE) and Pete Bungard (PB).

2. 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)

There were no interests declared at this meeting.

2.1 The meeting was declared to be quorate.

3. Final Accounts 2022-23

3.1.1 The Chair explained that the decision to delay the onset of the ICB to 1st July 2023, had resulted in two sets of annual accounts and two reports (one to close down the CCG, which existed until the end of June 2022, and the other report for the first nine months of the ICB).

3.1.2 The Chair stated that the members would see in the papers it was clear where decisions were taken pertaining to the three months of the CCG (1 April to 30 June 2022) and as a formal ICB (1 July 2022 to 31 March 2023). As Mary Hutton was on leave, Ellen Rule was the acting Chief Executive for this Board meeting. CL would take the meeting through the first part of the Agenda.

3.2 Report on Audited Accounts 2022-2023 (Months 1-3)

3.2.1 CL stated that there were some small changes still being made to the accounts; she confirmed that with regard to statutory duties for that period the CCG declared a break-even position. The CCG remained within its running costs, there was no capital resource limit and no capital spend. The cash drawings were within the remit specified by NHSE.

3.2.2 The audit of the M1-3 2022-23 accounts for the CCG was substantially complete. Nothing material had been found and the auditors had stated that that they expected to issue an unqualified opinion. The CCG accounts for the period showed a breakeven financial position.

3.2.3 CL reported that the accounts together with the Letter of Representation which outlined the ICB's managerial responsibilities, must be signed off by the Board.

3.2.4 JSo confirmed that the Audit Committee on 27th June 2023 reviewed the accounts and Letter of Representation, along with associated documentation, including the Annual Report and were happy to recommend the documents to the Board for approval.

3.2.5 **Resolution: The Board approved the audited accounts for the CCG, Months 1-3, for 2022-2023.**

4 Report on Audited Accounts 2022-2023 (Months 4-12)

3.7 These accounts were for the 9 months of the ICB operated during 22-23. The audit was substantially complete with finalisation over the wording needed, and the auditors were expected to issue an unqualified opinion. The auditors reported positively on the annual accounts and had not found any significant weaknesses. There were some improvement recommendations. One was around financial governance where a medium term financial plan needed to be developed (and was currently in progress) this followed on from the Joint Forward Plan. The ICB also needed to continue to develop the system efficiency schedule. A Data Quality policy must be drawn up and some escalations and tidying up around quality needed to be made. There were no findings concerning regularity.

3.8 The accounts demonstrate that statutory duties were achieved for the period in question as well as the cash resource limit and achieved expectations. One change was made and a briefing was made to the Non-Executive Directors on this.

3.9 During the audit, the accounting treatment of a number of s.256 agreements was challenged by the external auditors and as a result these were adjusted in 2022/23 and will fall as expenditure in 2023/24; the net change was therefore c£6.9m.

3.10 The 2022/23 annual resource limit was allocated by NHS England and a proportion received by the ICB to cover months 1-3 of 2022/23 equivalent to expenditure, the remainder of the resource limit for 2022/23 was received by the ICB and the financial performance for 2022/23 will be assessed by NHS England (NHSE) by looking at the full year period.

3.11 The Board was asked to give approval for the accounts and also for the Letter of Representation for which it was the ICB's responsibility to sign this.

3.12 JSo informed the Board that all the papers were reviewed in detail by the Audit Committee on 27th June 2023 and it was recommended that the accounts and Letter of Representation were signed off. The Audit Committee would follow up any improvement recommendations made by the external auditors, which was standard practice, and there would also be a review of the year end processes to help improve planning for next year, again this was usual due process at the year end.

Resolution: The Board unanimously approved :

- **The audited accounts for the ICB (Months 4-12) for 2022/2023**
- **The Letter of Representation to auditors.**

4. NHS Gloucestershire ICB Annual Report 2022-2023

4.1 The Chair stated that the Annual Report was different this year and was important for two reasons; the first being that it was the final sign-off for the CCG and that the report did identify much of the positive work the CCG had undertaken; so it was right and proper that due respect was shown and that this Annual Report was signed off by the Board.

4.2 The second Annual Report showed the ICB Annual Report for nine months. The importance here was that one of the assessment processes that NHS England was now using to work out how the ICB had performed during 2022/2023 was to use the Annual Report to answer many of their questions, especially around performance management.

4.3 The Chair introduced Anthony Dallimore from the Communications team and stated that a lot of the materials that were examined and celebrated came from Anthony and his team, saying that in her opinion, the ICB enjoyed the benefit of some exceptional communication skills, bringing good relationships between the teams in the partner organisations. This allowed real coherence around communications. Anthony would be talking in future to a group of ICBs about communicating in a joined-up way.

4.4 ER commented that the two Annual Reports covered a significant amount of excellent work that had been delivered across the Gloucestershire system by each of the partner

organisations. It had been difficult to narrow down which case studies to include in the Reports as it was recognised that people had taken a great deal of time and effort writing them.

4.5 ER recognised the fantastic range of exciting and innovative projects represented in the Annual Reports as well as all the corporate and statutory parts that needed to be included. This had been no mean feat to bring all this information together and to present all the work in the excellent way that it had been.

4.6 The Report was aligned under the three strategic priority pillars of the Integrated Care System:

1. Making Gloucestershire a better place for the future
2. Transforming what we do
3. Improving health and care services today

ER thought the Reports reflected the challenges, opportunities and risks facing the ICB, the wider health and care community (ICS) and progress made to address these, along with ambitions for the future.

4.7 ER stated that the final draft was being worked on and should colleagues spot anything then it would be helpful to inform her or AD so that these things could be corrected. The request to the Board today was for the approval of the two Annual Reports.

4.8 JSo informed the Board that the Annual Reports had been reviewed at the Audit Committee meeting on 27th June 2023, recognising the enormous amount of work that had contributed to their production. The Audit Committee did not have any further comments and wished to recommend the Annual Reports to the Board.

4.9 The Chair recognised the high quality work that had gone into the Reports. AD stated although the Reports were lengthy, it was important this year to have an Annual Review Summary to celebrate the work happening with all staff across the ICS. The Review would be sent to Healthwatch who will review the structure and content to help with next year's Report. AD acknowledged the input from the Governance team who had assisted with the statutory content in the Report, the Finance team and all the Directors who had helped to bring the Reports together.

4.10 Resolution: The Board approved the two NHS Gloucestershire ICB Annual Reports for 2022-2023

5. Joint Forward Plan 2023-2028

5.1 The Chair requested that the Board delegate authority to the Chair and Ellen Rule, Acting CEO to sign off the Joint Forward Plan as the process was nearing its end and a number of Boards were still to look at this, with an Extraordinary Meeting being held on 30th June 2023 to allow this. The Joint Forward Plan had been presented both in the Board held in public and in Development Sessions. The Chair stated that the most important thing was to invest in the long term strategic plan which was the Integrated Care Plan. Significant time had been spent consulting as widely as possible which had been led through SF and her team and the ICB.

5.2 The deadline had been externally imposed. There was a need to complete the final parts of the Joint Forward Plan. The Chair thought that the Joint Forward Plan well represented the dovetailing of the local imperative with the national expectation.

5.3 The Chair mentioned that Dan Corfield had worked extremely hard to ensure that this had been socialised in as many places as possible, because this work was all about delivery of the ICP strategy of which the ICB was a part but was not the only important element.

5.4 ER explained that the Joint Forward Plan (JFP) was the NHS five-year delivery plan in response to the One Gloucestershire ICS and its three pillars. The JFP was aligned with the system annual Operational Plan and described how the ICS would meet its 17 legislative requirements of ICBs. It was a document which aimed not to replicate the detail contained in other plans, but rather to summarise and signpost. The intention had been to make the JFP as publicly accessible and as consumable as possible. The document had been through detailed review and feedback from the Healthwatch Gloucestershire Reading Group, with the plan being to produce an Easy Read version.

5.5 ER informed the Board that the JFP had been produced in close collaboration with delivery programmes across the system, working collaboratively to bring a detailed programme plan alongside the narrative content and milestones together for the JFP's detailed programme of delivery. Altogether, 40 different groups and forums had been identified with whom the JFT had been developed. It had been as engaging and inclusive an exercise as possible within the tight timeframe.

5.6 DCo commented that the document had been kept concise and had involved a huge effort from many people across the entire system and in future, it was intended to increasingly blend this in with the Operational Planning process and the Joint Forward Planning process refresh. It also dovetailed in nicely with the Annual Report as the refresh on the year gone would set the scene for the following year. It would be good to include operational delivery as well as transformation. Great support had been secured from the Health and Wellbeing Board.

5.7 The Chair recognised that the Board needed to be assured that in the constraints of what was required of the ICB, that things could be dovetailed, and the amount of work reduced in an effort to make documentation clearer in future. The Chair asked if anybody noticed anything that needed to be changed, typos etc., then they were asked to inform Dan Corfield directly. The Chair requested the Board, (provided there were no substantive changes) gave delegated authority to agree the Joint Forward Plan with Ellen Rule on behalf of the ICB. The Chair gave assurance that any changes would be communicated with the Board.

Resolution: The Board gave delegated authority to the Chair and Ellen Rule on behalf of the ICB to agree the Joint Forward Plan 2023 – 2028.

6. **Any Other Business**

6.1 There were no items of Any Other Business at the meeting.

ICB Board meeting to be held on 26th July 2023 2.00 to 4.30pm

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log

July 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.	**July-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 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**	**Tracey Cox**	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. **July 23:** This item is on the agenda and due to be presented to Board. **Action to be closed**.	**Requesting Closure**
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**	**July 23**: Conversations remain ongoing around the development of the strategic BAF at both Audit & System Resources committees. Item to be brought back to Board once fully developed. **Action to be closed.**	**Requesting Closure**

29/03/2023	**Min 12.1 Health Inequalities**	**Siobhan 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**	**July 23:** Significant work on engagement is underway across health and care and a report will be provided to the Board in the Autumn. Proposed to close this action. **Action to be closed**.	**Requesting Closure**
31/05/2023	**Min 12.11 Digital Strategy**	**Lucy White**	LB was asked to take this back to ensure that a name is given from Healthwatch enabling a future conversation on communication to take place between them and GHFT.	**July-23**	**July 23:** There is now a resourced plan on digital inclusion and this includes engagement with Healthwatch . **Action to be closed**.	**Requesting Closure**
31/05/2023	**Min 12.11 Digital Strategy**	**Paul Atkinson**	The Chair requested that PA write a small piece on AI and Healthcare in order that this could be encompassed with this work and thought that some time could be spent reflecting on this so that when the refresh and iteration comes up, this was also incorporated.	**July-23**	**July 23:** This item on AI & Healthcare has been added to the ICB Board Development session forward plan. **Action to be closed**.	**Requesting Closure**

Person story – 'Let's cook with Josie'

Briefing Paper

July 2023

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Background:

Gloucestershire Funders (GF) is a collaboration of organisations and foundations that came together in response to the Covid-19 pandemic. The aim of GF is to provide funding for charities, groups and activities in Gloucestershire. The aim of the process was to simplify the application process for funding and speed up the distribution of funds. The ICB has been a member of the Gloucestershire Funders group since April 2021 which comprises of the following other funders:

- Barnwood Trust
- Active Gloucestershire
- Gloucestershire Community Foundation
- National Benevolent Charity
- National Lottery
- Julia & Hans Rausing Trust
- Create Gloucestershire

Barnwood Trust acts as the central point of contact for GF and run the administration of the process for applications.

Aim of our involvement:

- Partnership: be a key funding partner around the table
- Relationships: To develop relationships with the VCSE sector, a key partner in much of the work of the ICS, leading to more collaborative working
- Resource allocation: test a different outlet and governance for non-recurrent resource allocation
- Strategic: develop understanding about funding in a different way – contributing to our work on VCSE Partnership Strategy and social value
- Funding reach: to get funding swiftly to grassroots organisations who can quickly deploy funding to make a difference on the ground
- Funding reach: To fund organisations not normally funded or known to ICB but who are delivering services or support making a real difference to Gloucestershire residents

ICB funding:

Our focus for the distribution of funds has been on supporting organisations having a positive impact on health inequalities and our ICS priorities. In numerous circumstances our funding (and funding we have collaborated with other members of the GF group to deliver) has been the difference between the receiving VCSE organisations being able to continue delivering their critical support functions to our population or no longer being able to function. The Healthy Communities & Individuals (HC&I) Team liaise with ILP leads and commissioning managers when reviewing applications to ensure a more joined up approach to funding VCSE organisations in a particular area.

Allocation of the funds in response to applications to the GF panel is overseen by the ICB HC&I Team. Applications are scored against a set of criteria across 4 domains:

- Health inequalities
- VCSE sector support
- ICS priorities
- Encouraging collaboration

Impact – System

Being part of GF brings a host of benefits to the ICB:

- Development of the ICB position within the VCSE, enabling us to become a 'trusted entity' connecting us to more organisations and bringing positive reputational benefits which lead to opportunities for partnership working and collaboration
- Development of understanding of the VCSE sector and organisations working within it. Leading to greater connection, ability to deliver positive impact and potential for collaboration
- Development of relationships with other member organisations of GF. Enabling collaborative funding and intelligence sharing
- Reputational benefits for the ICB and our position as a member of the Gloucestershire 'ecosystem' supporting on the ground delivery at a hyper-local level
- Ability to respond swiftly to current circumstances and get funding where it is needed 'on the ground' in a responsive, quick way. For example, able to shift our funding priorities in response to the emerging cost of living crises and support VCSE organisations to respond and support people on the ground
- Ability to contribute to the sustainability of the local VCSE sector and disseminate funding that supports core infrastructure for organisations across the patch in an efficient way
- Development of strategic thinking on 'place held' and 'untagged' infrastructure funds as a result of being part of a VCSE-led funders' partnership
- Delivery of essential funding to grassroots organisations in a way that allows swift deployment of funds

Impact: Grant recipients' example – 'Let's cook with Josie'

'Let's Cook with Josie' is a voluntary, community and social enterprise (VCSE) organisation that teaches cookery skills to children from disadvantaged backgrounds encouraging them to:

- Learn about making healthy food choices
- Learn where food comes from (air miles, carbon footprint, locally grown/seasonal produce)
- Learn to cook healthy meals that are easily replicated at home for the family
- Learn about minimising food waste
- Improve life chances & life skills
- Engage with others through small group classes, feeling included in the project/community no matter their background/disability
- Actively engage with the community through trips to the local community allotment

Josie works with children from Glenfall Primary School and Charlton Kings Junior School who are seen as vulnerable in some way. Most of the children who have previously attended have been on pupil premium and from single parent families, armed force families, are 'looked after children' (adopted, fostered, or living with their grandparents), and/or have mild learning disabilities. More recently two Ukrainian children who have moved here locally with their families have attended. Josie also supports children who may be experiencing a particularly difficult time due to bereavement or difficulties at school.

Josie runs the classes from her own home and over the course of 4 weeks builds on the children's basic skills in the kitchen. All food cooked is vegetarian, healthy, budget friendly and easy to replicate at home. Discussions take place around healthy food choices, health and safety in the kitchen, minimising food waste, making a family meal and where food comes from. Josie also takes the children to the local community

allotment where they can assist with weeding, planting, and watering etc. At the end of the course, they are all given a folder of the recipes from the sessions to enable them to replicate what they have made at home with their families/carers.

A snapshot of the difference 'Let's Cook with Josie' is making to the children she is supporting as well as to their families/carers is shown below. The contribution of Josie's classes to the Children and Young People's healthy weight agenda and tackling food insecurity in Gloucestershire is also acknowledged.

Let's Cook with Josie

Amount funded: £1,700 by ICB through Gloucestershire Funders

Aim of the funding:

Let's Cook with Josie teaches both young people and adults from disadvantaged backgrounds cookery skills, information about healthy good choices and how to budget. This funding was used to offer cookery classes to groups of young people including the cost of equipment and ingredients.

Josie is currently working with groups of children from Charlton Kings Junior & Glenfall Primary in Cheltenham, with the schools deciding which young people may benefit from joining her sessions.

"It's not just about the cooking for me, but also about offering a friendly, homely environment for the young people where they can feel safe and not only learn new cookery skills but also understand a bit more about the impact that a healthy diet has on their health and wellbeing, both mentally and physically." – Josie

"I thought I wouldn't like the beetroot and mouli we put in the spiralized salad, but I loved them both." – Young person

Josie picks the young people up from school & walks them back to her house where they collectively cook a meal to share with their family. Josie's classes offer peer support for the young people who may be experiencing challenging times & allows them to have fun in a warm & welcoming atmosphere, whilst also learning a range of life skills.

"I really enjoyed learning new techniques I can use in the kitchen & I've made lots of nice things to eat" – Young person

I've enjoyed making new recipes & getting to walk to Josie's house with my new friends " – Young person

With the grant from Gloucestershire Funders, Josie will be reaching **24 young people** in total from now until July 2023.

She has also found that it's not just the young people that the classes make a difference to. They can take their recipes home in their own recipe folder & share ideas with their families, having a go themselves and passing skills onto their parents/carers and siblings.

" R has gotten so much out of the classes, she loved being with the other girls & is a lot more confident in the kitchen at home" -Parent

"I can't believe the food my granddaughter has tried. She has never eaten vegetables or shown any interest in cooking but has now offered to help me in the kitchen" -Carer

4

Health & Wellbeing Partnership

‘Let’s Cook with Josie’

ICB Board

26th July 2023

@One_Glos
www.onegloucestershire.net

Background

Healthy Communities and Individual's team – Transformation Directorate

"a complete change in the appearance or character of something or someone, especially so that that thing or person is improved"

Why transformation? Health equity – social change

"Change is disturbing when it is done to us, exhilarating when it is done by us." Kanter

Myron's maxims

- *People own what they help create*
- *Real change happens in real work*
- *Those who do the work, do the change*

What does this mean?

Community empowerment – transformation happens 'out there'

Team remit - understand what this means for us as a health system

Gloucestershire Funders work is part of this journey

1

‘Let’s Cook with Josie’

- Charlton Kings – pockets of vulnerability in affluent area
- Schools – identification of need
- The children who attend the classes
- Format of the classes
- Examples of dishes cooked
- Food donations
  - Community Fridge
  - Local allotment visit
- Looking to the future

Health & Wellbeing Partnership

Difference made…

"I've enjoyed making new recipes & getting to walk to Josie's house with my new friends"
-Young Person

"I can't believe all of the food my granddaughter has tried. She has never shown any interest in cooking but has now offered to help me in the kitchen at home"
– Carer

"I've really enjoyed learning new techniques in the kitchen & have made lots of nice things to eat"
-Young Person

" I really enjoyed the roasted vegetable pasta bake… I don't even eat any vegetables!"
- Young Person

"R has gotten so much out of the classes, she loves being with the other girls & is a lot more confident in the kitchen at home"
– Parent

"Let's Cook with Josie has been an amazing experience for some of our more vulnerable children and those who just need to do something a bit different. They have all enjoyed the sessions and often came back into school the next day with some of their creations to share amongst the staff. A truly unique experience.
- Headteacher – Glenfall Primary

One Gloucestershire
Transforming Care, Transforming Communities

Health & Wellbeing Partnership

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@One_Glos

Agenda Item 7

NHS Gloucestershire ICB Board (Public Session)

Wednesday 26th July 2023

Report Title	**Board Assurance Framework**					
Purpose (X)	**For Information** X		**For Discussion**		**For Decision**	
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					
Key Risks: Original Risk (CxL) Residual Risk (CxL)	Without a BAF and the identification of strategic risks the Board would not know about emerging and potentially damaging risks to the ICB. 5x4 if there was no BAF reporting within the ICB 5x1 residual risk after risk mitigation					
Management of Conflicts of Interest	There are no conflicts of interests involved in producing this report.					
Resource Impact (X)	**Financial**	X	**Information Management & Technology**			
	Human Resource	X	**Buildings**			
Financial Impact	See the Finance risk ref 3.					
Regulatory and Legal Issues (including NHS Constitution)	The ICB has a host of legal duties and responsibilities around financial management and provision of services which relate to the risks (NHS Act 2006 as amended)					

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

Glossary of Terms	**Explanation or clarification of abbreviations used in the paper**
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise
FFTF1	Fit for the Future – Phase 1
FFTF2	Fit for the Future – Phase 2
DMBC	Decision-making Business Case
RSG	ICS Resources Steering Group
NHSE	NHS England

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Strategic Risks - Board Assurance Framework July 2023

<table>
<tr><th colspan="6">Strategic Objective</th></tr>
<tr><td colspan="6">Support improvements in urgent and emergency care–ensuring a range of options are available to those who need it</td></tr>
<tr><td>Risk Ref: 1
Strategic Risk</td><td>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</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>Seek</td><td rowspan="3">5x4=20</td><td rowspan="3">4x3=12</td><td rowspan="3">4x2=8</td><td rowspan="3"></td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Ellen Rule, Deputy CEO/Director of Strategy and Transformation</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHC
GHFT
GCC</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">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</td></tr>
<tr><td>Committee</td><td>Strategic Executive</td><td colspan="2">Review Date:</td><td colspan="2">July 2023</td></tr>
</table>

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. • System approach to operational planning for 23/24 agreed producing one plan for UEC transformation and operational optimisation.	• UEC Transformation Programme to be mobilised by end August 2023 (, Steering Group, 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. • Benefits Realisation for UEC programme to be in place from September 2023.

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• 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 • Transformation capacity and capability identified, UEC Transformation Programme Board in place.			

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
1. Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. Transformation programme Board to be in place May 2023, with delivery resource mobilised from early summer. 2. System wide operating plan submission to align with Transformation priorities for 2023/24 3. Learning from winter 22/23 to be factored into Transformation programme 4. Priority Transformation programmes to be articulated April 2023, built from existing schemes where work is underway and impact already starting to be seen. 5. Agree funding for improvements as part of the 23/24 operating and financial planning process.	**Updated: 18/07/2023** 1. Delivery Partner in place with phased mobilisation of resource through July and August 2023. Programme Board in place, with phased implementation of full governance structure underway 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 being mobilised, building on existing arrangements. Revalidation of diagnostic underway to assess current context and opportunity for improvement over winter and into 24/25. 5. Schemes within priority committee process notified of outcome. Increased focus on benefits realisation across all schemes. 6. Systems Thinking and Leadership masterclasses completed, with colleagues from across the UEC in attendance.

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

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<table>
<tr><td colspan="8">Strategic Objectives</td></tr>
<tr><td colspan="8">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</td></tr>
<tr><td>Risk Ref: 1
Strategic Risk</td><td colspan="2">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.
Urgent referral to treatment times have improved and routine waits have reduced but there are a number of people waiting over a year.</td><td>Original Score
(I x L)</td><td colspan="2">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 colspan="2">Cautious</td><td rowspan="3">4x3=12</td><td colspan="2" rowspan="3">4x3=12</td><td rowspan="3">2x3=6</td><td rowspan="3">⟷</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td colspan="2">Benedict Lee, Director of Integration</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td colspan="2">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.</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="7">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</td></tr>
<tr><td>Committee</td><td colspan="2">Quality Committee</td><td>Review Date:</td><td colspan="4">17th July 2023</td></tr>
<tr><td colspan="2">Current Controls (what do we have in place to mitigate the risk?)</td><td>Gaps in Controls</td><td colspan="2">Current Assurances
(how do we know the controls are working?)</td><td colspan="3">Gaps in Assurance</td></tr>
<tr><td colspan="2">• Eating Disorder Programme including system wide prevention through to crisis workstreams established.
• CAMHS recovery plan including within service provision and system wide to support improvements.
• Neurodevelopmental business case and plan in place. Funding identified to reduce some of current waits</td><td>• 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.</td><td colspan="2">• Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput.
• Demand and capacity modelling and skill mixing required to meet ongoing demand and complexity being modelled.</td><td colspan="3">• No significant gaps identified.</td></tr>
</table>

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	• No significant gaps identified as a monthly meeting is in place with CAMHs and s system wide multiagency meeting monitors progress bi monthly.	• Waiting times for urgent and non urgent referrals are reducing for eating disorders • New staff are starting in September and a significant recruitment and retention initiative is being planned across the ICB is taking place in the autumn	

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• Ongoing monitoring of the mitigations and engagement with service review around increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals. • Proposal to commence 3 year contract for both TIC+ and Young Gloucestershire to enable security and retention of staff and ensure business continuity. • Regular reporting to the Children's Mental Health Board • NHS Gloucestershire Board has been appraised of the need to focus on SEND, Operational Executive paper to be discussed regarding key areas of work and future investment.	**17/07/2023** 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 CYP access

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<table>
<tr><td colspan="6">Strategic Objective</td></tr>
<tr><td colspan="6">Deliver our workforce programme to attract new people into Gloucestershire to work across health and social care
Bring together specialist resource across the county to deliver new models of care through Fit for the Future</td></tr>
<tr><td>Risk Ref: 2
Strategic Risk</td><td>People & Culture: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans.
Due to: High levels of vacancies across many staffing groups
Impact: Increased pressure on existing staff, impacting staff morale and wellbeing and leading to higher bank and agency usage.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Cautious</td><td rowspan="3">4x4=16</td><td rowspan="3">5X4=20</td><td rowspan="3">3x2=6</td><td rowspan="3"></td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Tracey Cox, Director of People, Culture and Engagement</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHC – BAF Risks 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.</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">6 identified risks rated 15 and above:
1. Inadequate Workforce Supply (risk score 16 – slightly reduced risk score)
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. 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</td></tr>
<tr><td>Committee</td><td colspan="2">People Committee</td><td>Review Date:</td><td colspan="2">Reviewed July 20th</td></tr>
</table>

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 for Continuing Professional Development to support staff training & development	• Lack of an adequately defined and resourced system-wide and medium-term plan for staff and leadership development	• Reporting to the People Board, People Committee and the Board of the ICB	• Implementation details relating to now published NHS Workforce Plan.

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<table>
<tr>
<td colspan="2">• 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.</td>
<td>(recruitment or role to map current leadership development offers across ICS)</td>
<td>• On-going monitoring progress on key workforce metrics through Integrated Performance Report (see below)</td>
<td></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">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</td>
<td colspan="2">Updated 09/07/23
1.Bids from Clinical Programme Groups for 2023/24 workforce transformation funding round to be finalised during July)
2. Proposed bid under development for System wide housing support role to assist with needs of international recruitment.
3. Retention lead is completing diagnostic position for system to inform future retention plan.
4. No change
5. Staff passporting – exploration of opportunity to enhance existing approach.
6. System wide meeting on agency spend took place on 30/5/23 to share approaches across system.
7. Provider appointed to help develop campaign, diagnostic phase underway.
8. No change.</td>
</tr>
<tr>
<td></td>
<td colspan="4">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</td>
</tr>
</table>

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<table>
<tr><th colspan="6">Strategic Objective</th></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
– Decrease in productivity within the system
– Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding
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</td></tr>
</table>

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	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 recurrent financial sustainability				
Aligned to current ICB Risks	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				
Committee	**System Resources Committee Audit Committee**	**Last Review & Update Date:**	**10/07/2023**		

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

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<table>
<tr><td colspan="2">• GHFT internal financial improvement plan being updated further with additional measures & controls and implemented in order to mitigate financial pressure. reporting through to the GHFT Finance Committee.
• System Financial Improvement actions in place, ongoing updating for additional actions to improve the system financial position.</td><td>Updated: 10/07/2023
• System medium term plan in development which will be underpinned by financial plans, due autumn 2023,
• Urgent care diagnostic implementation being planned, Directors of Finance will sit on the benefits realisation programme
• System wide financial risk sharing protocol agreed
• Work underway within GHFT on changes in productivity since 2019/2020 to identify key areas of focus for the future</td></tr>
<tr><td></td><td colspan="2">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</td></tr>
</table>

Document Last Updated: 19/07/2023

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

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

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

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<table>
<tr><th>Committee</th><th colspan="2">Quality Committee</th><th>Last Review & Update Date:</th><th>17th July 2023</th></tr>
<tr><th>Current Controls (what do we have in place to mitigate the risk?)</th><th>Gaps in Controls</th><th colspan="2">Current Assurances
(how do we know the controls are working?)</th><th>Gaps in Assurance</th></tr>
<tr><td>• 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><th colspan="2">Actions to mitigate risk & implementation dates</th><th colspan="3">Director's update on actions to date (quarterly update)</th></tr>
<tr><td colspan="2">1) 23/24 plan in place and submitted nationally. Monitoring progress through Planned Care Delivery Board (ICS level meeting with GHFT represented).
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: 17/07/2023
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), additional activity in place for several modalities including Echocardiography which will be provided by locums while substantive roles are resourced. 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. 8) Learning from other systems around waiting list prioritisation to be scoped with clinical leads and plans for task and finish work to improve booking/ prioritisation will be developed according to the findings of this exercise.	3) Two additional theatres at CGH now operational. 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 agreed and signed off. 7) Planning monitoring set up underway – assurance taking place through Planned Care Delivery Board monthly. 8) NHS Gloucestershire colleagues attended King's Fund workshop in elective recovery and waiting list prioritisation to learn from national research and other areas experience in this area (June 2023). 9) Industrial action has significantly impacted elective recovery, with Junior Doctors action in June and Junior Doctors/ Consultant action in July causing a large number of elective cancellations. Work is underway to assess impact on ERF in additional contingency planning for further industrial action likely to take place throughout 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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<table>
<tr><td colspan="6">Strategic Objective</td></tr>
<tr><td colspan="6">Continue changes in services that enable care to be delivered closer to home. Our Clinical Programme Approach and the work within Primary Care Networks are key to making this happen.
Improve integrated care across the life course–increasing our focus on the needs of Children and Families and supporting people to age well
Improve access to care, recovering from the last two years. This includes work to recover elective care, reducing long waits whilst ensuring that those waiting are given advice and support to manage their conditions</td></tr>
<tr><td>Risk Ref: 5
Strategic Risk</td><td>Quality: - Failure to deliver safe, effective, responsive, caring and well-led services and reduce harm.
Due to: Lack of robust oversight arrangements to ensure high quality care is delivered by organisations with NHS contracts.
Impact: Patients and citizens will be put at risk and have a poor experience if those with NHS contracts are unable to deliver high quality care.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
↓ ⟷ ↑</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Zero</td><td rowspan="3">5x2 = 10</td><td rowspan="3">5x2=10</td><td rowspan="3">5x1=5</td><td rowspan="3">⟷</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Dr Marion Andrews-Evans, Chief Nursing Officer
Dr Andy Seymour, Chief Medical Officer</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHFT: SR1 Breach of CQC regulations or other quality related regulatory standards.
SR3 Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework
GHC: There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support…</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">C 2 - There are some clinical areas where aspects of NICE guidance have not been fully implemented. Therefore there is a potential risk to patient care and outcomes.
ID 10 - CHC unable to meet the NHSE target for the assessment of people with a learning disability
ID 11 - Waiting List for Wheelchair Service provision in the recovery phase.
ID 25 - Increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals
ID 27 - Child/young adults not receiving the specialised care they would receive in a Tier 4 Eating Disorder Bed
ID 44 - Medically complex and vulnerable children in non-health care settings (eg school nursery) are not supported with their medical needs
INT0017 - Maternity staffing and workforce training</td></tr>
<tr><td>Committee</td><td>System Quality Committee</td><td colspan="2">Last Review & Update Date:</td><td colspan="2">17th July 2023</td></tr>
<tr><td>Current Controls (what do we have in place to mitigate the risk?)</td><td>Gaps in Controls</td><td colspan="2">Current Assurances</td><td colspan="2">Gaps in Assurance</td></tr>
</table>

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		(how do we know the controls are working?)	
• 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	• Our ambition to develop a System Safety Group linked to the development of the new Patient Safety Incident Response Framework remains. Informal networks are making good progress. • Discussions at System Effectiveness Group are helping to develop how we can have more robust oversight of deviations from NICE along with other indicators of effectiveness.	• Reporting to Quality Committee • Quality Assurance discussions • Contract Management Boards • Regulatory reviews	• We are assured that the governance process in place mean that we have full oversight.

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• ID 27: Work with National and Local VCS providers to develop range of community options to be used to facilitate discharge. • ID 44: Expansion of a nurse training service to meet the growing needs of training within non-heath care settings (eg schools)	**Update: 17/07/2023** • New system-wide workshop planned for 20th July to help develop Quality Governance. • NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. • Next System Mortality group planned for August 3rd. We will be looking at community dementia diagnosis and how this is affecting SHMI and patient outcomes. .

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

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

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		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. • Health Inequalities Improvement Manager now in place to improve coordination of the work underway on inequalities and ensure system-wide actions are coordinated.	• 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) • New Health Inequalities Improvement Manager in post since 19th June 2023 to understand and coordinate the breadth or work being undertaken on health inequalities and prevention, and to identify gaps and opportunities for improvement. • 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). • Comparison with south-west and national health inequalities dashboards and actionable insights underway.	**Updated: 17/7/2023** • Health Inequalities Improvement Manager post commenced 19th June 2023. Initial priorities include a stocktake of work underway to reduce health inequalities across programmes and projects and a refresh of the Core20Plus5 strategy for Gloucestershire. • Operational plan finalised May 2023 with extensive ambition on health inequalities detailed for key programme areas, especially relating to national priorities including inclusive elective recovery. • System representation at King's Fund workshop on inclusive elective recovery. • Development work for reporting on health inequalities workstreams and progress is ongoing. • ICB SROs for health inequalities confirmed as Siobhan Farmer (Director of Public Health) and Douglas Blair (CEO for Gloucestershire Hospitals NHS Foundation Trust).

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<tr><td colspan="2">

- Incorporation of regular health inequalities measures into Integrated Performance Report to be identified and developed.
- Development of a Health Inequalities Improvement Delivery Group to develop and implement approaches to tackling health inequalities across the Core20Plus5 priority areas underway.

</td><td>

- Stocktake of all health inequality funded (non-recurrent and recurrent through programme budgets) underway.
- Instigation of health inequalities analysis mapping session has taken place and a cross-organisational health inequalities analytical network to improve joint working across the ICS is being established.

</td></tr>
<tr><td></td><td colspan="2">

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

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

</td></tr>
</table>

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<table>
<tr><td colspan="6">Strategic Objective</td></tr>
<tr><td colspan="6">No exact correlation with the strategic objectives but is a key priority for the ICB</td></tr>
<tr><td>Risk Ref: 7
Strategic Risk</td><td>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)</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
↓ ↔ ↑</td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Cautious</td><td rowspan="3">5x3=15</td><td rowspan="3">5x2=10</td><td rowspan="3">5x1= 5</td><td rowspan="3">↓</td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Cath Leech, Chief Finance Officer</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>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: SR11 Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">There are no current operational risks around sustainability included in the risk system</td></tr>
<tr><td>Committee</td><td colspan="2">TBC</td><td>Last Review & Update Date:</td><td colspan="2">10th July 2023</td></tr>
</table>

<table>
<tr><td>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>• 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</td><td>• Available, timely and accurate data
• Financial resource
• Lack of staff resource
• Tracking delivery of detailed plans and projects</td><td>• Plan document
• Minutes of meetings
• Project plans</td><td>• Co-ordinated reporting across the system on implementation and progress against plans</td></tr>
<tr><td colspan="2">Actions to mitigate risk & implementation dates</td><td colspan="2">Director's update on actions to date (quarterly update)</td></tr>
<tr><td colspan="2">• Agree shared priorities
• Developing and sharing resources, including programme and project management
• Improving data and ongoing tracking
• Shared commissioning of specialist resource</td><td colspan="2">Updated: 10/07/2023
• ICS contribution to Climate Leadership' Gloucestershire finalised including contribution to Gloucestershire Adaptation Plan
• GCC and the ICB on developing specification to take forward specific areas within travel</td></tr>
<tr><td></td><td colspan="3">Relevant Key Performance Indicators: (taken from the Integrated Performance report)</td></tr>
</table>

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<table>
<tr><th colspan="6">Strategic Objective</th></tr>
<tr><td colspan="6">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</td></tr>
<tr><td>Risk Ref: 8
Strategic Risk</td><td>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</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">3x3=9</td><td rowspan="3">2X3=6</td><td rowspan="3">2x2=4</td><td rowspan="3"></td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Tracey Cox, Director of People, Culture and Engagement</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHC; BAF Risk Nos 7: Partnership Culture
GHFT; BAF risk SR7: Failure to engage and ensure participation with public, patients and communities.</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5"></td></tr>
</table>

Committee	ICB Board People Committee	Review Date:	July 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	• Embedding new ways of working and 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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<table>
<tr><td colspan="2">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</td><td></td><td></td><td></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">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.</td><td colspan="2">Updated 18/07/23
1. This group has now been mobilised. Next meeting 25/07/23.
2. BDO report on review of ICB Committee Effectiveness completed and to be shared with ICB Board at the July meeting. The outcome of that audit will be reflected in the assurances.
3. To be confirmed subject to the review of the above.
4. ICB Board Development session took place on 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.</td></tr>
<tr><td></td><td colspan="4">Relevant Key Performance Indicators: (taken from the Integrated Performance report)

TBC – Annual 360 survey as part of review of effectiveness of ICB</td></tr>
</table>

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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					
Emergency Preparedness, Resilience and Response (EPRR)	**EPRR:** - Failure to meet the minimum occupational standards for EPRR and Business Continuity. **Due to:** Lack of effective EPRR systems and On-Call EPRR training **Impact:** Unable to fulfil our responsibilities as a Category One responder.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Zero**	**4x3=12**	**4x3=12**	**4x1=4**	⟷
Strategic Risk Owner (Director)	**Dr Marion Andrews-Evans, Chief Nursing Officer**				
Aligned to other system partners risks (include ref no.)	System EPPR				
Aligned to current ICB Risks	N/A				

Committee	**System Quality Committee**	**Last Review & Update Date:**	**17th July 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.	• The reset rota for on-call Tactical and Strategic leads has commenced. • Training session for on-call staff continue. • AEO due to retire in the Autumn, plans need to be confirmed to ensure continuity of cover.

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

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5x5 Risk Matrix

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

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

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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 26th July 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 • **Primary Care Networks (PCN) Quality Improvement Projects** • **Integrated Locality Partnerships (ILPs)** • **Proactive Care and Living Well with Frailty in Cheltenham** • **Creating Active Schools in Gloucestershire** • **Clinical Programmes Respiratory** • **Eye Health** • **VCSE and Clinical Programme Event** • **Further delegation of specialised commissioning responsibilities to ICBs** • **GP Patient Survey Presentation (see Addendum)**					
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)	See section 5 on the further delegation of specialised commissioning duties to the ICB.
Impact on Health Inequalities	See section 2.1.3 Proactive Care and Living Well with Frailty in Cheltenham
Impact on Equality and Diversity	
Impact on Sustainable Development	See section 3 Creating Active Schools in Gloucestershire Active Travel policy and action – working with Think Travel, the local community, and parents & children to develop their cycling and scooting to school resulting in 73% of Years 3-6 traveling actively to school. 34.4% of which have parked further away at designated areas and walked/scooted/cycled.
Patient and Public Involvement	See section 4.3 VCSE and Clinical Programme Event
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

26th July 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. Primary Care Networks (PCN) Quality Improvement Projects

2.1.1 As noted in the previous report, a further £950k has been secured for 2023/24 Quality Improvement (QI) Initiatives. PCNs have been developing their proposals, based on their population, for how they plan to spend the funding, which included presentations and discussions at the PCN away day on 22nd June 2023. To date 13 out of 15 PCNs have shared their QI project proposals. These proposals are currently going through a review process to ensure they adhere to the criteria parameters. Early themes of PCN projects focus on Frailty, Mental Health and chronic disease management.

2.1.2 Integrated Locality Partnerships (ILPs)

2.1.3 Partners from our six Integrated Locality Partnerships deliver a range of projects to promote health and wellbeing, impact the root causes of health inequality and support people to live well at home. An example of our work in the interface between the PCN Neighbourhoods and ILP Localities is shown below.

2.1.4 Proactive Care and Living Well with Frailty in Cheltenham

The Cheltenham Integrated Locality Partnership is made up of partners including health, housing and voluntary and community sector organisations and includes representatives from the three PCNs within Cheltenham; Central PCN, Peripheral PCN and St Paul's PCN. The three PCNs are planning to use QI funding to target frailty with proactive care planning. The proposed projects include utilisation of the virtual whiteboard database approach as well as a one stop shop clinic to identify patients within the GP registered lists who are at risk of increasing frailty. The virtual whiteboard is used to stratify patient risk factors based on age, hospital admissions and co-morbidities. The one stop shop clinic hopes to bring together professionals from pharmacy, social prescribing and nursing to assess and signpost patients according to need. The PCNs will work alongside existing partners including the Complex Care at Home service to pilot the use of data to target patient cohorts. The proactive care projects set out to aid the planning of recruitment strategies, establish dedicated MDT meetings and initiate care coordination. Therefore, reducing the reliance on unplanned care and out of hours services whilst supporting people to live well for longer in their communities.

3. Creating Active Schools in Gloucestershire

3.1.1 Creating active schools is a process of transforming the school environment and culture to promote physical activity and well-being for all students and staff. Active schools aim to provide opportunities for movement throughout the day, such as active breaks, active lessons, active transport, and active play. By creating active schools, educators can enhance learning outcomes, foster social and emotional skills, and improve health and fitness levels for their school community.

3.1.2 In Gloucestershire we are in the second year of our CAS programme. The first year sought to understand the concept and in the second year to expand the programme to 12 schools.

3.1.3 Move More connected with 19 schools in the initial stages of year two with 12 taking up the offer. 10 schools have fully engaged with the programme over the last twelve months with two stepping back due to capacity issues at the time.

3.1.4 There have been 6 community of practices through the year, which has enabled the schools to connect with each other and share good practice, learn from how things have worked and collectively shape their plans. These meetings have been invaluable for the school CAS Champions, it has changed the focus of CAS from being about PE to being integrated into the whole school.

3.1.5 We have learnt that attendance from leaders in the school really advances the programme and where schools have involved their wider stakeholders, from children to parents and from teachers to governors the impact is always higher.

3.1.6 Each school has a whole school plan, it's not just looking at one small element, but developing the inclusion of physical activity into every aspect of the school across the policy, environment, stakeholders, and opportunities. By starting at a policy level, we see that schools shift the conversation about being active from PE and sport to every lesson that is taught. There are some great examples of how schools have established their active school programme.

- Recruitment – our recruitment policies have been improved; candidates are asked to share their 'vision' for a physically active school at interview
- Active Travel policy and action – working with Think Travel, the local community, and parents & children to develop their cycling and scooting to school resulting in 73% of Years 3-6 traveling actively to school. 34.4% of which have parked further away at designated areas and walked/scooted/cycled.
- Active Lessons – working to design and develop active lessons which create space in classrooms for children to move around as well as encouraging learning through movement. In one school 75% of lesson plans are now developed with some form of movement as part of the session. Either in the form of 5 minute 'brain breaks' or in the design of the classroom and lesson plan to include movement of some form.
- Schools are being re-organised and decluttered – creating easier access to open space, outdoor classrooms and clutter free areas that feel easier to move in for both teachers and children.

3.1.7 A full evaluation of year two is underway and year 3 is in the planning phase. Further insights and information will be available once this has been completed. Year 3 aims are to open this work into Gloucester City with a focus on the primary feeder schools for three of the focus secondary schools Gloucester Academy, Barnwood and Seven Vale.

Please see attached video: [We can move Changemaker - MoveMore - YouTube]

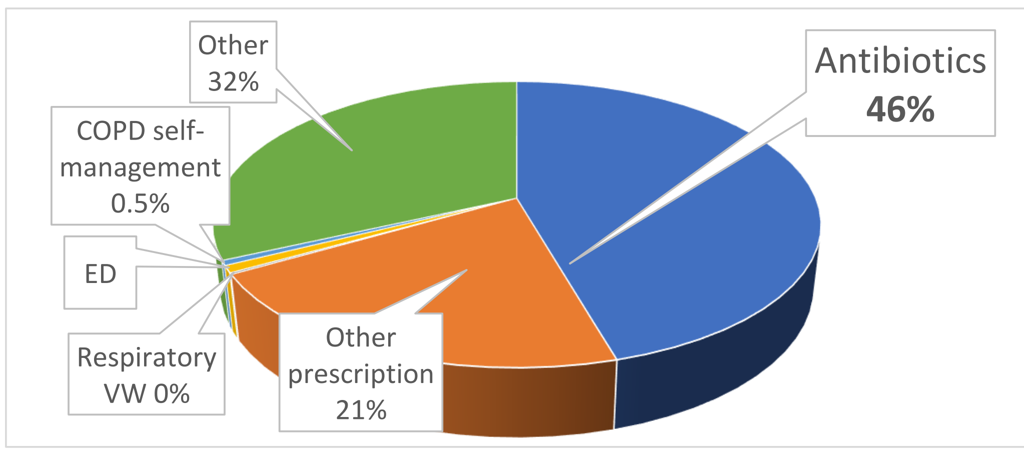
4.1 **Clinical Programmes Respiratory**

4.1.1 Our acute respiratory infection hubs that were established in Cheltenham and Gloucester has completed an initial evaluation, which is showing promising results in both patient and clinician satisfaction and potential impact on reducing attendance in emergency departments with respiratory illness. The evaluation is ongoing, with plans in place to continue the clinics this winter. The data shows that the clinics were used most by patients within deprivation decile 1; showing how targeted work like this locally can help address health inequalities; especially with the additional benefits that would not be received in an emergency department, such as identification of undiagnosed chronic conditions such as COPD, opportunistic vaccination offers, medicines review and support with smoking cessation referral and social prescribing in their local area.

4.1.2 Initial results are shown below:

ARI Hubs	Appointments attended	Appointments unattended	DNA rate
TOTAL	**4,420**	**216**	**4.9%**

Overall, how would you rate your experience at the ARI Hub today?	Percentage of responses
Very good	**92.2%**



4.1.3 The table below shows where service users reported that they would have attended if the hub appointments were not available to them:

What would you have done if you hadn't been offered an ARI appointment?	Response percent (multi-response question)
Visited Accident and Emergency (A&E) at the Hospital	21%
Called NHS 111	23%
Visited Gloucester GP Health Access Centre (GHAC)	4%
Waited for a GP appointment at your own practice	51%
Visited a Community Pharmacy	7%
Unsure/Don't know	18%
Called 999	1%
Other	3%

For Gloucester and Cheltenham localities there was a 43% decrease in activity between 90 days prior to the setup of ARI's and 120 days post. This is mostly due to seasonal variation however when we compare the rates for all other localities the rate of decrease is 37%. This shows the drop has been higher in the localities with ARI hubs (6%). Given that these are areas are closer to the emergency departments this difference may be even more significant.

4.2.1 **Eye Health**

The Eye Health CPG were nominated by Rt Hon Alex Chalk KC MP and Richard Graham CMG MP for the Future NHS Award at the NHS Parliamentary Awards for the work on Community Ophthalmic Link (COL). Gloucestershire is the first in the country to support community optometrists with access to hospital eye images, diabetic screening, and referral information via COL.

4.2.2 The team was selected as Regional winners of the award but did not win the National final. The awards coincided with the NHS 75 celebrations and the team were grateful to be part of the awards which has highlighted the innovation work successfully implemented in Gloucestershire.

4.2.3

4.3. **VCSE and Clinical Programme Event**

4.3.1 The VCSE and clinical programmes event was held on 13th July at the Guildhall in Gloucester. The event was very well attended with over 120 delegates from a wide range of VCSE organisations across Gloucestershire- and some very interesting conversations were held on how we best link our work together. The outputs and themes will be shared in a future report.

5. **Further delegation of specialised commissioning responsibilities to ICBs**

5.1.1 As Board members are aware from previous updates, a statutory joint specialised services committee is in place in the South West region for 2023/24. This involves all the ICBs working with the NHSE specialised commissioning team to oversee and take commissioning decisions for fifty-nine specialised services (at present the responsibility and liability remains with NHSE). This committee is currently chaired by NHSE (Rachel Pearce, Regional Director Commissioning) with Director level representation from each system. The committee will be moving to an independent chair who will be appointed by this Autumn.
To further enact the national roadmap for specialised commissioning, NHSE are now proposing that further delegation for the identified fifty-nine services fully transfers to ICBs from 1st April 2024. This would mean that responsibility and liability for these services would fully transfer to ICBs.

5.1.2 What this means in practice is that:

- specialised commissioning budgets will be delegated i.e. specialised commission spend will become part of the ICB and ICS financial position (with agreement that we should continue to consider some form of regional risk sharing arrangement);
- it is proposed that that the joint committee made up of ICBs and the regional team in the South West continues into 24/25 run by the NHSE specialised commissioning team from the newly established Collaborative Commissioning Hub;
- we are being asked to assess our readiness against an updated Pre-Delegation Assessment Framework (PDAF) and to get Board sign off in relation to our state of readiness in September (with the process to be completed by December).

5.1.3 The executive team have considered the following issues in relation to this process:

- the financial allocation at ICB level is not known so neither is the extent of financial risk and to date there has not been any discussions regarding risk share arrangements;
- a significant proportion of this activity relates high value low volume procedures so there is an inherent risk;
- further work is necessary to understand in detail current patient and financial flows relating to this activity;
- we have not yet had the opportunity to work through the implications in terms of additional workloads for our teams, this should be considered against the backdrop of the national running cost requirement for ICBs.

5.1.4 There will be regional finance and transition groups working to resolve these issues which we will be contributing to. A discussion on the transition process took place at the joint specialised

services committee this month. This led to systems agreeing that, particularly in the absence of detail regarding allocations and the needs-based formula/pace of change, that we should delay the move to 'fully devolve' from 2024/25 and agree to extend current joint arrangements for a further year (overseen by a new independent chair). Discussions on this proposal continue and we will continue to keep the Board updated on progress.

6. **The GP Patient Survey 2023**

6.1 The GP Patient Survey (GPPS) is an England wide survey. The data was collected from January to March 2023 and provides information about patient experiences of their GP practices. The attached slide pack presents some of the key results from the survey for One Gloucestershire Integrated Care System. The pack also covers peoples experience of accessing dentistry and their experiences of Gloucestershire dentistry (see slides 18-21).

7. **Recommendation**

7.1 The Board is asked to note the CEO report

GP PATIENT SUR
NE GLOUCESTERSHIRE
est survey results
Survey
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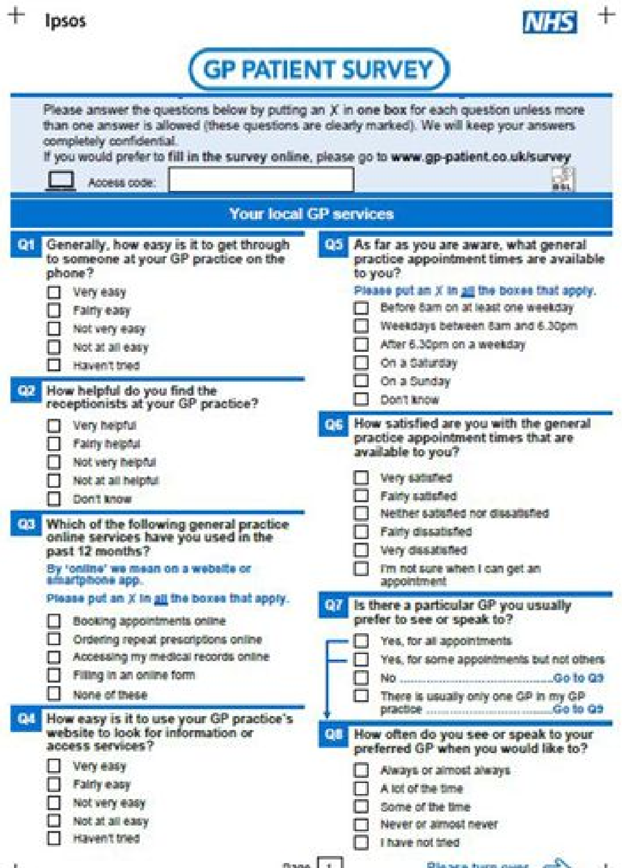
roduction

ıe GP Patient Survey (GPPS) is an England-wide survey, ɔviding data about patients' experiences of their GP practices.

ıis slide pack presents some of the key results from the 2023 GP ıtient Survey for **ONE GLOUCESTERSHIRE (Integrated Care ystem)**.

ONE GLOUCESTERSHIRE, 21,569 questionnaires were sent ıt, and **8,505** were returned completed. This represents a sponse rate of **39%**.



Ipsos

NHS

GP PATIENT SURVEY

Please answer the questions below by putting an X in one box for each question unless more than one answer is allowed (these questions are clearly marked). We will keep your answers completely confidential.
If you would prefer to fill in the survey online, please go to www.gp-patient.co.uk/survey

Access code:

Your local GP services

Q1 Generally, how easy is it to get through to someone at your GP practice on the phone?
- Very easy
- Fairly easy
- Not very easy
- Not at all easy
- Haven't tried

Q2 How helpful do you find the receptionists at your GP practice?
- Very helpful
- Fairly helpful
- Not very helpful
- Not at all helpful
- Don't know

Q3 Which of the following general practice online services have you used in the past 12 months?
By 'online' we mean on a website or smartphone app.
Please put an X in all the boxes that apply.
- Booking appointments online
- Ordering repeat prescriptions online
- Accessing my medical records online
- Filling in an online form
- None of these

Q4 How easy is it to use your GP practice's website to look for information or access services?
- Very easy
- Fairly easy
- Not very easy
- Not at all easy
- Haven't tried

Q5 As far as you are aware, what general practice appointment times are available to you?
Please put an X in all the boxes that apply.
- Before 8am on at least one weekday
- Weekdays between 8am and 6.30pm
- After 6.30pm on a weekday
- On a Saturday
- On a Sunday
- Don't know

Q6 How satisfied are you with the general practice appointment times that are available to you?
- Very satisfied
- Fairly satisfied
- Neither satisfied nor dissatisfied
- Fairly dissatisfied
- Very dissatisfied
- I'm not sure when I can get an appointment

Q7 Is there a particular GP you usually prefer to see or speak to?
- Yes, for all appointments
- Yes, for some appointments but not others
- No ....Go to Q9
- There is usually only one GP in my GP practice ....Go to Q9

Q8 How often do you see or speak to your preferred GP when you would like to?
- Always or almost always
- A lot of the time
- Some of the time
- Never or almost never
- I have not tried

Page 1

Please turn over

w to use this data for improvement

ata in this slide pack can be used and interpreted to help to improve GP services, in the following wa

mparison of an ICS against the national result: this allows benchmarking of the results to identify ether the ICS is performing well, poorly, or in line with the national picture. The ICS may wish to focu: as where it compares less favourably.

alysing trends in an ICS's results over time: this provides a sense of the direction of the ICS's formance. The ICS may wish to focus on areas which have seen a decline in results over time.

mparison of PCN's results within an ICS area: this can identify PCNs in an area that seem to be c forming or under-performing compared with others. The ICS may wish to work with individual PCNs: t are performing particularly well may be able to highlight best practice, while those performing less v y be able to improve their performance.

eractive dashboard providing more detail at PCN level can be found here: https://www.gp-t.co.uk/pcn-dashboard.

: note PCNs have been aligned to the ICS based on the Lead Sub ICB Location identified by the NHS Digital ePCN mapping file, sed via the NHS Digital organisation data service. There were a very small number of PCNs which crossed ICS boundaries – if th case, this will be noted below.

verall experience
f GP practice
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ɜrall experience of GP practice

LOUCESTERSHIRE

ɔverall, how would you describe your experience of your GP practice?

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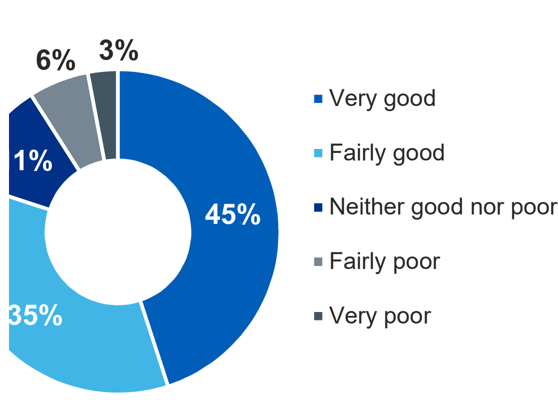
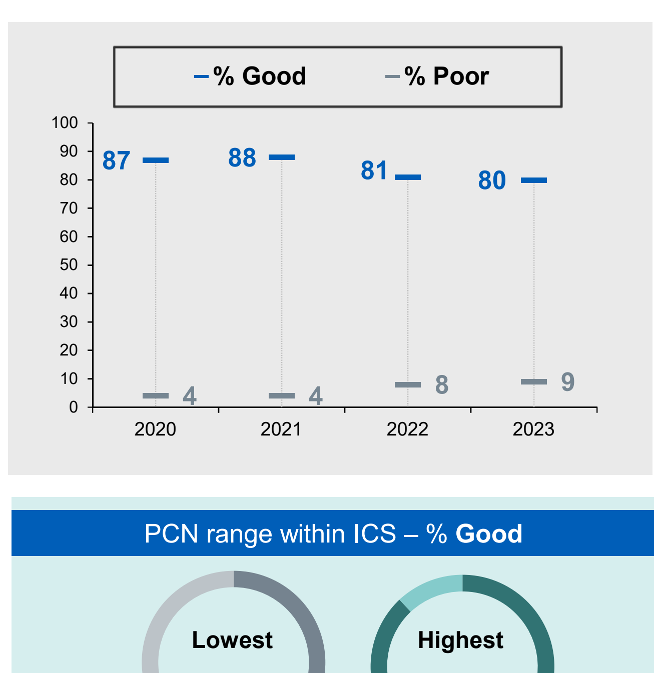
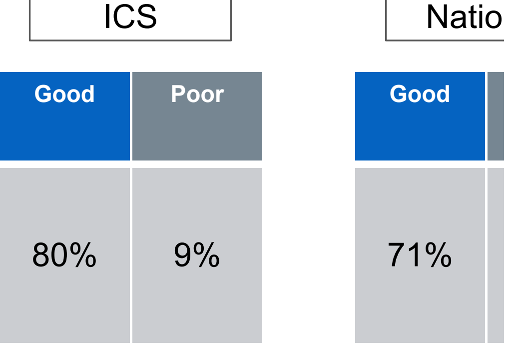


ICS result over time



Comparison of results



%Good = %Very good + %Fairly gooc
%Poor = %Very poor' + %Fairly poor

of all patients. National (749,020); ICS 2023
2022 (8,136); ICS 2021 (9,701); ICS 2020 (8,342);
ange from 122 to 1,300

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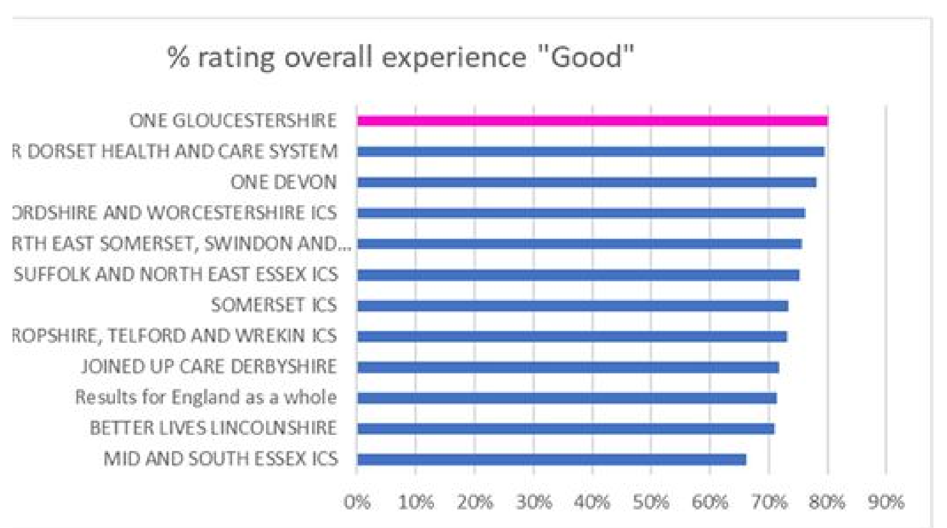
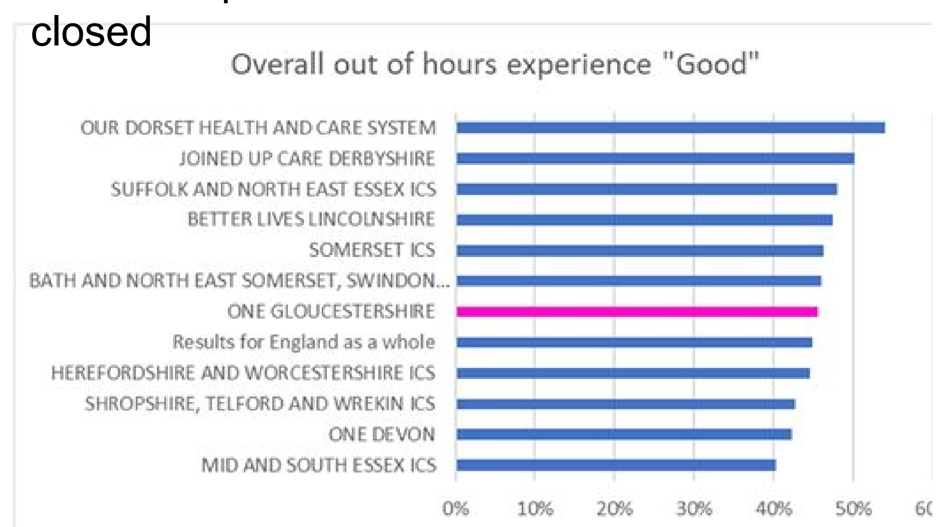
ıll GP experience benchmarking against our "Peer" 10 ICSs

erall experience of GP practice



Overall experience of NHS services when GP is closed



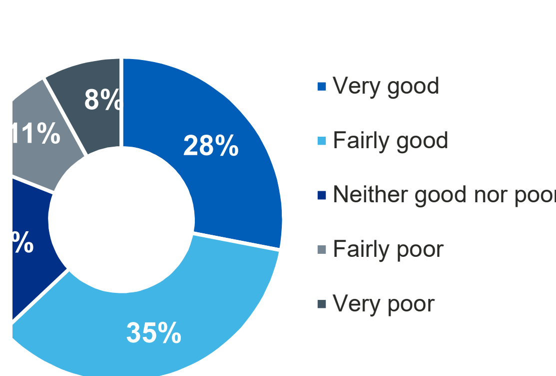
cestershire overall has the highest % of our peer group for people rating their overall experience of GP practice as "Good" (all positive responses) with 80% people stating their experience was positiv
ːall experience of NHS services when their normal surgery was closed (Out of Hours) was far lower, only 46% of people rating their overall experience positively.

ɜrall experience of making an appointment

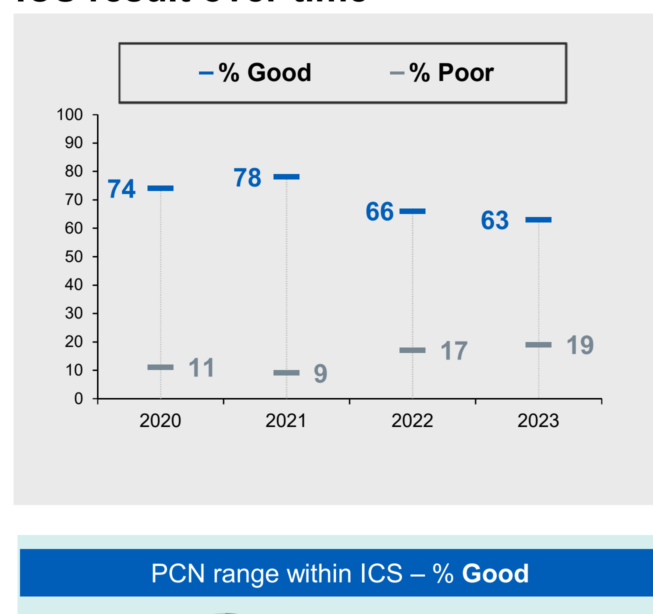
LOUCESTERSHIRE

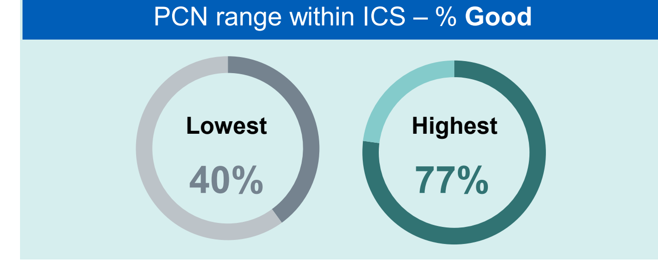
ɔverall, how would you describe your experience of making an appointment?

ɜsult

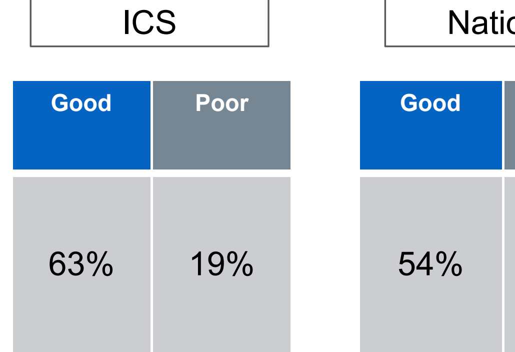


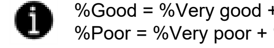
ICS result over time





Comparison of results





d of patients who have tried to make an appointment
registered with current GP practice. National
CS 2023 (7,969); ICS 2022 (7,671); ICS 2021
S 2020 (7,929); PCN bases range from 115 to 1,213

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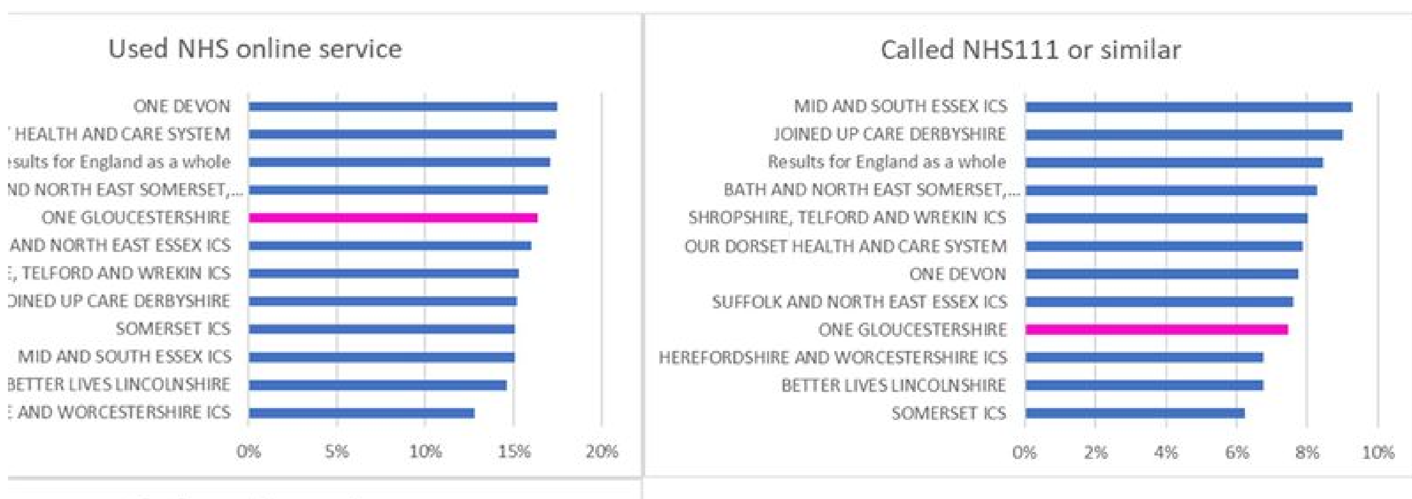
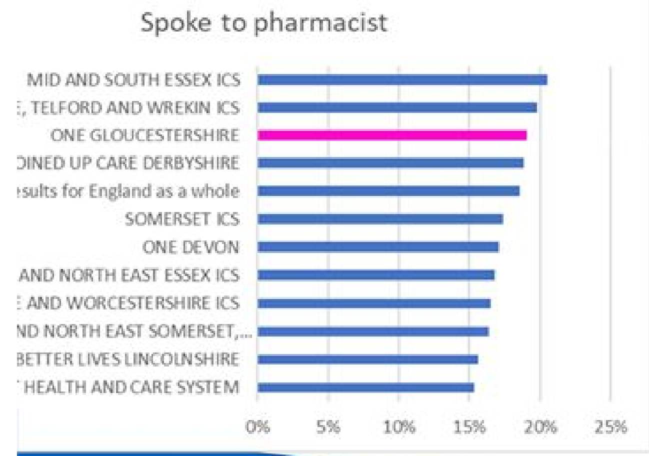
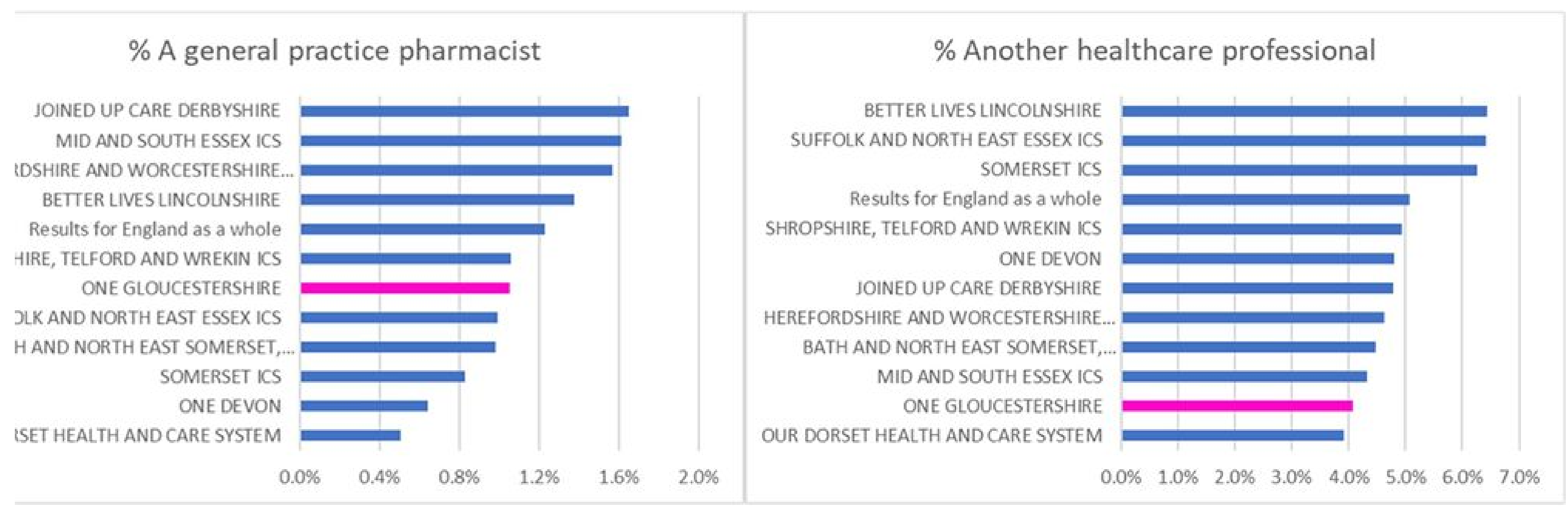
'e contacting primary care benchmarking against our "Peer" 10 ICSs





When asked if people had used a service before contacting their GP practice, Gloucestershire residents were more likely to have tried an online service or pharmacist than the peer group average. They were less likely to have attempted to call NHS111 before contacting their surgery. (This pattern is also seen for patients accessing services out of hours – see slide 5).

# of alternative clinical roles in primary care benchmarking against "Peer" 10 ICSs



atients seen in primary care, around 1% of Gloucestershire residents saw a general practice pharmacist – ıge for our peer group. A smaller proportion than average reported seeing an alternative healthcare ssional. Note: this question relates to the most recent contact with primary care, and is self reported (an ıge of 4% of people cannot remember who they saw at their last appointment).

erceptions of
are at patients'
ast appointment
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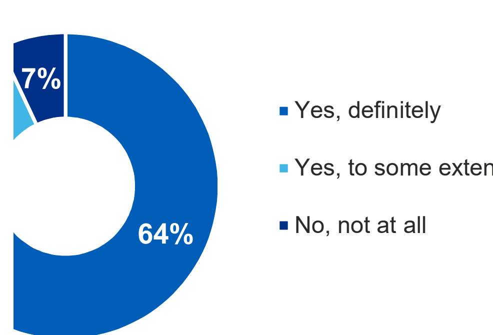
ɘds met at last appointment

LOUCESTERSHIRE

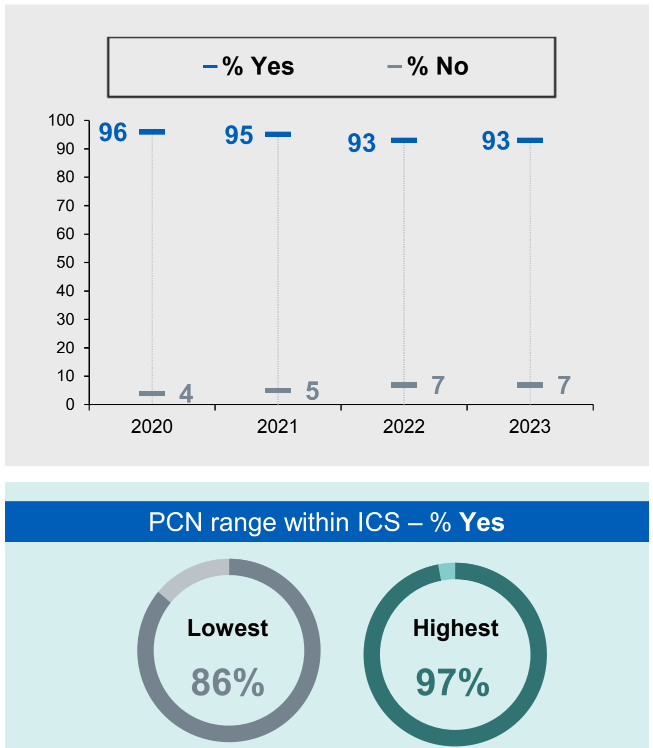
hinking about the reason for your last general practice appointment, were your needs met?

sult

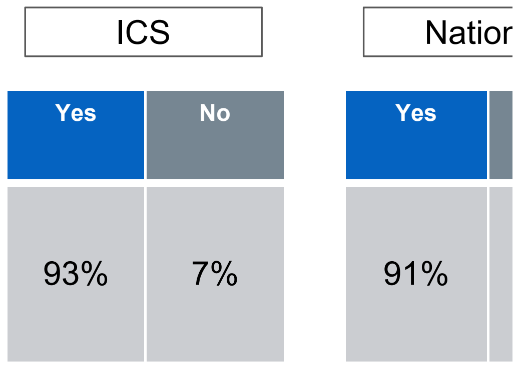


ɜked of patients who had an appointment since being ɘd with current GP practice. Patients who selected 'Don't an't say' have been excluded. National (688,092); ICS 803); ICS 2022 (7,594); ICS 2021 (8,939); ICS 2020 PCN bases range from 108 to 1,197

ICS result over time



Comparison of results



%Yes = %Yes, definitely + %Yes, to s

lanaging health
onditions
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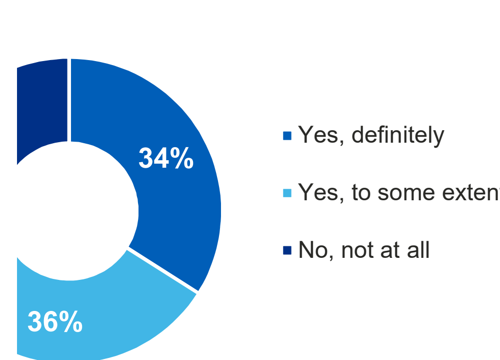
›ort with managing long-term conditions, disabilities, or ›sses

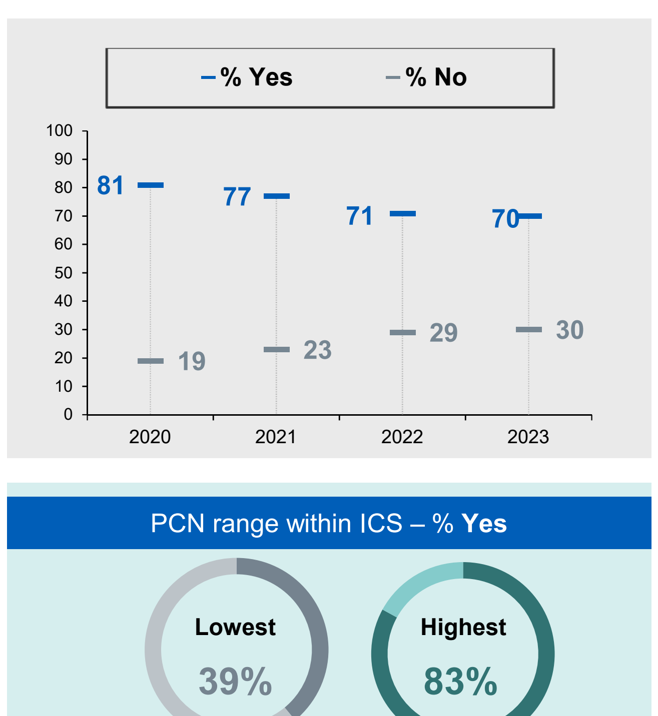
LOUCESTERSHIRE

› the last 12 months, have you had enough support from local services or organisations to help you to m› ondition (or conditions)?

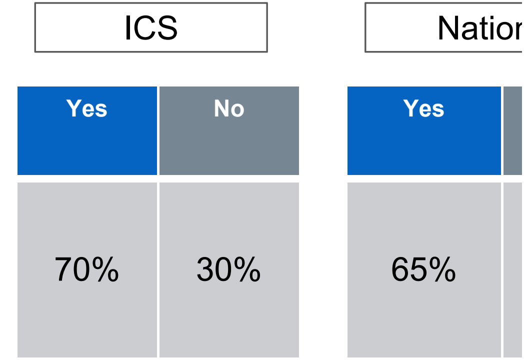
›esult



ICS result over time



Comparison of results



%Yes = %Yes, definitely + %Yes, tc

›d of patients with a long-term condition, illness, or ›atients who selected 'I haven't needed support' or › / can't say' have been excluded. National (293,843); ›,181); ICS 2022 (2,937); ICS 2021 (3,422); ICS ›'); PCN bases range from 58 to 523

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ervices when GP
ractice is closed
uestions are only asked of those people who have recently used an
vice when they wanted to see a GP but their GP practice was
s such, the base size is often too small to make meaningful
sons at PCN level. The PCN range within ICS has therefore not
luded for these questions.
ote that patients cannot always distinguish between
rvices and extended access appointments. Please
results in this section with the configuration of your
vices in mind.
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e of services when GP practice is closed

LOUCESTERSHIRE

Considering all of the services you contacted, which of the following happened on that occasion?[1]

	ICS	National
called an NHS elpline, such as NHS 111	58%	57%
I used an online NHS service	23%	21%
I used a non-NHS online service, or looked online	10%	11%
A healthcare professional called me back	18%	17%
A healthcare professional visited me at home	3%	2%
I went to A&E	31%	34%
I spoke to a pharmacist	23%	20%
I used another general practice service	3%	4%
I contacted or used another NHS service	8%	8%
I contacted or used another non-NHS service	4%	4%
Can't r	8%	

Asked of patients who in the last 12 months contacted NHS services when their GP practice was closed. National (152,554); ICS 2023 (1,372)

isons are indicative only: differences may not be statistically significant

s in the past 12 months contacted an NHS service when they wanted to see a GP but their GP practice was closed.

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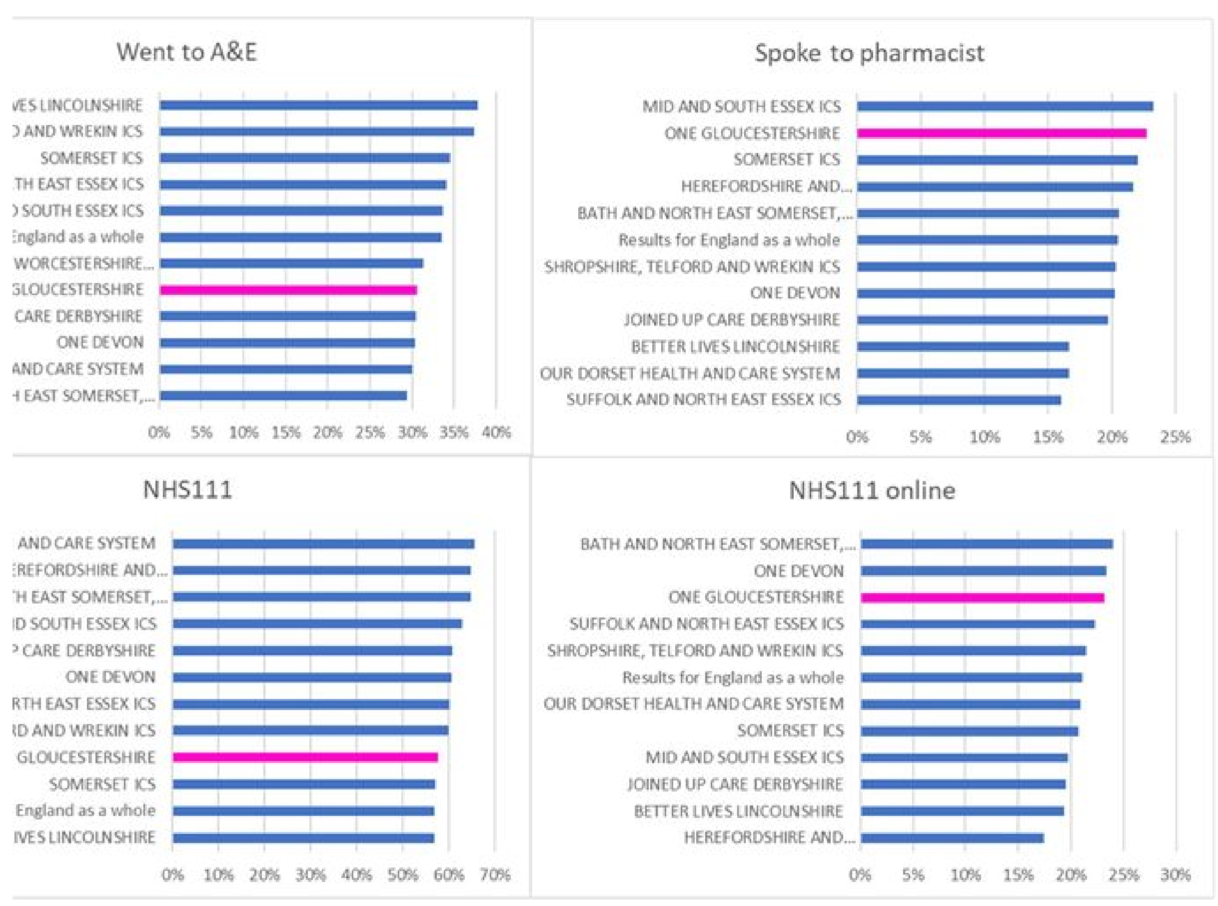
ıatives to GP – when GP was closed benchmarking against ‹
‚” 10 ICSs



Compared with our peer group, Gloucestershire has a lower % of peo stating they went to A&E and a higher people accessing pharmacy as an alternative suggesting progress in dire patients towards community services than reliance on ED as the back stop primary care.

Use of the NHS111 online service was higher compared to our peer group, w calls to the NHS111 service among th lower (but variance in proportions of patients saying they contacted the se were not large, and note that this is se reported utilisation by the group who responded to the survey).

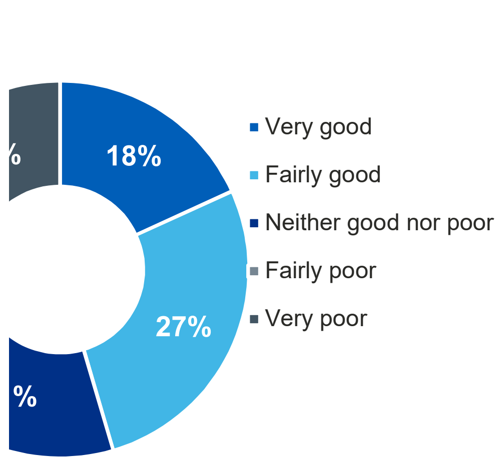
Selected outcomes for the question “What services did you access when your usual surgery was closed”.

·all experience of services when GP practice is closed

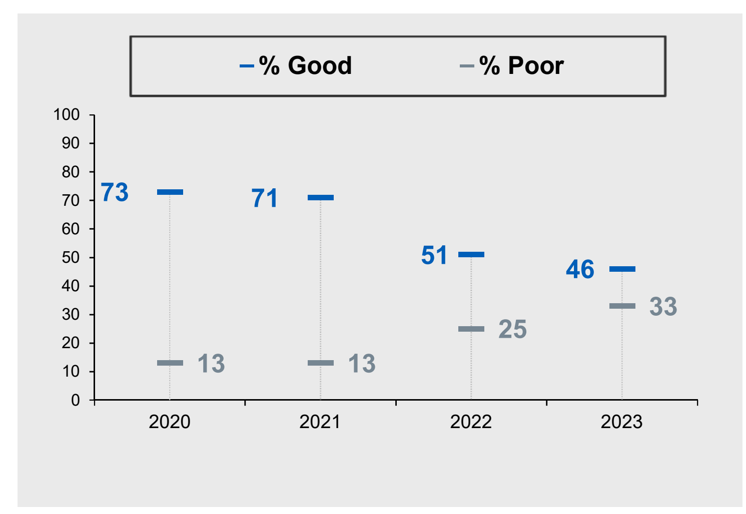
LOUCESTERSHIRE

)verall, how would you describe your last experience of NHS services when you wanted to see a GP but y ce was closed?

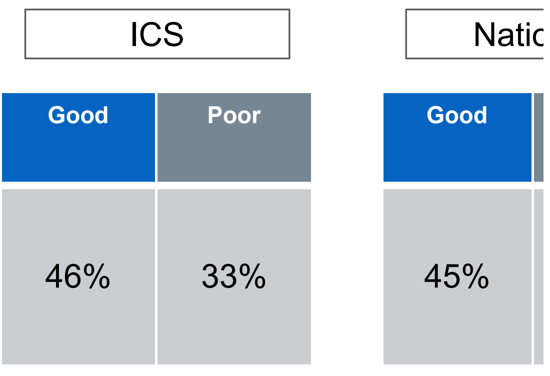
esult



ICS result over time



Comparison of results



%Good = %Very good + %Fai
%Poor = %Very poor + %Fairl

‹ed of patients who in the last 12 months contacted ices when their GP practice was closed. Patients who Don't know / can't say' have been excluded. National ; ICS 2023 (1,284); ICS 2022 (1,218); ICS 2021 CS 2020 (1,386).

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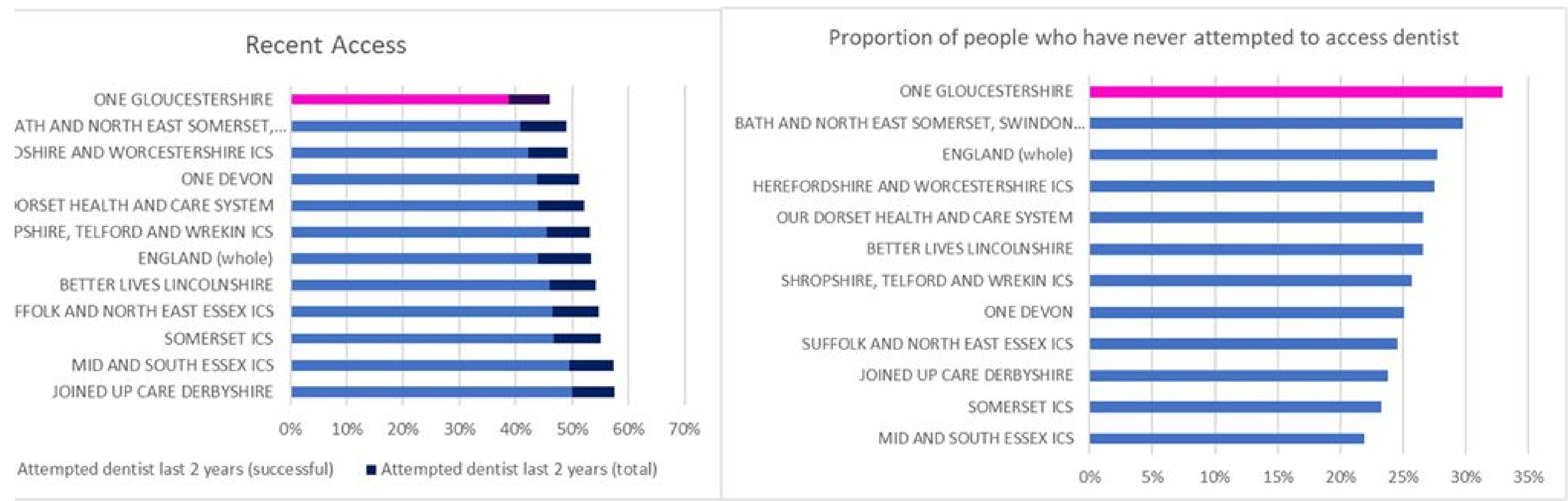
HS Dentistry
Patient Survey 2023 ICS Slidepacks | Version 1

stry Services benchmarking against our “Peer” 10 ICSs

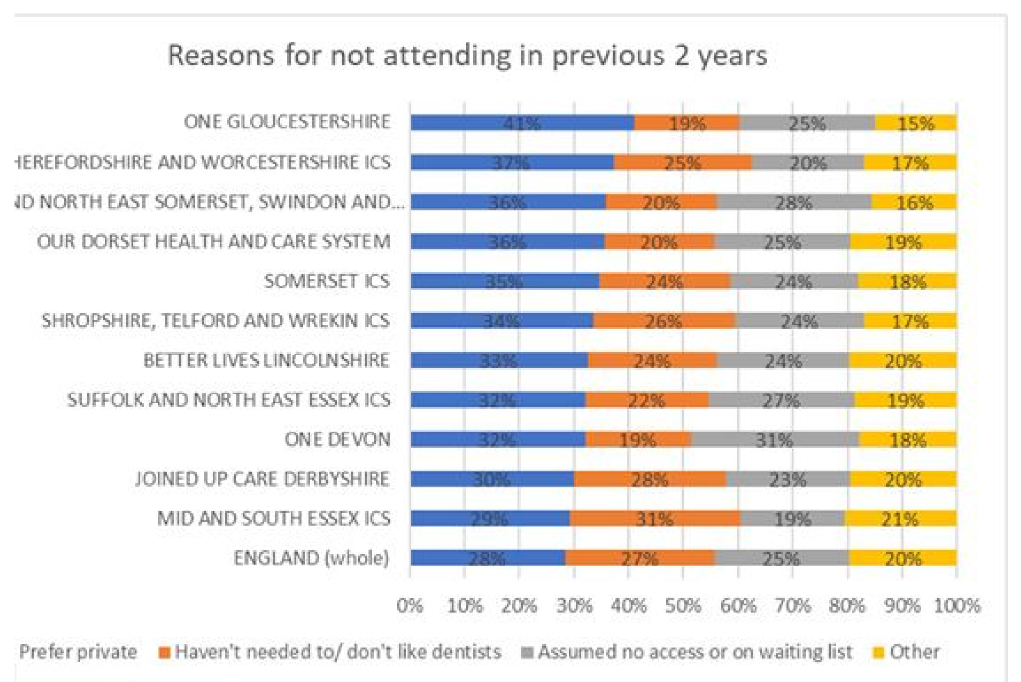


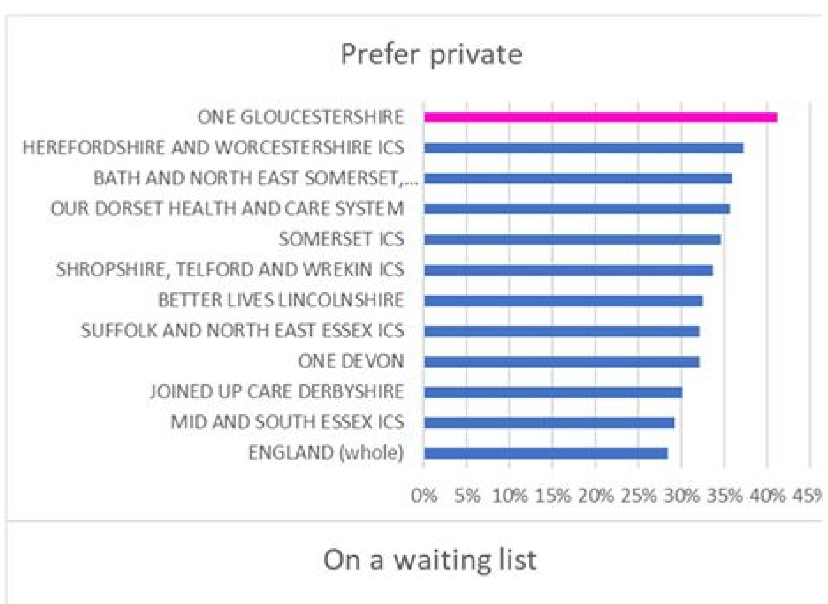
r shows proportion of all survey respondents who ted to access the dentist, and of these the % who uccessful in securing NHS services (part bar).

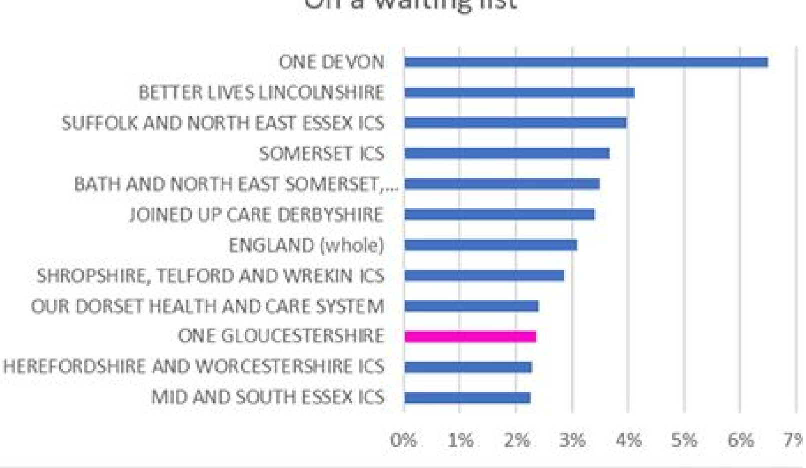
Compared to the whole peer group, Gloucestershire h highest proportion of people who have never attempte access NHS dentistry, and the lowest proportion of pe who have attempted to access NHS dentist services i last 2 years.

stry Services Benchmarking against our ," 10 ICSs

Gloucestershire people said they preferred to access private services no need of a dentist – similar to Hereford and Worcestershire and ith Essex. This is higher than other peer group areas – with stershire having the highest proportion of people choosing to access services, and one of the lowest proportions of patients on an NHS vaiting list.



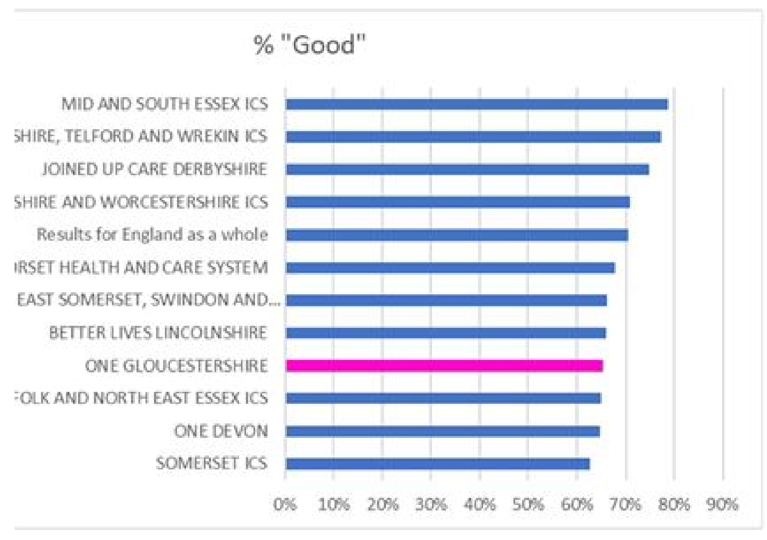


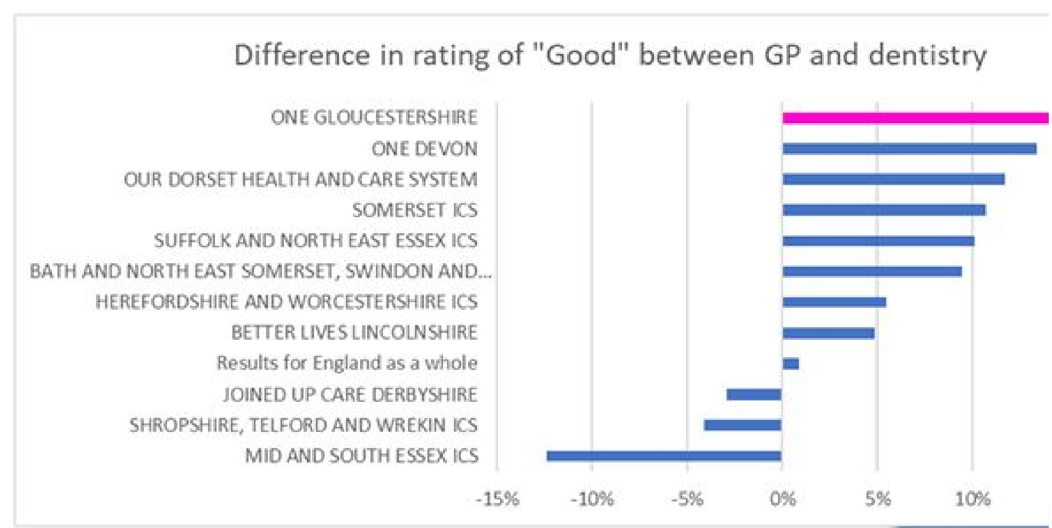


rall Dentistry erience chmarking against "Peer" 10 ICSs

Compared to other ICS peers, Gloucestershire has a lower % people rating dental services in the county as "good". Fewer rate NHS dentistry services as good compared to overall expe at GP practices in the county (65% rate dentistry good, 80% ra overall GP experience good).

This pattern is not consistent across all areas, with some area people rate their dental service more highly than their GP prac (e.g. Derbyshire, Shropshire and Mid/South Essex).





ppendix
Ipsos
Ipsos MORI
Patient Survey 2023 ICS Slidepacks | Version 1

ckground information about the survey

e GP Patient Survey (GPPS) is an **nual** England-wide survey about **tients' experiences of their GP actice** and is administered by Ipsos on half of NHS England.

e survey covers a range of topics luding:

- **Your local GP services**
- **Making an appointment**
- **Your last appointment**
- **Overall experience**
- **COVID-19**
- **Your health**
- **When your GP practice is closed**
- **NHS Dentistry**
- **Some questions about you (including relevant protected characteristics and demographics)**

- The survey provides data at **practice level** using a consistent methodology, which means it is comparable across organisations. The survey also provides data at **Primary care network** (PCN), **Integrated care system** (ICS) and **National** level.
- Minor changes were made to the questionnaire in 2023 to ensure that it continued to reflect how primary care services are delivered and how patients experience them.
- The effect of the pandemic should be taken into account when looking at results over time.

- The latest 2023 questionnaire inclu past versions, and the Technical A for further information about the su can be found here: https://gp-patient.co.uk/surveysandreports.
- Survey considerations:
  - Sample sizes at practice leve relatively small.
  - The survey is conducted ann and provides a snapshot of p experience at a given time.
- Data users are encouraged to use from GPPS as one element of evid when considering patients' experie of general practice in order to iden potential improvements and highlig best practice.

The next slide suggests ideas for how the data can be used to help to improve services.

os | GP Patient Survey 2023 ICS Slidepacks | Version 1 | Public

atistical reliability

ınts in a survey such as GPPS
ıt only a sample of the total population
st – this means we cannot be certain
results of a question are exactly the
 if everybody within that population had
ırt ("true values").

r, we can estimate the true value by
ing the size of the sample on which
re based, and the number of times a
r answer is given.

fidence with which we make this
 is usually chosen to be 95% – that is,
ıces are 95 in 100 that the true value
vithin a specified range (the "95%
ce interval").

e gives examples of what the
ce intervals look like for an ICS and
h an average number of responses, as
he confidence intervals at the national
sed on weighted data. Confidence
 will be wider when results are based
aller number of responses.

An example of confidence intervals (at national, ICS and PCN level) with an average number of responses.

	Average sample size on which results are based	Approximate confidence intervals for percentages at or near these levels (expressed in percentage points)		
		Level 1: 10% or 90%	Level 2: 30% or 70%	Level 3: 50%
		+/-	+/-	+/-
National	759,149	0.10	0.15	0.17
ICS	17,122	0.66	1.00	1.09
PCN	592	3.23	4.94	5.39

For example, taking an ICS where 17,12
people responded and where 30% gave
particular answer, there is a 95% likeliho
the true value (which would have been o
if the whole population had taken part in
survey) will fall within the range of +/-1.0
percentage points from that question's r
(i.e. between 29.00% and 31.00%).

When results are compared between se
groups within a sample, the difference m
"real" or it may occur by chance (becaus
everyone in the population has taken pa
survey).

erpreting the results

GP PATIENT SU

ıumber of participants answering each ion (the unweighted base) is stated ıch question.

mparisons are indicative only. ences may not be statistically icant.

uidance on statistical reliability, or for s of where you can get more nation about the survey, please refer end of this slide pack.

- Note on the presentation of the data:
  - A * represents a percentage greater than 0% but less than 0.5%
  - There are cases where percentages for each of the different responses to a question do not add to the combined percentage totals (e.g. 'Very good' and 'Fairly good', compared with the combined total 'Good'), or where results do not sum to 100%. This may be due to computer rounding, the rounding of weighted data, or where questions allow for multiple responses.
  - In cases where fewer than 10 patients have answered a question, the data have been suppressed and results will not appear within the charts. This is to prevent individuals and their responses being identifiable in the data.
  - Please note on pie charts where the results are 2% or less, these labels are not shown. Hovering over the segment on the pie chart will show the percentage.

- Trends:
  - 2023: refers to the 2023 survey (fieldwork 3 January to 3 April)
  - 2022: refers to the 2022 survey (fieldwork 10 January to 11 Apr
  - 2021: refers to the 2021 survey (fieldwork 4 January to 6 April)
  - 2020: refers to the 2020 survey (fieldwork 2 January to 6 April)
- Where available, ICS trends start f 2020 survey. When looking at the r over time, please bear in mind that have developed as organisations c this period, including some bounda changes.
- For further information on using the please refer to the end of this slide

rther information about the survey

survey was sent to around **2.6 ion patients aged 16 or over** stered with a GP practice in England.

overall response rate to the survey **3.6%,** based on **759,149** completed eys.

icipants are sent a **postal stionnaire**, also with the option of pleting the survey online or via phone.

GP Patient Survey is conducted on nnual basis and has been since 7.

ghts have been applied to adjust data to account for potential age and der differences between the profile of ble patients and the patients who ally complete a questionnaire. The ghting also takes into account neighbourhood statistics, such as levels of deprivation, in order to further improve the reliability of the findings.

- For more information about the survey please visit https://gp-patient.co.uk/.
- For general FAQs about the GP Patient Survey, go to https://gp-patient.co.uk/faq.
- Further information about the methodology and technical information including questionnaire design, sampling, communication with patients and practices, data collection, data analysis, response rates and reporting can be found in the technical annex for each survey year, available here: https://gp-patient.co.uk/surveysandreports.

2.6 million

Surveys sent to patients a 16 or over registered with practice in England

759,149

Completed surveys in the publication

28.6%

National response rate

ıere to go to do further analysis …

reports which show the results broken down by ICS, PCN and ctice for all questions, go to https://gp-ent.co.uk/surveysandreports - you can also see previous s' results here.

ook at this year's survey data using the interactive analysis go to https://gp-patient.co.uk/analysistool. Data can be ysed at national, ICS, PCN, or practice level.

analysis tool allows users to filter on a specific participant ıp (e.g. by age), break down the survey results by survey stion, or to create and compare results by different participant groups'.

ook at results over time, go to https://gp-ent.co.uk/analysistool/trends.

For further information about the Patient Survey, please get in tou with the GPPS team at Ipsos at GPPatientSurvey@ipsos.com

We would be interested to hear a feedback you have on this slide pack, so we can make improvements for the next publication.

os | GP Patient Survey 2023 ICS Slidepacks | Version 1 | Public

Agenda Item 9

NHS Gloucestershire ICB Board

Wednesday 26th July 2023

<table>
<tr><td>Report Title</td><td colspan="4">Integrated Performance Report</td></tr>
<tr><td>Purpose (X)</td><td>For Information</td><td colspan="2">For Discussion
X</td><td>For Decision</td></tr>
<tr><td rowspan="3">Route to this meeting</td><td colspan="4">N/A</td></tr>
<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>
<tr><td>Executive Summary</td><td colspan="4">This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for July 2023. The report focuses on our closing position for 2022/23 (where information is available).
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>
<tr><td>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>
</table>

<table>
<tr><td rowspan="2">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></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

July 2023

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Integrated Performance Report Contents

Page	Title
Feedback from Committees	
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4	People Committee (Workforce)
5	Quality Committee (Quality)
Summary of Key Achievements & Areas of Focus	
7	Performance
8	Workforce
9	Quality
10	Finance & Use of Resources
Detail of Key Achievements & Areas of Focus	
11 – 17	Performance: Improving Services & Delivering Outcomes
18 – 19	Workforce: Our People
20 – 28	Quality: Safety, Experience and Effectiveness
29 – 41	Finance and Use of Resources: Gloucestershire Integrated Care System (ICS)
42 - 51	Finance and Use of Resources: Gloucestershire Integrated Care Board (ICB)
Supporting Performance and Workforce Metrics – see document here.	

System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	6th July 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Health Economics – Board Development Session follow on	N/A	Committee reviewed the feedback from the Board Development session on health economics. It considered the definition of value for the ICS and the practical application of approaches to allocative efficiency (looking at the value created from interventions within a pathway) and technical efficiency (looking at how we ensure that value is being created by core services).	Agreed to circulate feedback from the Board Development session to ICB. A follow on session will take place with ICB in the Autumn.	November 2023
Medium-Term Financial Plan	Limited	Committee discussed initial work underway on the Medium Term Financial Plan and work being undertaken to contribute towards this – including work on the run-rate, benchmarking and August workstreams.	Follow up work being undertaken with system partners on the Medium Term Financial Plan including work to ensure ownership by programmes	October 2023
Benefits Realisation and Evaluation	Limited	Committee considered the work being undertaken to prepare for Autumn benefit reviews to assess the impact of key schemes & services.	Preparatory work to be undertaken on Autumn benefit reviews with the support of a newly established Evaluation Task and Finish Group	November 2023
Performance	Limited	Committee received an update on monitoring arrangements against the Joint Forward Plan commitments. Reports provided detailing performance across priorities for 23/24 were received including performance impacted by industrial action although some stabilisation in urgent care.	Continued support to, and monitoring of delivery through programme boards. September IPR will monitor against specific Joint Forward Plan commitments.	Ongoing
Finance	Limited	Committee received an update on the audited outturn position for the CCG/ICB in 2022/23 as well as the current financial outlook for 2023/24 including a breakeven financial forecast. However, financial pressures were highlighted including industrial action, workforce and inflation.	Continued delivery of the savings programme across the system for 23/24 and mitigation of cost pressures as highlighted within the Integrated Performance Report.	Ongoing

Assurance Level	Colour to use in risks/actions below
Not assured	We are not assured as to the adequacy of current action plans. If red, commentary is needed in “Next Actions” to indicate what will move the matter to “full assurance”
Limited	We are assured appropriate action plans are in place to address any gaps
Significant	We have a high level of confidence in delivery of existing mechanisms / objectives
Full	Delivered and fully embedded

Issues referred to another committee

Topic	Committee
None	None

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

Issues referred to another committee

Topic	Committee
None	None

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	7th July 2023

Issues identified at the Committee

On 7th June the Quality Committee was repurposed as an exploratory workshop to talk about priorities and risk. However, the discussion identified that a fuller session was needed in a facilitated workshop. This has been arranged for 20th July. As 'Business as Usual' was not covered, the previous key areas have not been updated.

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.	Deferred to next meeting
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.	Deferred to next meeting
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 during the transition.	The GICB had asked for a Transition Plan but there were still concerns around the data quality and any concerns encountered should be swiftly escalated through the appropriate channels.	Deferred to next meeting

Assurance Level	Colour to use in risks/actions below
Not assured	We are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Limited	We are assured appropriate action plans are in place to address any gaps
Significant	We have a high level of confidence in delivery of existing mechanisms / objectives
Full	Delivered and fully embedded

Issues referred to another committee

Topic	Committee
None	None

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)

Summary of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- The Eating Disorder service has made good progress in reducing waits across both adult and children and young people's (CYP) waiting lists. In May the CYP urgent access target was met with 100% urgent referrals being seen within one week. The overall number of people waiting for treatment from the service has significantly reduced and new triage processes ensure people are offered self-help or support far more quickly.
- Good progress has been made in reducing the number of patients waiting over 62 days for cancer treatment or for cancer to be ruled out. In June, patient numbers declined to 162 against a trajectory of 190.
- The continued achievement of the Fast Diagnosis 28 day standard is supporting the ability to make progress against the Early Diagnosis targets for cancer – GHFT were 17/140 providers for performance against this standard in May 2023.
- The UEC transformation programme has now launched, with workstreams currently being set up and system wide working groups in place.

Areas of Focus

- Industrial action continues to put significant pressure on both Urgent and Emergency Care and elective recovery across the system. As is the case across the country, significant numbers of patients have had inpatient and outpatient appointments cancelled and the extended period of industrial action by junior doctors and now consultants has impacted upon our elective recovery trajectories and makes the achievement of national long wait standards more challenging.
- Nationally the decision has been made to reduce the Elective Recovery Fund target by 2% in response to industrial action – how this will impact Gloucestershire is under review.
- Deterioration in diagnostic performance has seen the proportion of patients waiting more than 6 weeks increase to above the interim 23/24 target of 15%. This is predominantly driven by endoscopy and echocardiography. A task and finish group to support endoscopy has been formed, beginning to meet in July to determine an action plan, while additional capacity in echocardiography has begun in the community diagnostic centre.
- Plans for primary care recovery are in development, with the primary care team working closely with PCNs and the digital team to meet the expectations set out nationally for plan submissions and development of improved online/ telephone access for patients.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Steering Group Plans:
- 2023/24 Plans on a Page indicating priorities have been agreed at the OD, Education and Training and Workforce Steering Groups.
- The plans will sent for ratification to the next People Board (August)

Health and social care career promotion:
- 'We want you' outreach project team appointed. Preliminary scoping underway
- Scoping of existing and potential initiatives to promote health and social care careers across Gloucestershire by the people team. This will be reviewed and discussed at the steering groups. This will inform the implementation plan for the people strategy.
- Partner marketing supplier appointed for "Be in Gloucestershire recruitment campaign" and engagement commenced (pilot will in Primary Care workforce, particular focus on GPs)

ICS People Strategy Development
- Further engagement workshops held and draft shared with Steering Groups and feedback incorporated
- Most recent draft of strategy published and shared with ICS People Board and People Committee including 'Strategy on a Page' Summary.
- People Delivery plan agreed (based on Plans on a Page)

Development Programmes
- UEC systems thinking masterclass cohort completed, further cohorts (3 and 4) being promoted for Oct-Dec delivery
- Reciprocal Mentoring cohort 2 commenced, planning for further cohorts underway

Areas of Focus

NHSE Funding:
- Confirmation of workforce development funding for 2023/24 received (£310k). PIDs against the funding to be reviewed by Steering Groups and People Board prior to submission to NHSE for approval.
- Confirmation of CPD funding for Trusts 2023/24 received (£1.168m). Plans for spend being reviewed and agreed by Trusts.
- Offers of funding from NHSE will be reviewed against Plans on a Page and only those bids that align with these will be submitted.

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
- Align NHS Long-term workforce plan with local strategy and priorities
- Preparation of final Draft for approval by ICB board.
- Development of detailed implementation plans.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality

Key Achievements

- The warning notice has now been lifted in the most recent CQC report for Gloucestershire OOH (PPG).The rating will remain the same as the last visit for now, as the CQC have not conducted a full re-inspection at this point. However, the lifting of the warning notice represents progress made in the meantime.
- Training is being arranged for the whole system in relation to the new Patient Safety Incident Response Framework.
- Recruitment to clinical posts within mental health inpatient services is showing an improving position.
- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has remained within expected levels for Oct to Dec 2022 following the period of being an outlier between June 2022 to Sept 2022.

Areas of Focus

- The Patient Transport Advice Centre (which provides eligibility assessments for Non-Emergency Patient Transport) has experienced staffing difficulties, resulting in patient's waiting an excessive time. BSW ICB and Gloucestershire ICB have written to PTAC requesting an improvement plan.
- Gloucestershire ICB completed a site visit to Wotton Lawn Hospital on 31st of May. Following a Rapid Review Meeting on the 1st of June, services at Wotton Lawn Hospital will enter a period of enhanced surveillance and quality monitoring with a standing item on the System Quality Group.
- The LMNS and GHT are undertaking a gap analysis regarding the actions for ‘Ockenden 2’.

Finance and Use of Resources

Finance

- The ICS position as at month 3 2023/24 is:

	Year To Date (£k) (Overspend) / Underspend	Forecast Outturn(£k) (Overspend) / Underspend
GICB	275	0
GHFT	(884)	0
GHC	(74)	0
Total Surplus / (deficit)	**(683)**	**0**

- The ICS is currently facing a number of significant financial pressures. These include:
  - Impact of industrial action on operating costs and activity levels.
  - Workforce pressures leading to high expenditure on agency and locum staff
  - Ongoing inflationary pressures – pay and price and demand and growth pressures, particularly high cost placements.
  - Slippage in the delivery of savings plans
- Current pressures have been mitigated through primarily non-recurrent savings, slippage in investments and 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.
- The 22/23 audited annual accounts for NHS Gloucestershire ICB were submitted on 30th June. The ICB's final position was an in-year surplus of £6.9m; this is an increased surplus compared to the submitted draft accounts with the auditors challenging the accounting treatment of s256 agreements which will now fall as expenditure in 23/24.
- Within the ICS's capital envelope, YTD capital expenditure has a variance of £5.7m against the budget for the year, which mainly relates to early year slippage against schemes. The forecast is for system capital allocation funded schemes to recover by year end.
- Agency costs in month 3 are below the straight line value of the agency cap for the system.

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)

Detail of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Urgent & Emergency Care

- The UEC system has seen more stable performance over the last few weeks, with good progress on reducing ambulance handover delays and total hours lost. While emergency admissions have remained stable, there have been increases in both ED attendances and ambulance conveyances to ED specifically in June. Emergency Department (ED) type 1 performance in June 2023 was 59.7% against the 4-hour target. Whole system performance including Type 3 (MIIU) attendances was 74.7% in June. This represents a slight decline in performance, predominantly caused by challenging days in the week leading up to the junior doctor's industrial action (14th-17th June), which saw high demand, particularly due to increased respiratory symptoms caused by asthma and hot weather.

- Ambulance handover delay performance has just missed the trajectory for improvement in June 2023 – with a total of 2201 hours lost (against a target of 2068), and an average Cat 2 response time of 45 minutes. While this is a deterioration on May's performance, again this was predominantly due to pressure in the w/c 5th June, leading to significant performance challenges that were quickly resolved by the system.

- The UEC transformation programme has now launched, based around the Newton Europe review held last year, with workstreams initially focussing on gathering data and setting up governance. Cross system representation is in place on all key workstreams to ensure a joined-up approach. A key focus of the transformation programme is to support the UEC workforce, with the ambition for staff to feel less pressured, and have tangible time for reflection, development, and improvement. This will translate into improved care for patients and patient outcomes as staff feel more empowered and have improved health and well-being.

- Acute respiratory hubs have been set up in Gloucester and Cheltenham to help reduce the pressure on primary care and ED/MIU sites. Patient surveys have shown ED attendances have been avoided – more than 20% of patients would have visited ED if the service had not been available. Further evaluation will determine the future model – in particular for standing up again during winter and including widening access for Asthma and COPD.

- Further industrial action by Junior Doctors is taking place from 7am Thursday 13th July through to 7am Tuesday 18th July. Senior doctors (consultants) will then take part in industrial action from 7am Thursday 20th July to 7am Saturday 22nd July. Contingency plans have been put in place including the step down of CGH ED to an MIIU at 8pm 11th July through to 8pm 12th July. CGH ED and MIIU will then close from 8pm 12th July to 8am 18th July when normal BAU will resume. Public facing information/DoS/MiDoS will all reflect the changes to ensure safe patient flow.

Improving Services & Delivering Outcomes

Elective Care

- As of May 2023 Gloucestershire ICB commissioned value waited activity is 96.6% of 2019/20 against a plan of 109.5% (including pathways avoided). Year to date performance is 97.3% - note this data is flex and will likely increase, however there is significant gap in performance to target. Currently, the majority of underperformance is being driven by GHFT, where T&O, Gastroenterology and General Surgery are below plan, with lower numbers of Non Trauma procedures and Endoscopies being carried out in particular.

- The waiting list for elective care has been growing throughout 22/23, and saw significant increases in April 2023 (rising to 79,136 for all ICB patients waiting – an increase of 6899 on March). This is pre-dominantly due to the change in reporting due to the change in in responsibility for specialised commissioning (ICB reporting now includes dental and additional cancer pathways which were previously counted under NHSE patients). In May 2023 the overall waiting list size has risen to 79,709, with two specialties (ENT and T&O) accounting for 17,551 of the patients waiting. Review of patients waiting on multiple waiting lists is underway to explore how to support patients in a more joined up manner, and the elective care hub continues to offer support and signposting to services that may help, such as the community wellbeing service.

- Long waits (over 52 weeks) have risen with 2729 patients waiting more than a year in May 2023, and 429 waiting more than 65 weeks across all providers to the ICB. The ambition for 23/24 is to eliminate over 65 week waits, with continued focus on reducing elective long waits a commitment locally and nationally. GHFT continue to see no patients waiting over 78 weeks at month end.

- The planned industrial action 13th July - 18th July will have a significant impact on elective care, in particular the consultant industrial action. In common with previous industrial action, this will have a significant impact on elective recovery rates and achievement of the Elective Recovery Fund target in line with operational plans. Regional/ national approach to consideration of industrial action and ERF targets is under discussion.

- The new Chedworth Day Surgery Unit in Cheltenham was opened in May and has been successfully providing better and new/ expanded day surgery capacity in Cheltenham. The unit has been designed to include pods rather than beds, so will provide a protected day surgery environment in Cheltenham through winter to allow continuity of elective capacity.

- Further system work is taking place (co-ordinated by the Planned Care Delivery Board) to understand areas of under achievement at specialty level and to agree recovery actions. These will be supported by the additional ERF investment which has already been put in place.

Improving Services & Delivering Outcomes

Cancer

- May performance against operational planning commitments for cancer waits has met targets, with the number of patients waiting more than 62 days reducing at GHFT to 162 (May average, against a target of 190 set in operational planning), and 28 Faster Diagnosis standard achieving the 75% target with performance at 81.4%.

- 2 week wait performance also achieved the 93% target with 95.8% of patients seen within 2 weeks of referral on a cancer pathway. Treatment target waiting times were missed narrowly for 31 day treatments. The 62 day PTL has reduced in line with planning commitments, reaching 188 patients waiting over 62 days for treatment or discharge (against a target of 195 for May).

- Non specific symptom (NSS) referrals remained stable at 23 in April 2023, against a target of 43 – however the pathway is now fully operational and open to all PCNs, with NSS clinicians having visited all PCNs except Berkeley Vale and Severn Health to promote the pathway.

- Screening performance had been recovering since the pandemic and remains among the highest uptake in the country across all 3 sites, however there has been some deterioration in breast and cervical screening uptake in recent months. Changes to the invitation (letters sent without an appointment booked) are likely to be responsible particularly for the breast screening decreases, and the region is updating its protocol to revert to having a default appointment in the invitation letter to hopefully reverse this trend.

- Non specific symptom (NSS) referrals have risen slightly to 29 in May 2023, against a target of 48 – the pathway is now fully operational and open to all PCNs (by mid-July), with NSS clinicians having visited all PCNs except Berkeley Vale and Severn Health to promote the pathway. A service and patient experience evaluation for the NSS pathway is planned for July.

- The cancer team is working with community mental health teams to add screening uptake to health checks for people with Learning Disabilities or Serious Mental Illness based around successful roll out of the approach in Dorset. This will enhance the current offer to improve proactive care and increase early diagnosis in these groups.

Improving Services & Delivering Outcomes

Primary Care

- Following the publication of the GP Access Recovery Plan, the primary care team are working on how Practices and PCNs can support the increase in demand within Primary Care. The plan focuses around four areas: 'Empower Patients'; Implement 'Modern General Practice Access'; 'Build Capacity'; and 'Cut Bureaucracy'. A project plan has been developed to monitor progress of the requirements and summary of progress to date has been shared with NHSE. The ICB are required to report on progress of the Delivery plan to ICB board in November 23 and again in April/May 24. System Development Funding for 23/24 has been released which is proposed to support some of these workstreams.

- The primary care team are exploring the offers from NHSE around telephony and online access arrangements, supported by the digital team. The General Practice primary care strategy is being refreshed in line with the Delivery Plan expectations, while the team is also working to develop the local dental strategy and community pharmacy strategy working with local stakeholders following delegation of Pharmacy. Optometry and Dental (POD) responsibilities.

- Primary care remains busy, with 344,695 appointments carried out in May 2023 – with total year to date activity above planned levels for 23/24. PCNs have been required to submit Capacity and Access improvement plans to the ICB which support the implementation of the Delivery Plan. All PCNs submitted a baseline plan on 30th June. The ICB will review and provide feedback before final agreement by the 31st July deadline.

- A caretaker contract is now in place for Drybrook Surgery to allow the surgery to remain open, providing interim arrangements for 6 months and the tendering process for a new contract has begun – with the contract currently out to advert.

- The Inner-City respiratory team, based at Gloucester Health Access Centre, were announced as winners of the Association of Respiratory Nurse Specialists Excellence Award for Outstanding Contribution to Respiratory Care. The respiratory hubs have been widely acknowledged for their positive impact for patients as well as supporting the system in avoiding use of emergency care.

Improving Services & Delivering Outcomes

Diagnostics

- Despite an increase in diagnostic activity delivered in May 2023, the waiting list has grown and performance has declined moving from 11% reported in April 2023 to 15.8% in May. Activity is likely to be higher than reported figures due to non-submissions by high volume independent sector providers (in NOUS).

- Performance is slightly above the national ambition for all diagnostic modalities (to have less than 15% of patients waiting over 6 weeks by March 2024). GHFT overall performance in May was 14.3%, therefore meeting the target.

- The main areas of challenge for diagnostics are across endoscopy modalities with flexi sigmoidoscopy activity in particular dropping significantly in May. A dedicated endoscopy task and finish group has been stood up reviewing endoscopist capacity, elective and cancer demand, and estates across GHFT. The group will look specifically at the booking process and productivity in order to identify areas for improvement.

- May also saw performance deteriorate in Echocardiography which had recovered well at the end of 22/23 through use of independent sector provision (now ceased). The waiting list for this modality has increased in the last two months, and due to difficulty in securing permanent staff, monthly capacity has declined from the pre-covid position. Additional capacity via the Community Diagnostic Centre was due to start in April 2023 to support ongoing performance however this deployment slipped to June. With two additional locums now in place, performance should recover in the coming months and the cardiology service have implemented an action plan to mitigate these performance issues.

- Issues with the new radiology PACs system at GHFT had been expected to affect breast cancer pathway performance in May in particular, however this has not fed through into the data. This will be kept under review in the coming months.

Improving Services & Delivering Outcomes

Adult and Children's Mental Health

- The rate of out of area placements gives an indication of the ability of the system to respond to patients in crisis – where we see placements rising, this indicates more congestion in the system with higher reliance on procuring alternatives to local care options. The planned ambition for out of area placement days is 800 over the course of the year, with performance for April and May exceeding plans as the system declared no external placements (resulting in zero OOA placement days). While June data is yet to be confirmed, 5 placements were started in out of area settings in June (number of days to be confirmed).

- 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. Q1 23/24 data has just been reported to NHSE with performance maintained at 57%. There is ongoing work to ensure community mental health tams are also promoting cancer screening as part of these checks, and that data sharing is improved between primary and secondary mental health care to facilitate timely reminders and support for patients to attend health checks.

- Improving Access to Psychological Therapies (IAPT) access is at 1039 for May – below the rate required to reach the Q1 ambition set in the operational plan. Referrals remain low, with drop outs higher than planned also contributing to the difficulty in reaching planned access targets. The service has continued advertising across a number of mediums, and has implemented a digital choose and book system to improve appointment booking (especially for self-referrals). Recovery performance remains above target, with 51.3% patients achieving reliable recovery in May.

- Eating disorders – the proportion of patients assessed within target has improved significantly in the first quarter of 23/24. The May position (latest validated data) shows that for adults, 84.6% received assessment within the 4 week target. The target for CYP with an urgent referral to be seen within 1 week was met in May (5 cases, all seen within 1 week) for the first time since September 2020. While routine referrals for CYP achieved 30% (seen within 4 weeks) against a target of 95%, this represents significant improvement as the service is continuing to work through the backlog of less urgent cases – there are now 72 patients waiting for routine assessment, down from 209 at the highest point (June 2022). The service continues to offer support to those waiting, including provision of alternative services by VCS providers, and has implemented a referral triage process whereby all patients receive a phone call within 24 hours of referral so that appropriate support and self help can be offered.

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)

Detail of Key Achievements & Areas of Focus

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People

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

Growing for the Future

- International Recruitment bid for (domiciliary) care workers submitted to NHSE and Joint Commissioning Partnership Executive
- System-wide Recruitment events for healthcare support workers and estates and facilities being discussed
- Staff accommodation support proposals being developed with regional collaboration and NHSE support

Looking After Our People

- Recruitment to system-wide legacy mentors underway to support retention (pastoral care)
- Health and Wellbeing - proposal being discussed to develop a shared system staff health and wellbeing post recruitment check-in

Belonging in the NHS

- ICS wide Reciprocal Mentoring programme cohort 2 underway. Planning for further cohort commenced.
- ICS Leadership Development Programme Lead being appointed in order to map line management and leadership development provision across the system to understand what is on offer, the scope for collaboration & potential benefits and understand the links to the Messenger review to inform future needs.

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.
- Multiple NHSE funded training and education projects are underway to upskill community and social care workforce to support a reduction in referrals into primary care – examples include upskilling in end of life care, oral hygiene and diabetes.

Improving Services & Delivering Outcomes (Our Performance)

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The Quality Directorate continues to receive the NHSE SW Commissioning Hub Monthly Information Pack and have recently received the first Pharmacy, Optometry and Dental Quality Report for Q4 2023. The SW Collaborative Commissioning Hub (CCH) Quality and Safeguarding Team deliver the quality monitoring and assurance function across POD services on behalf of the seven ICBs and by agreement with the system quality leads, the CCH quality and safeguarding team will provide quarterly reports summarising key quality risks and issues, areas for improvement and learning. The ICB will be notified by the CCH of any significant quality issues when they occur.

- The Q4 report notes that no significant quality risks, issues or concerns have been identified in Q4. There have been low return rates for community pharmacy, optometry and dental safeguarding surveys and the CCH plan for integrated performance, quality and complaints reports to be produced moving forwards.

Transport

- Ezec and ERS Medical have now merged to become E-Med and now provide all of the main contract Patient Transport Provision. The Gloucester Depot was recently inspected by the CQC who have rated them Safe (Requires Improvements), Effective (Good), Caring (Good), Responsive (Good) Well-led (Good). The provider is currently in discussions with CQC as they disagree with the rating for 'Safe'.

- The CSU provided service the 'Patient Transport Advice Centre' (PTAC) is commissioned by five ICBs to provide eligibility assessments and transport booking. The service has been struggling to answer calls effectively which has led to patient complaints. Gloucestershire and BSW ICBs have formally written requiring improvement plans. All south-west ICBs who commission the service are working collectively to support PTAC to make improvements.

Urgent and Emergency Care

- Work continues to systematically redesign the way care is delivered in the One Gloucestershire system, including a Paediatric Urgent Care Event planned for July to explore recent system data and pathway assessments for Children's Urgent Care.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Community and Mental Health

- Following recent media reports, the Gloucestershire ICB Deputy Clinical Quality Director completed a site visit to Wotton Lawn Hospital on 31st of May. Following a Rapid Review Meeting on 1st of June, services at Wotton Lawn Hospital will enter a period of enhanced surveillance and quality monitoring with a standing item on the System Quality Group that will oversee implementation. The ICB Quality Committee will also receive updates on progress as will regional NHSE.

- Of note is the improving position with recruitment to clinical posts within mental health inpatient services, the widening implementation, following the successful introduction, of patient safety dashboards and a comprehensive and focussed piece of work being carried out at Charlton Lane Hospital around falls prevention which will have a positive impact for patients throughout the Trust. GHC continues to make good progress with the actions arising from the CQC core inspection which are now 96% complete.

Maternity

- Two final HSIB reports were received in April, both of which identify recommendations for GHFT. These recommendations will be implemented & 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 has been closed due to staffing difficulties since 30th September and is 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

- 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 May and June 2023

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

Incidents declared under the current framework

The previously declared Never Event by NewMedica has now conclude the investigation with a robust action plan in place.

Patient Safety Incident Response Framework (PSIRF)

The PSIRF is expected to replace the Serious Incident Framework in Autumn 2023.

Providers operating NHS commissioned services under the NHS Standard Contract need to create a response plan which must be agreed by the ICB. These will be taken to the Quality Committee for ratification later in the year, once they have been approved by provider organisation boards.

As part of the introduction of PSIRF we are working with GHC and GHFT to roll out system wide training to all parts of the ICS so that we take advantage of economies of scale and ensure that everyone has the same baseline knowledge.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Learn from Patient Safety Events (LFPSE)

To support PSIRF NHSE have launched the new LFPSE system. While larger providers with local risk management systems (LRMS) are working to flow information automatically, smaller providers and primary care will be able to use a webpage. So far only SWAST are reporting to LFPSE and have recorded 496 events in the south west. 'Events' include, incidents, risks, outcomes and good care.

NHSE will shortly be launching a BI module to allow us to view incidents at ICB level.

At a local level, we are currently working with the Urgent Care Team on a trial to test how the system can be used to flag concerns and issues with D2A beds.

Eventually LFPSE will take over from the NRLS and Quality Alert system we current use.

The table below shows general progress with PSIRF and LFPSE implementation:

Provider/ Sector	PSIRF understood	PSIRF Plans in development	LFPSE integrated in LRMS	Risks
GHFT	✓	✓	Yet to switch to Datix cloud	Datix are yet to send updates. Risk of missing national deadline.
GHC	✓	✓	Yet to receive updates from Datix	
Independent Sector providers	✓	✓	Some compatibility	Providers not using Datix report compliant systems for LFPSE and corporate PSIRF Plans
Very small providers	Some areas	Will use a template approach	Will use webform	Lack of knowledge and capacity to make systemic changes by the autumn

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%	

- 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 above.

** March 2023 data are not available at the time of preparing this report.*

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

- **Friends and Family Test results April 22 – February 23**
- National GP Patient Survey (GPPS) – 2023
- The national GP Patient Survey results for 2023 were published on 13 July 2023.
- ICS, PCN and individual GP practice level results are available on the GPPS website: https://gp-patient.co.uk
- We no longer receive a ranking by GP practice across the county.
- One Gloucestershire Headlines:
  - Maintaining above national average results
  - ‘Good’ results have dropped or stayed the same since last year (Nationally and in Gloucestershire)
  - As in previous years there is wide variation between PCN results – with Core 20 areas reporting lower satisfaction
  - SBV PCN areas results are consistently higher than the ICS average
  - Below national average for going to ED when GP practice closed or not able to get an appointment
  - Slightly above average use of 111 and speaking to a pharmacist when GP practice is closed

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

System Clinical Effectiveness Group

- The System Clinical Effectiveness Group (SCEG) was held on Monday 10th July
- GHT and GHC both gave verbal updates and progress reports on CQUINS and Audits
- There was a discussion on tissue viability and pressure ulcers. Instances are currently increasing across the system, thought to be related to longer waits at different points in the pathway reducing tissue viability. Prevalence is now at 13% worldwide so this is not a local issue.
- Staff training and knowledge remain at good levels. However the application of this knowledge can be challenging due to staffing and equipment, there is an opportunity to understand this better with the rollout of PSIRF. It was agreed to set up a task and finish group on Tissue Viability and to include wider system partners, including the care sector, community and public health
- It was agreed to look at Mortality and where we benchmark with other systems at the next Clinical Effectiveness group and to look at Audit across the system and where we have synergies.
- There were no new policies to review

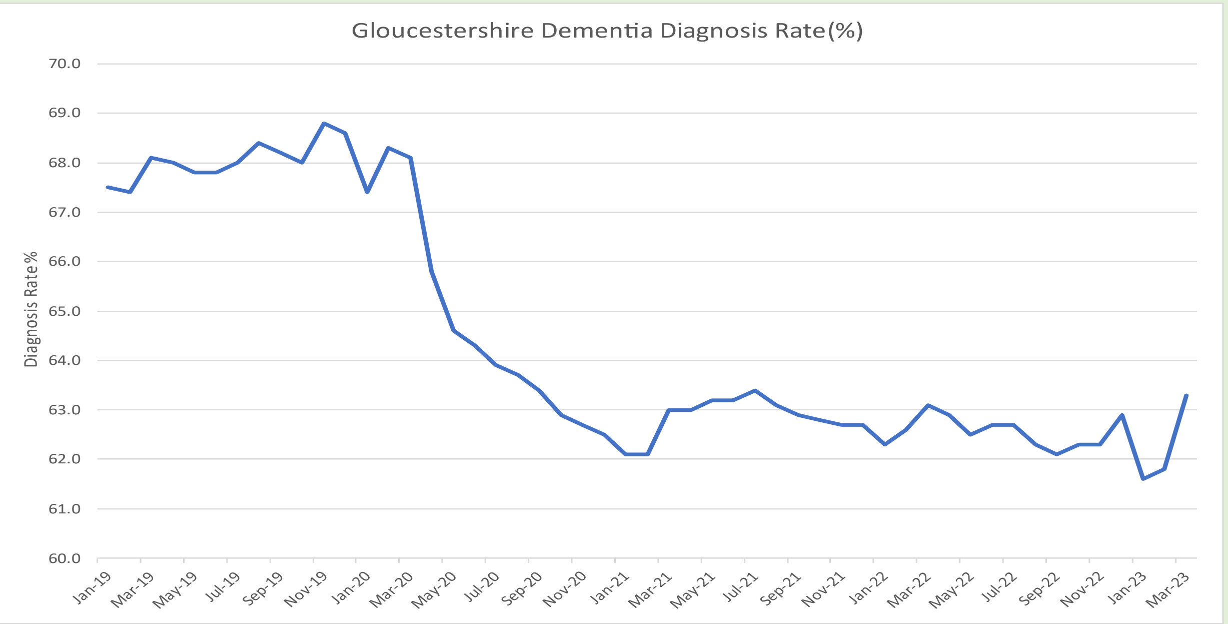
Quality – Safety, Experience and Effectiveness

Please note: The Quality report is updated bimonthly.

Effectiveness

Mortality

- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has remained within expected levels for Oct to Dec 2022 following the period of being an outlier between June 2022 to Sept 2022.
- Dementia diagnoses coding appears to be influencing mortality data and may be negatively affecting SHMI data. Diagnosis rates dropped dramatically at the start of the pandemic and have not recovered, often resulting in coding being affected through emergency admissions to GHFT. (See chart below)
- GHFT is currently undertaking further analysis in with a discussion tabled for the August system Mortality Group



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Detail of Key Achievements & Areas of Focus

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Finance and Use of Resources

Financial Overview & Key Risks

- The financial plan for 23/24 is a breakeven position for the system, and for each System organisation, this included a high level of savings and also a number of non recurrent financial savings, efficiencies and income.
- The ICS year to date financial position at month 3 2023/24 is an overspend versus plan of £683k. This is attributable to the net costs of industrial action incurred within GHFT, any potential lost Elective Recovery Funding (ERF) is not included in this number. The national target for elective recovery is being reduced by 2% to enable systems to cover the cost including lost ERF due industrial action in April. The impact of this change is currently being worked through. The overall risk of clawback due to underperformance against ERF for the system is 16%.
- The year end forecast out-turn is breakeven versus plan. Pressures and risks are emerging across the system relating to workforce costs including agency costs and the pay award, inflation, medicine costs, placement costs and in respect of the ability to deliver planned savings. The impact of the change to the year end accounts is currently being worked through. Organisations, supported by Directors of Finance are reviewing a range of actions to mitigate financial risks and also to support system financial control when expenditure run rates are out of line with budgets.
- System savings and efficiency plans are forecasting full delivery by year end. However, there are a number of risks within plans and non recurrent savings are being developed to help offset the risk of slippage in implementation. Risk ratings associated with full year delivery across the system remain at medium
- The system is developing a more detailed medium term plan following on from the Joint Forward Plan with an underpinning medium term financial plan, this process will include more detailed planning for 2024/25 including mechanisms to deliver a breakeven financial plan, as well as a recurrent breakeven position within the 3-5 year medium plan period.
- The year to date capital expenditure is £5.7m behind plan due to early year slippage across a number of schemes. The full year forecast is for catch up of slippage in respect of system capital allocation funded schemes and expenditure to be fully in line with plan.
- **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 financial performance particularly within GHFT. Vacancies, absence, operational pressures and, within GHFT, industrial action have led to increased use of bank and agency staffing as well as costs associated with ongoing recruitment and resultant pressures on existing staff when temporary staff cover shifts. Each organisation has implemented and is continuing to implement systems and controls to manage workforce; these include changes to processes to bring substantive staff into post more quickly, standard operating procedures for agency use plus increases in lead in times to enable better planning of shift and therefore bank and agency use. E-rostering for nursing is in place within both organisations.

- Both GHFT and GHC have international recruitment processes underway and an additional business case for non recurrent investment in 23/24 for additional overseas recruitment has been developed by GHFT; this case is being reviewed but should deliver an increase in substantive staffing and a reduction in agency costs in 24/25.

- The cost of recent industrial action is being impacted predominantly within GHFT. The year to date net cost is £683k. No assumptions have been made about the cost of future industrial action and these therefore represent a risk to the system position in terms of managing any costs.

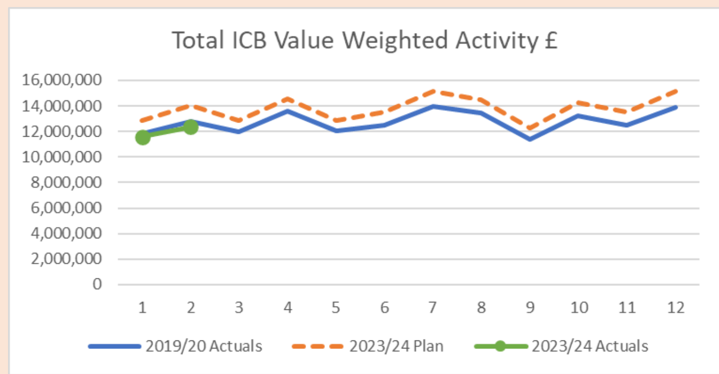
Finance and Use of Resources

Financial Overview & Key Risks

Key Financial Risks

- The 23/24 financial plan includes an assumption that Elective Recovery Funding (ERF) will be fully received in 2023/24 and the System has invested in a number of areas within GHFT, including the two new theatres in order to achieve the elective target. Systems have been notified that the maximum clawback for ERF is 16% and a 2% reduction in the national ERF target to enable Systems to cover the cost of industrial action and lost activity; this should translate into a 2% reduction in System targets and this is currently being worked through. The year to date position has been adversely impacted by recent strike action with the value of lost activity estimated at £150k-£190k per day with further industrial action in July. Income against out of county contracts within GHFT is currently shown as breakeven against plan and the assumption is that lost activity will be recovered by year end leading to receipt of both ERF and contract income. There remains a risk of lost activity not being recovered with the associated impact on funding received

- Initial activity for month 2 (flex data, so subject to change) shows ICB commissioned activity at 97.3% of the value weighted target with under delivery by GHFT (91.1%) and out of county NHS providers (73.3%). Independent Sector providers (119.5%). GHFT: low recovery rates in T&O and general surgery.



Finance and Use of Resources

Financial Overview & Key Risks

Key Financial Risks

- The 2023/24 pay awards impact is currently being finalised; the impact of the 2023/24 pay award on the GMS subsidiary is forecast to create a financial pressure for the system and work is underway on mitigating actions. The recurrent impact of the pay award will be built into the medium term planning process.

- There has been a national negotiation on Microsoft licences which will create a financial pressure in 2023/24, this is currently being assessed and mitigating actions identified by organisations. Funding responsibility will transfer from NHSE to local organisations from 2024/25 onwards and is likely to create a recurrent cost pressure.

- Delivery of savings plans remains a risk for the system. Savings plans include those associated with the Urgent and Emergency Care Transformation programme with £4m of savings for GHFT and £3.1m for the ICB. In addition, other areas of savings are rated as amber or red as there is slippage against schemes within GHFT (divisional schemes in particular), the ICB (CHC and placements savings) and GHC (non recurrent savings schemes). The full deliverables and milestones for these schemes are being progressed, representing a risk whilst plans are being reviewed.

- A business case for an improved neurodiversity service has been approved, with recurrent investment of c£1m. The change in service will help to stabilise and start to reduce the waiting lists in this area. This investment will not fully realise in 2023/24 and will only impact as a part year effect. Non recurrent funding has been identified to mitigate the short term impact of the investment, the recurrent cost will be a call on growth for 2024/25.

Finance and Use of Resources

Financial and Use of Resources: Dashboard

Key

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

Month 03 2023/24 – June Statement of Comprehensive Income	Year to Date Plan *Surplus / (Deficit)* £'000	Year to Date Actual Position *Surplus / (Deficit)* £'000	Year to Date Variance to Plan *Surplus / (Deficit)* £'000	Full Year Plan *Surplus / (Deficit)* £'000	Forecast Outturn Actual Position *Surplus / (Deficit)* £'000	Forecast Outturn Variance to Plan *Surplus / (Deficit)* £'000
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	(6,947)	(7,831)	(884)	0	0	0
Gloucestershire Health and Care NHS Foundation Trust (GHC)	120	46	(74)	0	(0)	(0)
Gloucestershire CCG / Integrated Care Board (ICB)	0	275	275	0	0	0
System Surplus / (Deficit)	**(6,827)**	**(7,510)**	**(683)**	**0**	**(0)**	**(0)**

Month 03 2023/24 – June Other Metrics	GHFT	GHC	ICB	ICS
Better Payment Practice Code *Total paid within 30 days of due date by value*	90%	99%	100%	99%
Capital Forecast Variance to Plan (Under) / Over Delivery - £'000	0	(0)	0	(0)
Cash Status	**GREEN**	**GREEN**	**GREEN**	**GREEN**

Finance and Use of Resources

Finance and USE OF Resources: Dashboard

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

Month 03 2023/24 – June Efficiency Programme	Month 03 Efficiency Plan £'000	Month 03 Efficiency Achieved £'000	Year End Variance *Favourable / (Adverse)* £'000	Full Year Efficiency Plan £'000	Forecast Outturn Efficiency £'000	Forecast Outturn Variance to Plan *Favourable / (Adverse)* £'000	Forecast Outturn as & of Target £'000	High Level In Year Risk Rating
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	6,245	6,498	253	34,721	34,721	(0)	100%	**AMBER – Medium Risk**
Gloucestershire Health and Care NHS Foundation Trust (GHC)	4,203	4,448	245	9,883	9,883	0	100%	**AMBER – Medium Risk**
Gloucestershire CCG / Integrated Care Board (ICB)	3,288	3,288	0	13,128	13,128	0	100%	**AMBER – Medium Risk**
Total	**13,736**	**14,234**	**498**	**57,732**	**57,732**	**(0)**	**100%**	**AMBER – Medium Risk**

Finance and Use of Resources

Elective Services Recovery Fund

		April	May	June	July	August	September	October	November	December	January	February	March
Day Case	Plan	4,207,799	4,624,824	4,387,840	4,964,822	4,260,904	5,087,051	5,145,648	4,900,200	4,069,755	4,990,872	5,401,505	6,287,964
		106.9%	108.4%	106.0%	107.7%	109.5%	119.0%	116.0%	110.1%	106.6%	109.8%	126.4%	134.6%
	Actual	3,863,493	4,289,838	*	*	*	*	*	*	*	*	*	*
		98.2%	100.5%	*	*	*	*	*	*	*	*	*	*
Ordinary Admissions	Plan	3,822,350	4,199,155	3,343,910	4,005,825	3,847,991	4,208,709	4,730,450	3,802,707	3,417,880	3,730,486	3,481,383	4,447,959
		105.9%	102.6%	97.2%	96.1%	93.6%	110.4%	103.5%	88.3%	97.1%	100.8%	91.3%	101.4%
	Actual	3,232,176	2,946,558	*	*	*	*	*	*	*	*	*	*
		98.6%	72.0%	*	*	*	*	*	*	*	*	*	*
Outpatient Attendances	Plan	3,093,449	3,408,255	3,061,899	3,437,994	2,981,847	3,346,830	3,588,256	3,543,763	2,976,257	3,812,490	3,385,542	3,712,067
		106.6%	111.4%	102.6%	105.5%	108.8%	107.6%	104.6%	109.6%	109.1%	110.9%	112.7%	112.9%
	Actual	2,787,403	3,258,551	*	*	*	*	*	*	*	*	*	*
		96.1%	106.5%	*	*	*	*	*	*	*	*	*	*
Outpatient Procedures	Plan	1,501,565	1,540,926	1,423,953	1,682,125	1,423,819	1,433,443	1,669,764	1,550,442	1,331,627	1,634,934	1,438,483	1,628,145
		108.3%	111.9%	102.3%	109.8%	111.4%	109.3%	109.6%	108.4%	103.5%	105.7%	103.4%	107.1%
	Actual	1,335,341	1,450,626	*	*	*	*	*	*	*	*	*	*
		96.4%	105.3%	*	*	*	*	*	*	*	*	*	*
TOTAL GLOUCES-TERSHIRE SYSTEM	**Plan**	**12,885,249**	**14,019,233**	**12,860,919**	**14,560,778**	**12,866,245**	**13,543,309**	**15,159,555**	**14,504,839**	**12,251,267**	**14,291,729**	**13,509,927**	**15,116,251**
		108.9%	**109.5%**	**107.6%**	**107.3%**	**107.0%**	**108.3%**	**108.6%**	**108.1%**	**107.9%**	**108.0%**	**108.3%**	**109.0%**
	Actual	**11,595,591**	**12,361,088**	*	*	*	*	*	*	*	*	*	*
		98.0%	**96.6%**	*	*	*	*	*	*	*	*	*	*

Finance and Use of Resources

Elective Services Recovery Fund

- At M2 Gloucestershire ICB commissioned value waited activity is 96.6% of 2019/20 against a plan of 109.5% (including pathways avoided). Year to date performance is 97.3%.
- May flex data continues to indicate low recovery rates in GHFT for Day cases, Inpatient spells and Outpatient Procedures.
- OOC NHS providers are delivering high activity volumes for outpatient attendances and procedures. However delivery of elective inpatient and daycase activity is low and therefore overall recovery rates remain below 19/20 levels for VWA.
- IS providers continue to exceed 19/20 levels and continue to carry out a large amount of activity in Eye surgery and Non-trauma procedures which is likely offsetting the underperformance in the NHS.

Finance and Use of Resources

Savings and Efficiencies

Month 03 2023/24 – June Efficiency Programme	Month 03 Efficiency Plan £'000	Month 03 Efficiency Achieved £'000	Year End Variance *Favourable / (Adverse)* £'000	Full Year Efficiency Plan £'000	Forecast Outturn Efficiency £'000	Forecast Outturn Variance to Plan *Favourable / (Adverse)* £'000	Forecast Outturn as & of Target £'000	High Level In Year Risk Rating
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	6,245	6,498	253	34,721	34,721	(0)	100%	**AMBER – Medium Risk**
Gloucestershire Health and Care NHS Foundation Trust (GHC)	4,203	4,448	245	9,883	9,883	0	100%	**AMBER – Medium Risk**
Gloucestershire CCG / Integrated Care Board (ICB)	3,288	3,288	0	13,128	13,128	0	100%	**AMBER – Medium Risk**
Total	**13,736**	**14,234**	**498**	**57,732**	**57,732**	**(0)**	**100%**	**AMBER – Medium Risk**

- Savings and efficiencies totalling £57.7m are planned across the system in 2023/24.
- As at month 3 reporting, the year to date delivery is £498k, or 3.6%, ahead of plan, across the system, however, the delivery of a number of schemes, particularly within GHFT is planned to be later in the financial year.
- The full year forecasts are on plan for each organisation in the system. The risk ratings for each organisation's full year delivery forecast are:
- GHC: Medium - further work to conclude on non-recurrent balance sheet savings yet to be identified.
- GHFT: Medium - £5m risk in respect of high risk savings relating to £4m UEC Transformation schemes and £1m Elective Recovery risk. Slippage is being reported in Genmed savings, which is being offset by procurement & corporate savings plus there is risk relating to the delivery of divisional savings schemes of c£5m.
- ICB: Medium – risk of c£3m savings. The risk relating to Discharge to Assess beds savings target of £3.1m is currently reducing as changes to pathways are currently being implemented. Detailed plans are being developed for CHC and Placements savings totalling £1.5m.

Finance and Use of Resources

Capital: Organisational Positions, Challenges and Opportunities

Month 3 2023/24 - June Capital Expenditure	Year to Date Plan £'000	Year to Date Actual Position £'000	Year to Date Variance to Plan (Under) / Over Delivery £'000	Full-Year Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan (Under) / Over Delivery £'000
Gloucestershire Hospitals NHS Foundation Trust	13,327	9,954	(3,373)	55,792	55,792	0
Gloucestershire Health and Care NHS Foundation Trust	5,048	3,188	(1,860)	12,868	12,868	(0)
Gloucestershire CCG / Integrated Care Board	0	0	0	1,860	1,860	0
Total System CDEL (NHS)	**18,375**	**13,142**	**(5,233)**	**70,520**	**70,520**	**(0)**
IFRS16 Lease Capital						
Gloucestershire Hospitals NHS Foundation Trust	271	0	(271)	1,478	9,501	8,023
Gloucestershire Health and Care NHS Foundation Trust	193	0	(193)	1,168	1,243	75
Total System Capital including IFRS16 Leases (NHS)	**18,839**	**13,142**	**(5,697)**	**73,166**	**81,264**	**8,098**

Capital Expenditure Category	£'000	£'000	£'000	£'000	£'000	£'000
Equipment	794	35	(759)	4,777	8,860	4,083
IT	1,734	876	(858)	11,561	11,561	(0)
Plant & Machinery	0	0	0	0	0	0
New Build	10,310	8,259	(2,051)	28,992	29,205	213
Backlog Maintenance	213	56	(157)	2,913	2,654	(259)
Routine Maintenance	1,122	828	(294)	10,422	10,468	46
Net Zero Carbon	0	0	0	500	500	0
Fire Safety	0	0	0	0	0	0
Fleet, Vehicles & Transport	36	0	(36)	157	387	230
Forest of Dean	4,313	3,088	(1,225)	8,851	8,851	0
GP Surgery Developments	0	0	0	0	0	0
Brokerage	0	0	0	0	0	0
Other	317	0	(317)	4,993	8,778	3,785
Total	**18,839**	**13,142**	**(5,697)**	**73,166**	**81,264**	**8,098**

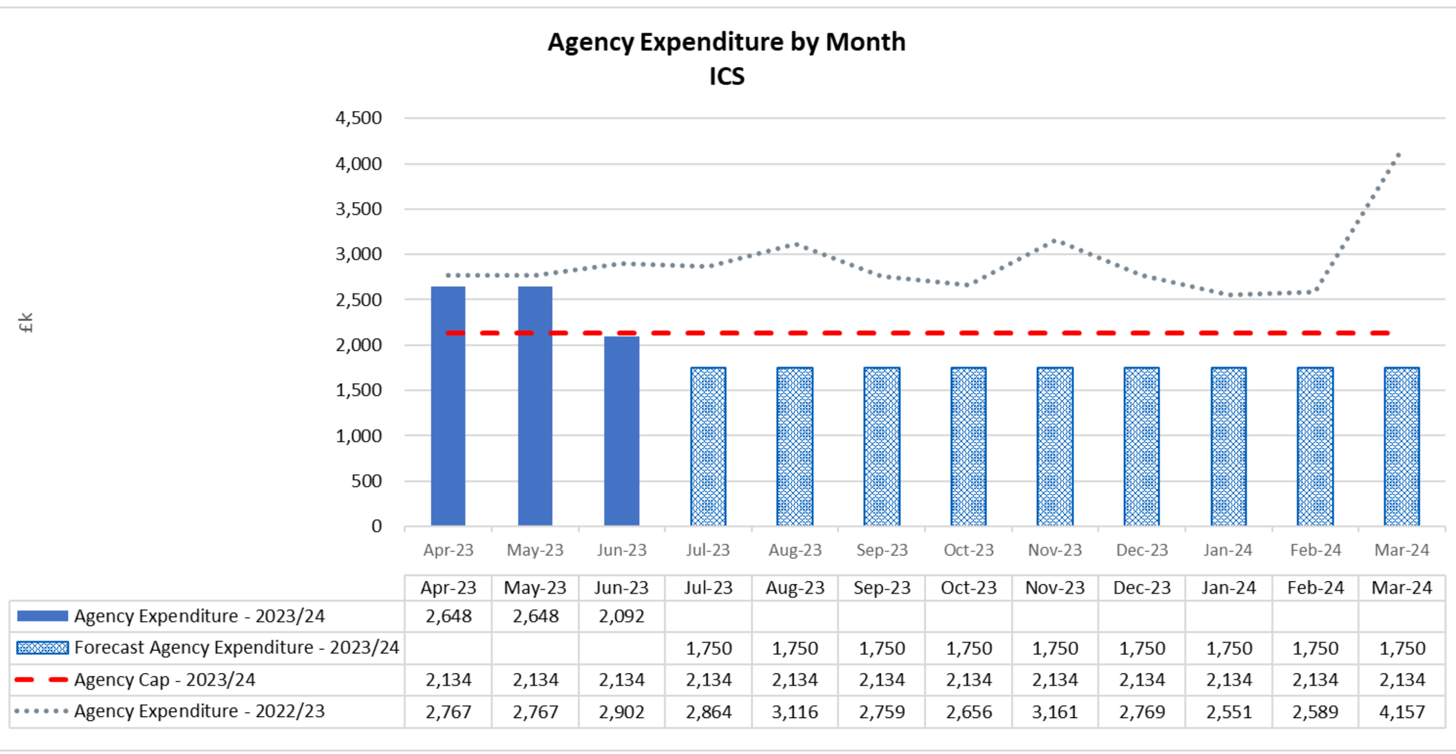
Funding Sources	£'000	£'000	£'000	£'000	£'000	£'000
System Capital	10,696	8,052	(2,644)	36,915	36,915	0
National Programme	4,585	1,621	(2,964)	22,820	22,820	0
Donations & Government Grants	2,814	3,188	374	7,799	7,799	0
Lease Liability - IFRS16	464	0	(464)	2,646	10,744	8,098
Residual Interest	0	0	0	0	0	0
IRFIC	280	281	1	1,126	1,126	0
CCG Capital Allocation	0	0	0	1,860	1,860	0
Total	**18,839**	**13,142**	**(5,697)**	**73,166**	**81,264**	**8,098**

Finance and Use of Resources

Capital: Organisational Positions, Challenges and Opportunities

- Within the ICS's capital envelope, capital expenditure is showing a £5.7m YTD underspend as at month 3 of 2023/24.
- GHFT are forecasting an £8m over delivery against their IFRS16 Lease capital. £4m of this is earmarked against Dialysis Equipment with a further £4m against various capital schemes.
- The GHFT YTD underspend versus plan accounts for £3.4m of the variance. This is primarily driven by the following projects:
  - Community Diagnostic Centre
  - 5th Orthopaedic Theatre
  - Fit for the Future (IGIS)
  - GSSD
  - Backlog Theatres Refurbishment
- Slippage with the GHC programme relates mainly to the Forest of Dean Hospital and spend will catch up by the end of the year
- The forecast outturn against capital, excluding IFRS16, is breakeven. The IFRS16 lease forecast is currently under review. DoH has not yet formally confirmed how the additional IFRS16 capital is to be funded. Subject to this funding decision, mitigations in other CDEL schemes may be necessary.

Agency Expenditure



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Agency Expenditure - 2023/24	2,648	2,648	2,092									
Forecast Agency Expenditure - 2023/24				1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
Agency Cap - 2023/24	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134
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 2023/24	**£23.142m**
Agency Expenditure 2022/23	**£35.057m**
Agency Cap 2023/24	**£25.609m**

- Gloucestershire ICS's agency expenditure limit was calculated as 73% of 22/23 expenditure, resulting in a cap of £25.6m.
- As at month 3, the rate of agency expenditure reduced to a level below the straight line trend of the agency cap and the forecast against the cap includes a number of assumptions around the impact of actions underway or planned.
- GHFT year to date agency spend includes the impact of industrial action, vacancy and sickness cover, and RMN costs.

ICB Finance Report

June 2023

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Finance and Use of Resources

Financial Overview and Key Risks

Overview

- The ICB month 3 position is showing a forecast outturn position of breakeven which is as per plan. The impact of the change to the 22/23 accounts on the 23/24 financial position will create a financial pressure and this is currently being worked through. There remain other pressures and risks within the financial position that are currently being managed, but, should they increase, may challenge the delivery of a balanced financial position.

- Children's services budgets show a £707k forecast overspend driven by external placements. Ongoing discussions are being undertaken between GICB, GCC and the providers to understand the overall position and ensure that appropriate review processes are in place ensuring that appropriate treatment plans are in place.

- A prescribing forecast of breakeven is included within the position: Prescribing data for Month 1 indicates an early overspend which is being monitored closely. It is anticipated that NCSO will remain a pressure in 23/24 based prescribing information received.

- The Integrated Community Equipment Service is reporting a £746k forecast overspend which is partly due to GIS restructure. The overspend is being monitored and mitigations will include procurement savings and improved return and recycle performance.

- Savings plans are in place, there is a risk relating to the delivery of the UEC savings and also those relating to placements and continuing health care. These programmes are being reviewed to look at the risk to delivery.

- The Mental Health Investment Standard (MHIS) for 23/24 is £106m and is forecast to be met.

- Financial Planning for 2024/25 and future years is underway, which includes a detailed analysis of the ICB's underlying financial position.

Finance and Use of Resources

Financial Overview and Key Risks

Key Financial Risks

- Inflation exceeds planning assumptions leading to the increased potential for providers (in particular for the cost of care packages both domiciliary and residential) to negotiate increases in contract amounts to cover costs.
- Pay award costs for 23/24 are in excess of the allocation received.
- The ICB and System plan is dependent on delivery of the elective activity as per the plan; the associated Elective Recovery fund is £26.67m which includes £1m primary care (POD). Due to ongoing industrial action in April and May, the national target is being reduced by 2% to enable systems to cover the cost of industrial action in that period. The impact of this change is currently being worked through. The overall risk of clawback for the system is 16% if there is underperformance.
- Additional high cost placements, particularly children's services and learning disabilities are a key financial risk for the ICB

Finance and Use of Resources

ICB Allocation – M03

- The ICB's confirmed allocation as at 30th June 2023 is £1,273m.

Description	Recurrent £'000	Non Rec £'000	Total Allocation £'000
M02 Balance Brought Forward	**1,242,611**	**22,084**	**1,264,695**
Adj to Inflation Fair Shares	3,371	(3,371)	0
UEC Capacity Funding		4,080	4,080
CDC Revenue		3,406	3,406
FTA Allocation		540	540
Children & Young People		55	55
SDF Mental Health (EIP)Adult Community		9	9
Additional Pay Awards		54	54
Primary Care Transformation Costs to support delivery		24	24
Primary Care Transformation Pharmacy Integration Leads band 8C		108	108
DOAC Rebate Q4 22/23		319	319
Pay Award Secondary Dental and Community Dental		170	170
COVID-19 Clinical waste allocations		11	11
TOTAL IN-YEAR ALLOCATION 23/24 @ M03	**1,245,982**	**27,489**	**1,273,471**

Finance and Use of Resources

CCG / ICB Statement of Comprehensive Income In-Year Position

Month 03 2023/24 – June Statement of Comprehensive Income	M03 Plan £'000	M03 Actual Position £'000	Year End Variance to Plan *Favourable / (Adverse)* £'000	Full Year Plan £'000	Forecast Outturn Actual Position £'000	Forecast Outturn Variance to Plan *(Favourable / (Adverse)* £'000
Acute Services	151,707	151,401	306	606,791	606,645	146
Mental Health Services	31,643	31,234	409	126,574	126,762	(188)
Community Health Services	28,931	28,982	(50)	114,345	115,136	(791)
Continuing Care Services	19,067	19,043	24	75,785	75,785	0
Primary Care Services	45,182	45,016	166	179,695	179,700	(5)
Delegated Primary Care Commissioning	29,242	29,242	0	116,968	116,968	0
Other Commissioned Services	7,618	8,871	(1,253)	30,472	31,386	(914)
Programme Reserve and Contingency	2,064	1,297	768	10,155	8,402	1,753
Other Programme Services	154	249	(95)	615	615	0
TOTAL COMMISSIONING SERVICES	**315,608**	**315,333**	**275**	**1,261,400**	**1,261,400**	**(0)**
Running Costs	3,018	3,018	0	12,071	12,071	0
TOTAL NET EXPENDITURE	**318,626**	**318,626**	**275**	**1,273,471**	**1,273,471**	**0**
ALLOCATION	318,626	318,626	0	1,273, 471	1,273, 471	0
Outside of Envelope	0	0	0	0	0	0
UNDERSPEND / (DEFECIT)	**0**	**275**	**275**	**0**	**0**	**0**

Finance and Use of Resources

2022/23 Efficiencies Programme – As At Month 03

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	Primary Care Medicines Optimisation	747	747	0	2,988	2,988	0	100.00%	AMBER – Medium Risk
	Home Oxygen	39	39	0	150	150	0	100.00%	GREEN - Low Risk
	TOTALS	**786**	**786**	**0**	**3,138**	**3,138**	**0**	**100.00%**	
CONTINUING HEALTHCARE	Continuing Healthcare / Joint Placements – All Age	387	0	(387)	1,547	773	(774)	49.97%	RED – High Risk
	TOTALS								
URGENT & EMERGENCY CARE (UEC)	Discharge to Assess Beds (UEC Efficiencies)	774	0	(774)	3,100	2,500	(600)	80.65%	RED – High Risk
	TOTALS	**774**	**-**	**(774)**	**3,100**	**2,500**	**(600)**	**80.65%**	
OTHER	ICB Recurrent and Non-Recurrent Efficiencies (e.g. 1.1% Efficiency, Running Costs and Additional Efficiencies)	1,341	2,502	1,161	5,343	6,717	1,374	125.72%	GREEN - Low Risk
	TOTALS	**1,341**	**2,502**	**1,161**	**5,343**	**6,717**	**1,374**	**125.72%**	
2023/24 ICB Savings Programme TOTALS		**3,288**	**3,288**	**0**	**13,128**	**13,128**	**0**	**100.00%**	AMBER – Medium Risk

Finance and Use of Resources

ICB Savings and Efficiencies

Overall Position

- Based the latest information, the ICB's £13.128m savings programme is anticipated to deliver to plan (100%, £13.128m) of the total GICB programme for 2023/24.
- Whilst there is no overall movement in the reported total forecast efficiencies delivery for the ICB between Months 3 and 2, Discharge to Assess Beds savings are now forecast to delivery £600k under plan.
- As a result, additional savings are being identified to manage the overall ICB savings delivery of £13.128m in-year savings. This remains a risk to the ICB in terms of overall delivery as we need to identify and assess further savings plans to deliver this mitigation.

Medicines Optimisation

- As at Month 3 the ICB has received ePact data for April. Trends have been reviewed from 2022/23 and this, combined with soft intelligence obtained from the Medicines Optimisation Team, has been used to arrive at the current position. The Medicines Team have an ongoing programme of active and potential savings projects and the 2023/24 savings programme includes benefit of c£1m for the full year effect of savings projects implemented during 2022/23.
- In addition the Medicines saving plan includes project implementation for further identified schemes (including Optimise RX, review of NHS prescribing of Over The Counter available medicines, review of 'do not prescribe' activities and review of dietary supplement prescribing) and also a programme of review of significant / unexplained practice prescribing variation. These project areas are anticipated to deliver the remaining savings requirement in 2023/24.

Finance and Use of Resources

ICB Savings and Efficiencies

Other Recurrent and Non-Recurrent Efficiencies

- This £5.343m programme area is focused on transactional efficiencies, these have been fully delivered at the start of the financial year.
- Additional savings requirement (£1.374m) are also reported at month 3 supporting the ICB wider savings and efficiency programme delivery.
- This remains a risk to the ICB in terms of overall delivery as we need to identify and assess further savings plans to deliver this mitigation.

Continuing Healthcare (CHC) and Placements

- This programme has been progressing with the preparation of a detailed project plan and business case to set-out the schemes that are being taken forward to deliver the £1.547m savings required in 2023/24.
- Key areas being focused on include review of joint funded placements, process development around assessments and review assessments and strengthening governance and monitoring around personal health budgets.
- Within this year there may also be some continuation of saving projects that were in place during 2022/23 (for example Electronic Call Monitoring).
- Pending further assessment of the plan forecast in-year delivery of savings is currently £773k however the programme is aiming to deliver above this level of savings.

Finance and Use of Resources

ICB Savings and Efficiencies

Urgent Emergency Care (UEC) – Discharge to Assess Beds

- This programme is focusing on a £3.1m reduction in the value of Discharge to Assess beds commissioned.
- This is being delivered through the urgent care transformation programme with a robust governance structure ensuring benefits are being realised in this area and across the system with regards to patient flow.
- This programme is being ramped up over the coming months including reduced spot purchase of discharge beds commencing from 1st July and decommissioning some block purchase discharge beds.
- The programme is currently forecast to deliver the £2.5m in-year within 2023/24 with £3.1m overall benefits delivered recurrently during 2024/25

Finance and Use of Resources

CCG / ICB Statement of Financial Position

	Closing Position as at 30/06/2023 £'000	Opening Position as at 01/04/2023 £'000
Property, Plant & Equipment	146	285
Intangible Assets	0	0
Total Non-Current Assets	**146**	**285**
Trade & Other Receivables	8,755	6,984
Cash & Cash Equivalents	12,471	7
Total Current Assets	**21,226**	**6,991**
TOTAL ASSETS	**21,371**	**7,276**
Trade & Other Payables	(51,188)	(83,369)
Provisions	(5,907)	(4,840)
Total Current Liabilities	**(57,094)**	**(88,209)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**(35,723)**	**(80,933)**
Non-Current Liabilities	0	0
Total Non-Current Liabilities	**0**	**0**
TOTAL ASSETS LESS TOTAL LIABILITIES	**(35,723)**	**(80,933)**
General Fund	35,723	(80,933)
Reserves	0	0
TOTAL EQUITY	**35,723**	**80,933**

Agenda Item 10

NHS Gloucestershire ICB Board (Public Session)

Wednesday 26th July 2023

Report Title	**Gloucestershire Health and Social Care Framework Agreement**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:				
	ICB Internal	**Date**	**System Partner**	**Date**	
	ICB Executive	27/06/2023	Corporate Leadership Team, GCC	06/2023	
Executive Summary	In April 2020, Gloucestershire County Council jointly commissioned a 4-year Framework Agreement on behalf of the Integrated Care System, to deliver a range of community-based support services for older people, adults with disabilities, autism, mental health conditions and children and young people with a disability who require care and support. The benefits of developing one Framework Agreement for community services, meant that contracts were merged and integrated procurement systems, helping to reduced duplication and created a framework which encouraged providers to grow and diversify. The current Framework Agreement will expire on 31st March 2024 and the Council is required to put in place new contractual arrangements for 1st April 2024 onwards. The existing Lots under the current Framework agreement are: - a) Supported Living (with floating support outreach option) - Non-Complex. b) Supported Living (with floating support outreach option) - Complex Needs. c) Forensic Support Services. d) Domiciliary Care. e) Floating / Visiting Support for Children and Young People. Following feedback from partners and stakeholders, the new Framework Agreement will be further developed to include the additional Lots for: - f) Support for People with Complex Physical Health Needs. g) Extra Care Sheltered Housing. The introduction of a new Lot for people with complex physical health needs will provide access to a pool of providers that have been robustly evaluated and are capable and suitable to meet the specific needs of individuals with critical and profound physical health needs (such as ventilator support and tracheotomies). Commissioners in Adults and Continuing Health Care are working with providers to build strong relationships and develop the market so that the new Framework Agreement Lot delivers a list of reliable and robust providers with capacity in Gloucestershire in order to avoid the use of high-cost staffing agencies.For the full report please see **Annex 1**.				
Key Issues to note	Identify the key issues that the report is attempting to address here, and any issues that have arisen during the project / programme / production of the paper itself.				

Key Risks:

Original Risk (CxL)
Residual Risk (CxL)

Risk	Rating	Mitigation
Risk of reduced market interest in the frameworks due to the recruitment and retention issues in the care market.	Low	Commissioners are working with providers to address issues via numerous initiatives outlined in Gloucestershire's Market Sustainability Plan.
Risk of providers not meeting the requirement to obtain the Cyber Essentials Certificate.	Medium	Commissioners will work with the Council's Information Management Service to engage with and inform providers prior to the procurement process. The procurement will allow additional time (post contract award) for providers to meet the standard.
Risk of challenge on Framework Agreement term longer than 4 years.	Low	The Council is working under the light touch regime that allows more flexible procurement and the Framework Agreement will open annually for new entrants.

Management of Conflicts of Interest

Answer the following questions:

- Who has been conflicted in the process / project?
  No-one
- How was this managed?
  Project team has met on monthly basis since June 2022. Project is managed by Disabilities Commissioning. There has been extensive engagement process with providers (workshops/surveys), professionals (workshops/surveys) and people with lived experience and their carers (Partnership Boards/ surveys).
- Has it been logged on the declaration of interest register?
  N/A

Resource Impact (X)

Financial	X	**Information Management & Technology**	
Human Resource		**Buildings**	

Financial Impact	The budgetary challenges faced by the public sector and the resultant impact on funding and budgets at national, regional and local levels are well known. However, the commissioners recognise their statutory obligations and the importance of these services in supporting some of the most vulnerable people in Gloucestershire. An indication of the annual gross spend in each service area for the financial year 2022-3 is as follows: • Learning Disabilities: c.£44.88m • Physical Disabilities: c.£10.41m • Mental Health: c.£5.39m • Older People's: c.£22.48m • Continuing Health Care: c.£9.7m • Disabled Children & Young People Service: c.£250k The hourly rates set for Lots under the current Framework Agreement benchmark well against neighbouring authority rates and we expect to continue to work with care providers to put into place pricing and payment mechanisms which demonstrate best value in the new Framework Agreement but that are realistic and support the market within the bounds of affordability. The introduction of a new Lot for people with complex physical health needs will provide access to a pool of providers and will avoid the use of high-cost staffing agencies.
Regulatory and Legal Issues (including NHS Constitution)	**Promoting diversity and quality in provision of services (Care Act 2014)**
Impact on Health Inequalities	The Frameworks are put in place to help to address health inequalities.
Impact on Equality and Diversity	**Age** - The contract will ensure that services for all individuals of all ages will be inclusive and accessible whilst ensuring quality statutory care is provided. The introduction of the Provider Assessment and Market Management Solution (PAMMS) system will help with contract monitoring and care quality and will be able to identify any age profiling quality issues. **Disability** - The service specifications have been developed to be inclusive and to provide statuary care to all individuals with a disability. The service outlines accessible information for all individuals and in a way that is appropriate for the individual. This will allow for a better understanding of individuals and their needs. It will also help produce achievable outcomes so individuals can lead a more meaningful life. We will continue to hear the voices of individuals at the Partnership Boards which will allow for any learning and gaps in provision to be identified. **Race** - The service specification outlines the provision of statutory care will be delivered in a person-centred way which does not discriminate against race or ethnicity. Care staff will be required to complete Equalities and Diversity training and also Health Inequalities Training which allows for better understanding and awareness of BAME communities and health inequalities. Providers are also required to have an Equalities, Diversity and Inclusion policy which must be adhered to. Care provision will also ensure information is accessible and in and accessible format and language that is appropriate for the individual.

Impact on Sustainable Development	The hyper-localised approach to commissioning domiciliary care will reduce the travel between individuals visits and improves upon existing practice. We will continue to liaise with Climate Change leads at the council and build consideration of environmental impacts into our approach where possible		
Patient and Public Involvement	Extensive engagement has been undertaken to evaluate the current Framework Agreement, procurement process and subsequent commissioning arrangements and feedback from a range of partners and stakeholders has been considered to include views from: - • The Partnership Boards • User-led Organisations • External Providers on the current Framework Agreement • External Providers not on the current Framework Agreement • Gloucestershire Care Providers Association • Operational Teams across Health and Social Care. The Partnership Boards are co-producing questions for evaluation and scoring in the procurement. For the Engagement Summary please see **Annex 2**. The Report will be published on Gloucestershire County Council's website		
Recommendation	The Board is requested to: • To note the Cabinet Report • Approval to go out to tender for a new Health and Social Care Framework of community services for 6 + 2 years.		
Author	**Holly Beaman**	**Role Title**	**Head of Integrated Commissioning (Learning and Physical Disabilities)**
Sponsoring Director (if not author)	**Benedict Leigh, Director of Integrated Commissioning**		

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

Annex 1 – Cabinet Report

Draft Cabinet Report Checklist

Report title: Gloucestershire Health and Social Care Framework Agreement

1. **Stage 4: Actions required by the report author prior to submitting this report for the CLT Meeting & Statutory Officers deadline**

Please put a cross in each box (double click on each box, click on 'checked' and then 'OK').

☐ Advice has been sought from all the relevant support services:

Support Service	Name of the person in each support service who has signed-off the near final draft report (Stage 2):	Date
Legal Services	Will Felgate	22/5/23
Finance	Derek Hughes	30/5/23
Strategic Procurement	Munesa Moolla	30/5/23
HR	Lee Taylor-Pockett	
Information Management	Alice Huggins / Jo Davies	24/5/23
Communications Team	Rita Rountree	19/5/23

☐ This draft report has been approved by the relevant Director

☐ This draft report has been shared with the Cabinet Member

☐ Further support from the Communications Team is not required

2. **Stage 6: Actions required by the report author prior to submitting this report for the Cabinet & CLT Meeting deadline**

☐ This draft report has been approved by the relevant Director

☐ This draft report has been approved by the Cabinet Member

3. **Stage 8: Actions required by the report author prior to submitting this report for the Cabinet Meeting deadline**

☐ This final report has been approved by the Director and Cabinet Member

or

☐ This final report has not changed since it was approved by the Director and Cabinet Member prior to the Stage 6 Cabinet & CLT Meeting deadline

Any reports submitted without the information above completed will be returned to the author

REPORT TITLE: Gloucestershire Health and Social Care Framework Agreement

<table>
<tr><td>Cabinet Date</td><td>19th July 2023</td></tr>
<tr><td>Cabinet Member</td><td>Cllr Carol Allaway-Martin, Cabinet Member for Adult Social Care Commissioning</td></tr>
<tr><td>Key Decision</td><td>Yes</td></tr>
<tr><td>Purpose of Report</td><td>To seek approval to conduct a tender process for a new multi-provider Framework Agreement commencing on 1st April 2024 for the supply of community-based support services for people with an assessed health or social care need including disabilities, autism, a mental health condition and/or older people.</td></tr>
<tr><td>Recommendations</td><td>That Cabinet delegates Authority to the Executive Director Adult Social Care, Wellbeing and Communities, in consultation with the Cabinet Member for Adult Social Care Commissioning to:

1. Conduct a competitive procurement process in respect of a multi-provider pseudo-Framework Agreement[1] for the supply of community-based support services for people with an assessed health or social care need including disabilities, autism, a mental health condition, complex physical health conditions and/or older people. The Framework agreement shall be divided into the following Lots:-
a) Supported Living (with floating support outreach option)
b) Supported Living - Complex Needs (with floating support outreach option)
c) Forensic Support Services
d) Domiciliary Care
e) Floating / Visiting Support for Children and Young People
f) Support for People with Complex Physical Health Needs
g) Extra Care.
The proposed Framework Agreement shall continue for an initial period of 6 years and include an option to extend its term for a further period of not more than 2 years;

2. Appoint each of the preferred tenderers to the relevant Lot under such Framework Agreement; and

3. Determine whether to exercise the option to extend the term of the Framework Agreement for a further period of not more than 2 years on the expiry of the initial 6-year term.

4. Procure as many Call-Off Contracts as may be required by the council under the relevant Lots of such Framework Agreement.</td></tr>
</table>

[1] It is called a Pseudo Framework Agreement as the contract length exceeds the 4-year maximum term usually set for procurement of a multi-provider framework. Adult Social Care services are procured under the light touch regime where there is more flexibility within the procurement regulations and the risk of challenge is mitigated by opening to new entrants annually.

Reasons for Recommendations	The current Health and Social Care Framework Agreement ends on 31st March 2024, therefore new procurement and contractual arrangements will need to be put in place to ensure a continuity of service. The current contracting strategy has provided an integrated commissioning approach across health and social care with consistency of processes, contractual terms and pricing. It has ensured equity of access to community-based services across all client groups in Gloucestershire through the consistent use of the brokerage function across the various Lots. Setting agreed rates ensures transparency and equity across the market and puts quality at the forefront when making decisions about provision. The procurement process is robust and provides a level of assurance for individuals, families, commissioners and operational teams when calling off individual packages of care and support under the Framework. The provider market is familiar with the procurement process and the commissioning processes that sit within a Framework Agreement and are supportive of a longer term to enable business planning, allocation of resources and stability and continuity of contract terms.
Resource Implications	The budgetary challenges faced by the public sector and the resultant impact on funding and budgets at national, regional and local levels are well known. However, the Authority recognises its statutory obligations and the importance of these services in supporting some of the most vulnerable people in Gloucestershire. There will be no financial impact on the current level of spending solely because of the recommendations set out in this report and demand remains the main influencing factor. An indication of the annual gross spend in each service area for the financial year 2022-3 is as follows: • Learning Disabilities: c.£44.88m • Physical Disabilities: c.£10.41m • Mental Health: c.£5.39m • Older People's: c.£22.48m • Continuing Health Care: c.£9.7m • Disabled Children & Young People Service: c.£250k The hourly rates set for Lots under the current Framework Agreement benchmark well against neighbouring authority rates and we expect to continue to work with care providers to put into place pricing and payment mechanisms which demonstrate best value in the new Framework Agreement but that are realistic and support the market within the bounds of affordability.

Background Documents	Appendix One – Engagement Health & Social Care Framework Cabinet Decision 19th June 2019 – Gloucestershire Health and Social Care Framework 2020-24 https://glostext.gloucestershire.gov.uk/documents/s53476/Item%207%20%20Gloucestershire%20Health%20and%20Social%20Care%20Framework%202020-24.pdf Gloucestershire's Housing with Care Strategy 2020-24 https://www.gloucestershire.gov.uk/media/2108909/housing-with-care-report_17feb_21.pdf Gloucestershire's Market Position Statement https://www.gloucestershire.gov.uk/media/2083902/market-position-statement-for-older-people-2018.pdf
Statutory Authority	**Promoting diversity and quality in provision of services (Care Act 2014)** (1) A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market— (a) has a variety of providers to choose from who (taken together) provide a variety of services; (b) has a variety of high-quality services to choose from; (c) has sufficient information to make an informed decision about how to meet the needs in question. (2) In performing that duty, a local authority must have regard to the following matters in particular … (d) the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not).
Divisional Councillor(s)	All
Officer	Name: Amie Wilson Tel. no: 01452 328633 Email: amie.wilson@gloucestershire.gov.uk
Timeline	Engagement with key stakeholders: November 2022 – May 2023 Procurement processes: September 2023 – February 2024 New contractual arrangements commence: 1st April 2024

1. Background

In April 2020, Gloucestershire County Council commissioned a 4-year Framework Agreement to deliver a range of community-based support services for older people, adults with disabilities, autism, mental health conditions and children and young people with a disability who require care and support. Through the development of one Framework Agreement for community services, it merged contracts and integrated procurement systems, helping to reduced duplication and created a framework which encouraged providers to grow and diversify. The current Framework Agreement will expire on 31st March 2024 and the Council is required to put in place new contractual arrangements for 1st April 2024 onwards.

The existing Lots under the current Framework agreement are: -

a) Supported Living (with floating support outreach option) - Non-Complex.
b) Supported Living (with floating support outreach option) - Complex Needs.
c) Forensic Support Services.
d) Domiciliary Care.
e) Floating / Visiting Support for Children and Young People.

Following feedback from partners and stakeholders, the new Framework Agreement will be further developed to meet the needs of the population of Gloucestershire and include the additional Lots for: -

f) Support for People with Complex Physical Health Needs.
g) Extra Care Sheltered Housing.

Gloucestershire has a mature local market of support providers in these sectors, who operate effectively within the terms of the Framework Agreement. There is a clear brokerage process where new packages of support are tendered via the Framework Agreement and Individual Service Contracts are issued.

Following robust feedback from the market that a longer-term agreement would be more beneficial, in terms of stability and allocation of resources, and given the existing Framework Agreement has worked well, it is proposed to implement a new 6-year Framework Agreement with the option to extend the contract for a further 2 years. Adult Social Care services are procured under the light touch regime where there is flexibility within the regulations to allow for a longer contract term.

2. Strategy

The legislative basis for commissioning adult social care services is set out within **the Care Act 2014** and updated in the recent **Health and Care Act 2022** (https://www. legislation.gov.uk /ukpga/2022/31/ contents /enacted). The Care Act states that '*high quality, personalised care and support can only be achieved where there is a vibrant, responsive market of services available*'. The Local Authority role is seen as critical and under section 5 of the Care Act, has 't*he duty to shape and maintain an efficient and effective market of services for meeting care and support needs in the local area'*.

The commissioning of community services through a Framework Agreement is a key part of delivering commissioning responsibilities within the Care Act. However, there are other strategies which also drive this work.

Gloucestershire's Market Position Statement 2018 sets out the commitment of Gloucestershire County Council to move away from the commissioning of traditional residential and nursing homes and increase the use of housing with care, providing security of tenure with the option of flexible onsite care arranged according to need. The aims set out within the strategy are: -

- Supporting Independence
- Community Support
- Rehabilitation, recovery and reablement
- Flexible Long-Term Support.

Gloucestershire's Housing with Care Strategy (2020) sets out the key priorities for housing with care in Gloucestershire for all adults with a care need that would be best met through housing with flexible onsite care. This includes that we: -

- Ensure a good standard of housing provision, complimented by high quality care.
- Improve the housing with care offer for people with a range of support needs, including complex needs and lifelong conditions, and reduce out of county placements.
- Increase housing with care across Gloucestershire so each district has an equitable offer for older local people appropriate to need.
- Increase the choice of supported living for younger adults with disabilities and mental health conditions.
- To utilise housing with care which delivers cost savings to the housing, health and care system.
- To provide a viable alternative to residential care.
- Sustainable long-term services, when people require long term services, we want to support these services to be reliable, sustainable and adhering to robust quality standards and regulations.

3. Demand/Needs

The Market Position Statement for Gloucestershire details the potential increase in demand on services: -

Learning Disabilities: An estimated 11,400 people aged 18 and over in Gloucestershire have a learning disability. Of these 2,400 have a moderate or severe learning disability. There are around 3,000 people in Gloucestershire who have received a diagnosis by local GPs. The overall number of adults with a moderate or severe learning disability is predicted to rise by 3.6% between 2015 and 2025.

Physical Disabilities: The number of adults aged 18+ in Gloucestershire is projected to rise from 492,300 to 576,600 between 2015 and 2039. An estimated 9,000 people aged 18-64 in Gloucestershire have a serious physical disability, and an additional 30,000 people aged 18-64 have a moderate physical disability. Both numbers are expected to increase moderately in the next 15 years.

Mental Health: The number of adults in Gloucestershire diagnosed by local GPs with depression is increasing, from 27,000 people in 2012/13 to 34,500 people in 2014/15. Of these, just over half were over-65s, and this number is predicted to rise to 20,400 by 2030 as the population ages. A total of 272 adults aged 18+ in Gloucestershire were receiving council-funded long-term care packages as at 31 March 2023.

Older People (included CHC): We expect the number of older people aged 65 and over in Gloucestershire to continue to rise at a faster pace than nationally, rising from 126,800 in 2015 to 206,300 by 2039. An estimated 25,400 older people have a long-term illness or disability that limits their day-to-day activities a lot. The number is predicted to rise to 39,000 by 2030.

4. Details of the Services within the Framework

There are currently 179 providers across the existing Framework who deliver care and support to adults with disabilities, and they range from large national charities through to small, owner-managed businesses. Fewer than 10% of support packages are commissioned outside of the Framework Agreement. Work has been undertaken to update and develop the service specifications to reflect current guidance and legislation as required.

Supported Living – Non-Complex
Supported Living services are delivered to individuals who are tenants within their own property, many of whom reside in shared accommodation. Support is delivered with the aim of increasing peoples independence, coping mechanisms, and life skills. The support can be shared between several individuals, sometimes referred to as "core" or "background" support or delivered on an individual 1:1 basis. This can include support at night via a sleep-in or waking night and may include delivery of regulated activity such as personal care as defined by the regulator, the Care Quality Commission.

Supported Living - Complex Needs
The lot for Complex Needs follows the delivery model described above and provides specialist support which could include complex and challenging behaviour, autism, Huntington's Disease, an Acquired Brain Injury (ABI) or a personality disorder.

Forensic Support Services
The Forensic Services Lot has been developed to ensure there are suitably experienced and qualified providers to support those individuals who have come into contact with the criminal justice system, have been admitted to a secure setting or at risk of doing so. This Lot will also support individuals who are stepping down from a secure setting.

A typical individual will usually have a long-standing and complex condition (or one or more comorbid conditions), require longer-term or more intensive rehabilitation and support which is no longer required or appropriate in a secure setting, be more likely to display behaviour at a level of risk greater than a non-specialist service would be expected to safely manage and be subject to MAPPA or other Ministry of Justice restrictions (such as release from prison on licence, conditional or supervised discharge, release on bail or probation, electronic tagging or a guardianship order) and which will impact on the delivery of the Services.

Domiciliary Care

There are currently 91 providers delivering community-based home care (domiciliary care) to adults under the existing Framework Agreement. The Lot for domiciliary care will remain unchanged in the new Framework Agreement but will now allow for the procurement of hyper-localised domiciliary care blocks as well as being used to call-off individual spot purchased packages of care where necessary.

A new schedule for Hyper Localised Domiciliary Care Blocks will run in parallel with the existing arrangements. These will consist of small clusters of Lower Layer Super Output Area (LSOA's), which are broadly based on existing wards where the Council currently commissions more than 140 hours of domiciliary care per week. The provider will be given a block of funding to accommodate existing care packages commissioned with in the area and to create capacity for any new packages of care or those that may require recommissioning. The provider for each LSOA will be expected to deliver support to all individuals within the specified area until capacity has been reached and requires a review.

The blocks will be tiered from 1 to 4 (tier dependant on number of hours commissioned). Providers expressing an interest via Brokerage will be allocated a suitable tier based on their staffing levels, with larger organisations being allocated to tier 1 blocks. The Framework Agreement will include a new pricing structure for the blocks with each LSOA grouping having a set rate assigned. Assigned rates will consider a combination of population density, geographical barriers, and proximity to urban locations.

Floating / Visiting Support for Children and Young People

Commissioners for Children and Families continue to face disparity in their market and hourly rates can be exceptionally high with some providers dictating a minimum block purchase of 3-4 hours per visit. There are 19 providers under the current children and young people's floating support.

Work to further develop the evaluation criteria and service specification has been undertaken to assure commissioners of the providers experience in order that more support packages can be brokered from this resource ensuring continuity of care through transition and consistent pricing structures across children's and adults. Specific market engagement will be completed to prepare existing providers to submit a tender and to encourage providers delivering to adults under other Lots to diversify and expand to include children with disabilities within their offer.

Support for People with Complex Physical Health Needs

Introducing a new Lot for complex physical health needs, will provide a more joined-up commissioning model across health and social care, ensuring colleagues across the system have access to a pool of providers that have been robustly evaluated and are capable and suitable to meet the specific needs of individuals with critical and profound physical health needs (such as ventilator support and tracheotomies). This Lot will be used in both Social Care and Health, where the Council purchases packages of care for people on behalf of the Integrated Care Board (ICB) the Local Authority will be reimbursed via Section 75 arrangements.

Commissioners in Adults and Continuing Health Care are working with providers to build strong relationships and develop the market so that the new Framework Agreement Lot delivers a list of reliable and robust providers with capacity in Gloucestershire in order to avoid the use of high-cost staffing agencies.

Extra Care Housing
Extra Care is independent housing with the provision of an on-site care team. Extra Care has a range of communal features to support independence and wellbeing. Depending on the size of the development these may also include an onsite restaurant, communal lounges, hairdressers and private gardens. Extra Care provides a real opportunity for GCC to provide more efficient care as the provider is on-site, reducing travel time and the ability to provide a more flexible, outcome focused service. The additional wellbeing aspects of extra care provide real benefits to both tenants and the local community. Most provide falls prevention classes as well as a range of wellbeing activities that help to keep people independent for longer and prevent, reduce and delaying the need for higher levels of formal care.

The new Framework Agreement will include commissioning arrangements for Extra Care under a specific Lot. Extra Care provision is currently commissioned via Memorandums of Understanding (MOU) so inclusion in the Framework will address the need for robust contracting terms and conditions that are equitable across the extra care market. Aligning referral processes with the other community-based services under the Framework Agreement will maximise the use of extra care as a viable housing alternative to residential care and will help to reduce pressure across housing, health and social care.

5. Options

Looking forward, the two most appropriate procurement models considered for community-based support are:

- To develop another Framework Agreement with individual Lots; or
- To develop a Dynamic Purchasing System (DPS)

The current arrangements, introduced in April 2020, provide an integrated approach across health and social care together with consistency of processes, contract terms and pricing. The introduction to the new Framework Agreement has been well received and accepted by the local market as the established procurement model for community-based support services.

Commissioners have undertaken a review of the existing arrangements and feedback has been positive. Operational services have benefited from the flexibility of being able to call off individual

services as and when required. The set rates for each Lot provide transparency of care costs for operational teams when support planning in order to maintain control over spend. Robust and clear contract terms have allowed for consistent contract management to happen across the various models of support and range of providers and with the necessary clauses in place for escalation of issues Commissioners have been able to resolve quality issues as they arise.

The mini-competition process carried out by Brokerage has also proved to be a fair and transparent mechanism for calling off individual packages of care and support and will be developed further for the new Lots under the Framework Agreement. Commissioning and Brokerage can maintain an overview of the packages across “shared” providers through the use of an electronic call monitoring system which ensures care delivery is efficient and that payments are made based on delivery of hours. This has been successful and will be a part of the new Framework Agreement including for the new Lots.

Consideration has been given to developing a Dynamic Purchasing System (DPS) which would enable providers to apply to join at any point, as it will remain open rather than opening on an annual basis. It could also be designed with fewer evaluation criteria requirements. Domiciliary Care has previously been commissioned under a DPS which proved to be difficult to manage and resource due to the unpredictable volume and timing of applications. The evaluation criteria was not suitably robust and resulted in several providers joining the DPS and being unable to meet the requirements and quality standards set by commissioners.

6. Recommended tender and procurement process

The recommended option is a Framework Agreement with separate Lots.

The Framework Agreement for community-based services will last for 6-8 years and will be reviewed at year 6 before extending to ensure the contracting arrangements continue to meet the needs of the system and the commissioning mechanisms are still working for the provider market. Review prior to extending for 2 years will allow the Local Authority and partners to evaluate the success of the Framework Agreement and consider alternatives. This Framework Agreement will open annually for the duration of the term where potential providers will have the opportunity to submit a tender.

5. Risks

In consultation with the Planning, Performance and Improvement Team, any risks associated with the project have been identified and a risk register prepared which will be regularly reviewed by the project team. Key risks and mitigating factors are: -

- Risk of reduced market interest in the frameworks due to the recruitment and retention issues in the care market. Commissioners are working with providers to address issues via numerous initiatives outlined in Gloucestershire’s Market Sustainability Plan.
- Risk of providers not meeting the requirement to obtain the Cyber Essentials Certificate. Commissioners will work with the Council’s Information Management Service to engage with and inform providers prior to the procurement process. The procurement will allow additional time (post contract award) for providers to meet the standard.

- Risk of challenge on Framework Agreement term longer than 4 years. The Council is working under the light touch regime that allows more flexible procurement and the Framework Agreement will open annually for new entrants.

6. Financial implications

The current Framework Agreement pricing model sets out a clear and consistent pricing structure for each Lot and allows transparency in the various costing models.

The Council will work with providers to set payment terms that are appropriate and fair. Across the new Framework Agreements, consistent methodology to uplift provider rates to reflect economic pressures will be captured through the technical exercise undertaken by Strategic Finance using indices EARN03, CPI and BMI.

7. Climate change implications

The hyper-localised approach to commissioning domiciliary care will reduce the travel between individuals visits and improves upon existing practice. We will continue to liaise with Climate Change leads at the council and build consideration of environmental impacts into our approach where possible.

8. Equality implications

Has an Equalities Impact Assessment (EIA) been completed? Yes.
Cabinet Members should read and consider the Equalities Impact Assessment in order to satisfy themselves as decision makers that due regard has been given.

9. Data Protection Impact Assessment (DPIA) implications

A Data Protection Impact Assessment has been undertaken. The outcome showed a medium risk - the minimum-security accreditation of “Cyber Essentials” will be required, as personal data will be processed.

10. Social value implications

For those providers on the new Framework Agreements with whom we spend over £500,000 per annum, the new contract will contain a requirement to demonstrate social value. It will focus on employment opportunities, engagement with the local community and improving the lives and outcomes of individuals. Social value will be included in the supplier evaluation process.

The Council will be using a new performance and evidence-based approach to Social Value, based on the National TOMs (Themes, Outcomes and Measures) which has been developed for the Council by the Social Value Portal. Tenderers will be required to propose credible targets against which performance (for the successful Tenderer) will be monitored. Tenderers are free to choose those measures that are proportional and relevant to their business and this specific contract. However, a key success factor for Tenderers will be to demonstrate the ability to deliver against the commitments made.

Tenderers will be required to provide the following as part of their tender:

a) A quantified Quantitative Social Value Proposal; and
b) A Qualitative Social Value Proposal providing evidence describing how the social value being proposed will be delivered against each of the measures offered.

The Council will make provision for these commitments in its contract with the winning Tenderer which will then be monitored and reported on periodically throughout the term of the contract.

The Council recognises that the process of measuring and delivering Social Value requires flexibility and a collaborative approach. Agreed Social Value commitments may require a certain amount of refinement as a result. A key requirement is the willingness of the provider to work openly and transparently with the Authority whilst bearing in mind that the overall value of Social Value commitments made must be delivered.

Full details on the Social Value Portal and the National TOMs framework is available here https://socialvalueportal.com/national-toms/.

11. Consultation feedback

Extensive engagement has been undertaken to evaluate the current Framework Agreement, procurement process and subsequent commissioning arrangements and feedback from a range of partners and stakeholders has been considered to include views from: -

- The Partnership Boards
- User-led Organisations
- External Providers on the current Framework Agreement
- External Providers not on the current Framework Agreement
- Gloucestershire Care Providers Association
- Operational Teams across Health and Social Care.

The Partnership Boards are co-producing questions for evaluation and scoring in the procurement.

12. Officer recommendations

It is recommended that Cabinet delegates Authority to the Executive Director Adult Social Care, Wellbeing and Communities, in consultation with the Cabinet Member for Adult Social Care Commissioning to implement the Recommendations contained in the corresponding section of this report.

13. Performance management/follow-up

The new Framework Agreement will be underpinned by quality monitoring arrangements and peer led performance monitoring. Contracts will detail robust contract management arrangements.

Annex 2

Gloucestershire Health and Social Care Framework

Engagement Summary

June 2023

Introduction

The existing Gloucestershire Health and Social Care Framework will end on 31st March 2024. We will need to put into place suitable contractual arrangements for 1st April 2024 and have undertaken extensive engagement work as part of the commissioning review of the current contract and processes. We will evaluate the effectiveness with key stakeholders to include;

- Individuals
- Family Carers
- User-Led Organisations
- External Providers
- Gloucestershire Care Providers Association
- Operational Teams
- Commissioners

Learning from the engagement will inform the proposals and plans for any new procurement strategy and contracting arrangements.

Aims of the Engagement

1. To evaluate the effectiveness of the contract Terms and Conditions to include the various Service Specifications
    a. Do the terms work for the purchasers and the providers?
    b. Are the specifications clear and do they define the services well enough?
2. To test whether the processes associated with the running of the framework (e.g. for sourcing individual packages of care and support) work well
    a. Do providers actively engage in the process and understand what they need to do?
    b. Is the process delivering the required outcomes for operational teams?
3. To review the procurement process and the support offered to providers
    a. Are there any areas we need to make clearer or offer more support with?
    b. Is the process as efficient as it can be?

Engagement Methods

The engagement has been inclusive and accessible with a variety of ways for stakeholders to give feedback via:

- Agenda items and discussion in established meetings and forums
- Electronic Surveys (email)
- Online Surveys
- Individual appointments for discussions as requested (in person, telephone or virtual)
- Drop-in events at public venues across the County
- Smaller Focus Groups – established to address issues raised in early engagement.

Where necessary we have taken advice and guidance from User-Led organisations on the best way to engage using easy-read communication where required.

Individuals and Family Carers

We attended the following Partnership Board meetings to engage with individuals and family carers;

- Learning Disability,
- Physical Disability & Sensory Impairment,
- Mental Health,
- Autism
- Carers
- Collaborative Partnership Board

We posed semi-structured questions and facilitated break-out room discussions to collect views on areas where services could be improved and prompted attendees to be solutions focussed. We analysed the feedback to identify key themes and discussed with the wider project team to understand where the commissioning model, procurement, contract and associated processes may need to be changed to support service improvements.

Individuals and Carers identified potential issues with additional training to support complex conditions such as Acquired Brain Injury, Myalgic Encephalomyelitus, Complex Emotional Needs, sensory needs and neurodiversity. Commissioners are developing a resource to share with providers on specialised training available in Gloucestershire and will update contract specifications accordingly. Colleagues in the Operational teams can complete checks on the relevant provider training prior to facilitating packages of support. The tender will include a request for the providers training matrix and commissioners will adapt the way we share provider lists wit operational teams and brokers to ensure specialist training is captured to better match individuals with providers.

Individuals and Carers across the Partnership Boards cited accessible communication as an issue in services – some people thought paid support workers needed to spend more time learning how to communicate effectively so they can better understand the wishes and preferences of the people they support. This in turn would improve the support generally. When asked what would improve this there were several suggestions as follows:

- Improved training and resources for paid support workers
- More time allowed for getting to know the individual supporting
- Providers could build better links with community resources and voluntary organisations and groups to improve their knowledge but also to link people in with local opportunities
- Providers could increase multi-agency working to improve their knowledge and understanding.

Commissioners will work with the user-led organisations to co-produce questions for the procurement to include robust evaluation criteria.

LGBT+

We wanted to engage with individuals from LGBT+ communities who have knowledge of the Gloucestershire Health and Social Care Frameworks to see if there are areas of learning for service improvement.

We engaged via PRISM (the staff network for the council and Gloucester City Council) and circulated an online survey to gather views on the following:

1. What would make a care provider excellent in supporting people?
2. What should Providers consider when delivering an inclusive service?
3. What do you think Care Providers could do differently to provide an inclusive service?

- The survey responses stated that providers need to be considerate of every person's identity and understand any health inequalities LGBT+ individuals may face.
- Respondents said providers need to be aware of the LGBT Action Plan 2018.
- Respondents suggested that recruitment processes need to be centred around values
- Respondents asked commissioners to check that providers have clear policies for staff
- Respondents stated the importance of training on Equalities, Diversity and Inclusion so paid support workers can improve their knowledge beyond their own lived experience and stated there needs to be an emphasis on these issues in their day to day practice to include opportunities for reflective discussion with peers and through supervisions.
- The LGBT+ network feel that the care sector could use more inclusive information with inclusive language. This would help individuals to feel welcome and comfortable to receive care services.

The procurement process will include checks on the relevant policies and includes questions and criteria on values based recruitment. The contract will stipulate the training and policy requirements, and this will be contract monitored robustly.

BAME Communities

We have completed a review of engagement done across commissioning areas to identify key themes which can also be addressed through questions in the procurement, robust evaluation, clear expectations for provider training and ongoing monitoring as follows:

- Accessible information on services that are available
- Accessible advocacy
- Inequality of healthcare experiences

External Providers

Engagement with providers is not limited to a single exercise and we have been discussing potential arrangements for after the current framework ends with the market at the quarterly forums, via the monthly newsletters and with the GCPA. We facilitated drop-in events across the county to provide opportunities for individual discussions with providers – these were successful and well-attended. We have used an online survey to gather the views of external providers as it enables confidential completion, can be done remotely and in a provider's own time and delivers data that is easily analysed. Summarised results and key findings (which have been presented back to the provider forum for discussion) are below:

- 75% of providers whose tender submission was unsuccessful did not attend any of the information events prior to application. The events organised by commissioners are useful and provide valuable support on the process.

- 48% of providers surveyed thought the tender instructions and documentations were easy to follow. Commissioners will review the tender documentation with colleagues in procurement to streamline and simplify where this is possible.
- 90% of providers surveyed said the Q&A process within the procurement was helpful.
- Providers found the ICT/Information Security documentation challenging. There are new requirements in the next procurement – commissioners will ensure ICT colleagues are available to support at the information events.
- 74% of providers surveyed said they would like a contract-length that is longer than 4 years. Commissioners propose a 6-years plus 2-years contract term.
- Providers surveyed preferred face to face meetings with commissioners and found sometimes replies were not timely. The drop in sessions held for providers were well received and commissioners plan to hold these twice a year to give opportunities for more face to face meetings. The contract monitoring process that underpins the contract will include the option for face to face meetings.
- Providers reported a lack of clarity around the definition of complex care. Commissioners facilitated a focus group to look at this issue in detail which will inform the service specification wording.
- Providers reported that they need timely feedback when they are not chosen to support an individual.
- Providers wanted clear guidance on the Brokerage process and the referral routes. This will be developed and form part of the tender pack.
- Providers stated a wish for more detailed information on individuals so that they can make decisions on whether their organisation is a good match for the person. Commissioners will work with colleagues in Operations and Brokerage to address and standardise as much as possible.
- Providers would like to receive Individual Service Contracts quickly following agreement. Improved systems will support a more efficient process for the issue and return of contracts.

Commissioners and Operational Teams

We have completed semi-structured interviews with colleagues and used an online survey to ascertain the effectiveness of the contracting arrangements and to ask for suggested improvements with a specific focus on the processes associated with the framework and the paragraphs and clauses in the contract itself. Commissioners have also been asked to collate a log of issues and queries that have arisen within the last 12 months. The following issues are highlighted for improvement in any new arrangements:

- Better understanding of complex needs by those supporting the commissioning of individual packages
- More information about the providers on the framework for operational teams

Feedback from internal stakeholders about the framework was positive. The uniform terms and conditions are helpful in ensuring clear contract management that is equitable and transparent. Uniform pricing has saved resource in negotiating costs and provides a clear and fair means to agreeing packages that allows quality of services to become the focus.

Agenda Item 11

NHS Gloucestershire ICB Board (Public Session)

Wednesday 26th July 2023

Report Title	ICB Governance Review		
Purpose (X)	For Information	For Discussion	For Decision
		X	
Route to this meeting	The BDO internal audit report Governance Review was considered by the Audit Committee at its meeting on 27th June 2023		
Executive Summary	In May 2022 BDO performed an advisory review on the progress being made to set up the governance and structure arrangements for the ICB. This established that the incumbent CCG was making good progress with regards to the transfer of staff and governance arrangements for the establishment of the ICB. Gloucestershire had evidence of good practice when compared to peer organisations in these areas of ICB arrangements. Following on from this work and as part of the internal audit plan for 2022/23, BDO Internal Auditors undertook a review of the effectiveness of the governance arrangements of the ICB in its first six months, which concluded 9 months later. The purpose of this advisory work was to review the ICB's governance infrastructure, including the Integrated Care Partnership and the Board effectiveness to ensure there are robust processes for identifying and monitoring finance, operational and governance matters within the existing committee structures. BDO asked 11 members of the Board to rate the effectiveness of the Board on a scale of one to 10, one being not at all effective and 10 being very effective. The average score across each of the Board members was 7.7/10, with the scores ranging between 6.5 and 10. This was an open-ended question which allowed the auditors to ask board members a range of questions and gather their insight into how governance arrangements were working in the ICB.		

<table>
<tr><td>Key Issues to note</td><td colspan="4">The attached presentation identifies the key findings from the governance review and the response of the ICB to those findings. In particular it is noteworthy that the ICB is continually seeking to shape and pro-actively respond to external and internal demands in the way that its governance structure, procedures and processes operate. As such the sub-committee terms of reference are frequently reviewed and where required updated by the relevant committee and submitted to the ICB Board for approval.

This iterative process ensures that the governance structure and processes are fit for purpose. Many of the findings that have been highlighted in the Governance review are already part of an on-going process to assess our governance structure and ensure that our committees remain agile and adaptive to new demands such as the inclusion of pharmacy, optometry and dentistry in the Primary Care & Direct Commissioning Committee. The feedback and recommendations from the review are being actively implemented as outlined in slide 3.

The report was presented and discussed at the Audit Committee meeting on 27th June. The Audit Committee noted the findings and will monitor the implementation of the management action plan.</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">Without a robust governance structure, procedures and processes the ICB would be unable to function and carry out its statutory duties.
Add a risk rating, even if low:
(5x2) 10
(5x1) 6 (residual meaning accepted risk)</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">This Governance Review has been conducted independently by the Internal Auditors BDO. There are no conflicts of interests related to this work.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>X</td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">There is no financial impact related to this governance review</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The governance structure and processes were reviewed by BDO in the light of the ICB’s statutory duties and responsibilities including those that concern financial and performance management.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">This report did not identify any findings related to health inequalities.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">This report did not identify any findings related to equality and diversity</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">This report did not address sustainable development</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">The report addressed the inclusion of VCSE, noting that the ICB has robust arrangements for including the VCSE on the ICP and Healthwatch and the VCSE are invited to ICB Board meeting to present as they choose on patient stories, which they wish to bring to the attention of the Board.</td></tr>
</table>

Recommendation	The Board is asked to discuss and note: • the Governance Review 22-23 • that the Audit Committee will monitor the implementation of the management action plan.		
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**		

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

NHS Gloucestershire ICB

ICB Board meeting 26th July 2023
Governance Review

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Findings

- BDO asked 11/17 members of the Board to rate the effectiveness of the Board on a scale of one to 10, one being not at all effective and 10 being very effective. The average score was **7.7/10**
- Good behaviours demonstrated by Board members
- Good spread of thinking, skills and background.
- Relationships and balance between NEDs, Partner Members and the Executive Directors allow for open dialogue and challenge
- Chair of the Board was reported as effective, knowledgeable, collaborative, sets a good tone
- CEO aspirational, down to earth and approachable.
- Board was unified, starting to gel, building on existing strong relationships
- Chair has developed relationships, provided support and facilitated shared learning through her meetings with system NEDs NED Network across ICS
- Strong partner relations and engagement across One Gloucestershire especially the work on urgent care

  NEDs acknowledged the skills and qualities of the ICB staff
- Robust risk management arrangements partners agreed on top three risks (UEC, Workforce & Finance)
- It was recognised that a huge amount of work had been undertaken by the One Gloucestershire Health & Wellbeing Partnership to develop the Integrated Care Strategy. Members felt that they had been adequately consulted
- Acknowledged early days and some complex issues would need to be addressed and they would want to ensure that there is *sufficient time for robust and open conversations to be led by the Chair with opportunity for them all to input*.
- There was a feeling that the Board member numbers were probably at a maximum for effective working. The Board was seen to be held accountable for its actions but respondents reported “it is developing and individuals are building up their knowledge but they weren’t ‘there yet”

In order to strengthen your Board effectiveness levels from the current perceived average of 7.7 to 10, the following should be considered:

Set up a process to review performance and effectiveness of Board and Committee meetings & changes to ToR and review of the frequency of Committee & ICS To include an assessment of assurances provided in all Committee meetings

- **There is an iterative process to reviewing the Board and Committee's remit and amend ToR on a regular basis**

Establish a skills matrix for Board & Executive members ensuring it covers all skills, knowledge and experience

- **Board Executives / NED specifically recruited to cover full range of knowledge, experience and skills required**

Review Board composition in order to ascertain if there is potential to bring in further skills around VCSE

- **VCSE included in ICP, developing strategy, Healthwatch VCSE are invited to present to the Board according to own priorities and highlight case studies to the Board**

To make the BAF objectives more succinct with a clear link to the ICB & ICS objectives

- **ICS strategic objectives for 23-24 currently being developed and linked to updated BAF**

Linkage of the individual strategies to the overall One Gloucestershire ICS Strategy with responsibility for delivery clearly articulated

- **Work has been undertaken to link current strategies to ICS Strategy and ensure delivery**

Development of a more comprehensive Board paper forward plan, so the timing of decisions and areas of assurance were clear in advance.

- **A comprehensive forward Board paper plan is underdevelopment**

Agenda Item 12

NHS Gloucestershire ICB Board (Public Session)

Wednesday 26th July 2023

<table>
<tr><td>Report Title</td><td colspan="5">NHS Workforce Plan – implications for the ICS</td></tr>
<tr><td rowspan="2">Purpose (X)</td><td>For Information</td><td></td><td>For Discussion</td><td></td><td>For Decision</td></tr>
<tr><td></td><td></td><td>X</td><td></td><td></td></tr>
<tr><td rowspan="3">Route to this meeting</td><td colspan="5">The NHS Workforce Plan was presented to the People Committee on the 20th of July 2023.</td></tr>
<tr><td colspan="3">ICB, ICS partners</td><td colspan="2">Date</td></tr>
<tr><td colspan="3"></td><td colspan="2"></td></tr>
<tr><td>Executive Summary</td><td colspan="5">The NHS long-term workforce plan was published on 30 June 2023. The plan takes a 15-year view (2021/22 to 2036/37) of the NHS clinical workforce and addresses how a staffing shortfall of between 260,000 and 360,000 will be addressed over this duration.
It sets out the case for change and investment in that, despite recent increases in staff, we are starting with high vacancy rates for many clinical roles, demographic changes (in the general population and staff), and an increased demand for services.

Investment of £2.8bn over the next five years to fund additional training and education places has been committed to.

The plan has three priority areas:

• Train: Substantially growing the number of doctors, nurses, allied health professionals and support staff.

• Retain: A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.

• Reform: Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

Whilst the plan is a national one, there are many elements that will need local response and action, and there is critical role for ICSs to work to connect local partners in delivery; the short-term focus will be on recruitment and retention.

There is a commitment to refresh the plan at least every two years.</td></tr>
</table>

<table>
<tr><td>Key Issues to note</td><td colspan="4">Some of the key plan highlights which we will need to take account of in our local plan and response:

• The plan has a number of assumptions built into it, not least that a productivity improvement of 1.5 – 2% (double the historical average).

• A shift from acute to community care, focused on proactive and preventative interventions.

• New and extended roles (e.g. nursing and physician, associates, advanced practitioners)

• Digital and genomic technologies will provide opportunities to innovate, transform work and enhance productivity. Upskilling the workforce to maximise opportunities from digital technologies. Expanding the scientist training programme to increase the Genomics Medicine Service.

• Bringing people into the workforce differently and more efficiently. Examples include an increase in medical apprenticeships, earlier introductions into the workforce for those in training, shorter training programmes (e.g. paramedics three to two years), accreditation of prior learning.

• Improving learner experience, widening participation and more diverse and integrated clinical placements (e.g. multi-profession, system-based rotational placements)</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The national plan excludes social care, so any local impact and considerations for this important staff segment will need to be reviewed and planned for locally.
There are a number of emerging risks associated with the plan's implementation including concerns about adequate staffing infrastructure to support educational supervisors and training as well as placement capacity.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">There are no identified conflicts of interest that have arisen in the collation of this paper.</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">Additional national investment of £2.8bn has been announced to support the education and training elements of the plan. It is presumed further details on this will follow.
No announcement of local funding has been made, we will need to produce a local response and implementation plan, aligned to our local People Strategy, and alongside develop an investment plan</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The workforce plan, builds on the NHS Long- Term Plan, NHS People Plan, NHS promise and 10 People Function Outcomes.</td></tr>
</table>

Impact on Health Inequalities	The plan makes explicit reference to supporting the health of local communities and reduce inequalities through access to training and employment opportunities and NHS organisations maximising their role as anchor organisations within the communities they serve.		
Impact on Equality and Diversity	The plan makes explicit reference to implementing the NHS people promise to embed a culture of belonging in the NHS and improve the staff experience.		
Impact on Sustainable Development	Not applicable.		
Patient and Public Involvement	The national plan has had engagement with a selection of organisations during its formation, further wider engagement is expected to follow.		
Recommendation	The People Committee is requested to note and discuss the NHS National Workforce plan, it's local impact and the local priorities we should focus on		
Author	**Tracey Cox**	**Role Title**	**Director, People Culture & Engagement**
Sponsoring Director (if not author)	**Tracey Cox, Director, People Culture & Engagement**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
CSU	Commissioning Support Unit
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council

Overview of NHS Workforce Plan and implications for the ICS

1. Introduction

The NHS Long Term Workforce Plan was published on 30 June 2023. It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period and working in new ways to improve staff experience and patient care. The proposals set out a costed plan with over £2.4 billion committed to fund additional education and training places over the next five years, on top of existing funding commitments.

The plan has 3 main priorities: -

- **Train**: Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.

- **Retain**: A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.

- **Reform**: Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

2. The Plan in Numbers

- Double the number of medical school training places to 15,000 by 2031/32
- Increase the number of GP training places by 50% to 6,000 by 2031
- Increase adult nursing training places by 92%, with 24,000 more nursing and midwifery training places a year by 2031
- Increase train nurse associates to 10,500 by 2031/32
- Provide 22% of all training for clinical staff through apprenticeship routes by 2031/32, (currently 7%)
- Introduce medical degree apprenticeships, with pilots running in 2024/25. It is proposed 2000 medical students will train via this way
- Expand dentistry training places by 40% to 1,100 places by 2031/32
- Enable more than 6,300 clinicians to start advanced practice pathways each year by 2031/32
- By increased domestic training, reduce the reliance on international recruitment (to 9-10.5% compared to nearly 25% now)

3. Key Assumptions

The plan also has a number of key assumptions which we will need to take account of in our local plan and response:

- A productivity improvement of 1.5 – 2% (double the historical average).
- A shift from acute to community care, focused on proactive and preventative interventions.
- A higher growth in the Mental Health and Learning Disabilities workforce.
- An expansion in personalised care roles (e.g. care co-ordinators, Health and wellbeing coaches, social prescribers)
- New and extended roles (e.g. nursing and physician, associates, advanced practitioners)
- Digital and genomic technologies will provide opportunities to innovate, transform work and enhance productivity. Upskilling the workforce to maximise opportunities from digital technologies. Expanding the scientist training programme to increase the Genomics Medicine Service.
- Bringing people into the workforce differently and more efficiently. Examples include an increase in medical apprenticeships, earlier introductions into the workforce for those in training, shorter training programmes (e.g. paramedics three to two years), accreditation of prior learning.
- Improving learner experience, widening participation and more diverse and integrated clinical placements (e.g. multi-profession, system-based rotational placements)
- Doctors other than GPs more easily able to work in Primary Care and further expand the Additional Roles Reimbursement scheme (ARRS)
- We are able to address historical regional imbalances in medical training placements and reach previously under-served communities.
- A move towards blended learning programmes using more digital delivery.

4. Implications for the ICS

The strategy assumes a key role for ICSs in the delivery of the NHS Workforce plan's ambitions. There is a significant lead in time for the mobilisation of additional education and training capacity meaning in the short term there will need to be a greater and an unrelentless focus on the retention of existing staff and looking at opportunities to recruit via domestic pipelines through local attraction strategies. This aligns locally with some of the workforce ambitions we have set out within the Integrated Care Partnership Strategy.

There are also significant implications for our future work programme including but not limited to: -

- We will need to develop a plan for significant further expansion of our apprenticeship offer for the training of clinical staff

- Further strengthening the relationship and joint strategic planning with higher education institutions to support students, placement capacity and accreditation of prior learning

- We will need to develop the necessary infrastructure to cope with the significant expansion of clinical placements and implement the new educator strategy which sets out actions to increase capacity and the quality of educators.

- Increasing our capability and capacity on workforce planning at every level of service

5. Next Steps:

The timing of the publication plan and the production of our own One Gloucestershire People Strategy means that we are able to see how these priorities align with our local ambitions. We are confident there is good synergy between the two. We will bring the One Gloucestershire People Strategy to the ICB in September for approval.

NHS Employers have produced a helpful guide on key actions that need to be taken. We have begun to review and self-assess our current and intended plans against this framework. We need to review what actions would best be delivered across the system and what is better delivered by local organisations separately.

Agenda item 13

NHS Gloucestershire ICB Board (Public Session)

Wednesday 26th July 2023

Report Title	**Hewitt Response – Government Response**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting	Strategic Executive → Integrated Care Board					
	ICB Internal	**Date**	**System Partner**	**Date**		
			Strategic Executive	20th July 2023		
Executive Summary	The Government issued a combined response to the Hewitt Review and House of Commons Select Inquiry into Integrated Care Systems in June 2023. The NHS Confederation have undertaken a detailed review of the response. This is provided in Appendix 1 along with the breakdown of the Government response to each action. Overall, the response to recommendations is positive with the majority of recommendations across both the Hewitt Review and Select Inquiry accepted. There is continued support to Integrated Care Systems with a commitment of devolution to local systems – with meaningful transparency. There is a commitment to fewer national targets and parity to local priorities to help unlock devolution alongside a commitment to support to the development of Health Overview and Scrutiny Committees. Although Government didn't go as far as approving the 1% of spend to be moved into prevention over the next five years it has committed to supporting systems in making their own local decisions in this area. The response includes a commitment to rolling more funding into allocations rather than drip-feeding funding through individual funding pots. This is alongside an urgent review of capital spending to ensure there are no further delays in funding reaching local systems.					

<table>
<tr><td>Next Steps</td><td colspan="4">Government will be taking forward those recommendations accepted in both reviews.

There are areas that NHS Gloucestershire ICB may wish to further consider in light of the Government response:

• How locally we can commit a greater percentage of funding going towards prevention
• The development of a local shared outcomes framework following publication of Government guidance and, in light of this, further refinement of locally co-developed priorities in future iterations of the Integrated Care Strategy and Joint Forward Plan
• Further work that can be undertaken to support interoperability and information sharing across the system including with adult social care organisations
• The continued maturity of One Gloucestershire ICS drawing on approaches such as peer review and leadership development to support local improvement.</td></tr>
<tr><td>Key Risks:</td><td colspan="4">No risks registered.</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">The Government response sets out a commitment to reviewing the capital funding regime as well as reducing the number of ad hoc funding pots for local systems.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The Hewitt Review and Select Committee inquiry is about increasing autonomy for local systems. There are no direct regulatory/legal implications at this stage for Integrated Care Systems.</td></tr>
<tr><td>Impact on Health Inequalities
Impact on Equality and Diversity</td><td colspan="4">The Government response reflects the need for systems to determine local priorities – including a commitment to addressing health inequalities and having an impact on equality and diversity. For Gloucestershire this commitment is set out in our Integrated Care Strategy and Joint Forward Plan.</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">None.</td></tr>
<tr><td>Recommendation</td><td colspan="4">Strategic Executive / Integrated Care Board are asked to note the Government response to the Hewitt Review and House of Commons Select Inquiry.</td></tr>
<tr><td>Author</td><td>Mark Golledge</td><td>Role Title</td><td colspan="2">Programme Director – PMO & ICS Development</td></tr>
</table>

Sponsoring Director (if not author)	**Mary Hutton** **Chief Executive Officer**

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
JFP	Joint Forward Plan
VCSE	Voluntary, Community and Social Enterprise

APPENDIX 1: NHS Confederation Briefing: 20th June 2023

Available at: https://www.nhsconfed.org/publications/governments-response-hewitt-review-and-health-and-social-care-select-committee-report

Key points

- The government has responded to Patricia Hewitt's review of integrated care systems (ICSs) and the Health and Social Care Select Committee's inquiry into ICSs. Overall, the response is positive, with enthusiastic support for the review's central message, most recommendations supported, and only around six of the total 36 rejected.

- The response demonstrates a significant degree of continued support from within government for ICSs, their four core purposes and their role in the health and social care system. Ministerial backing from across government departments over the long term will be crucial to their success, so we welcome a more expansive view of ICSs as more than just health or the NHS.

- We are encouraged that the government endorses the need to shift to a preventative model and acknowledges that further devolution is needed to achieve this – two key priorities for our members. The government's new NHS mandate is evidence of a more streamlined approach to national target-setting and should be followed through in interactions between the Department of Health and Social Care (DHSC) ministers and officials, and system leaders.

- We welcome the commitment to rolling more funding into allocations where possible, avoiding a 'drip, drip' of small, ringfenced funding pots being allocated in-year in an inefficient way, which will better enable local leaders to plan. The review of capital spending will also give quicker access to funding for infrastructure and building digital capabilities.

- It is, however, disappointing that the government has not committed to a social care national workforce plan to complement the forthcoming national NHS workforce plan.

- We also have concerns about the 10 per cent planned further reduction to ICSs' running cost allowance (RCA) in 2024/25, which the government is still planning to go ahead with, contrary to the Hewitt review's recommendation, and risk distracting from ICSs' purposes. This is on top of the 20 per cent cuts that are due in 2023/24 and an effective real-terms cut from inflation. There continues to be an under-valuing of the importance of NHS management and we believe this should be revisited ahead of the next financial year.

- NHS England's letter to ICS leaders also indicates its strong support for the review. We will continue to work with NHS England to support implementation of its operating framework.

- We welcome many of the recommendations of both the Health and Social Care Select Committee inquiry and the review, which represent many of our members' key priorities. We look forward to working with our members, the government and key partners including DHSC, NHS England, the Care Quality Commission (CQC) and the Local Government Association (LGA) to support a collaborative approach to implementation of the Hewitt review.

Background

The government chose to provide a joint response to both the Hewitt review and the Health and Social Care Select Committee's ICS Autonomy and Accountability inquiry, as there is significant overlap. However, the two reports have different functions and implications.

Independent reviews are commissioned by ministers to consider particular issues and potential changes to policy. There is no obligation for government to adopt any of the recommendations, but more likely than an inquiry given the government has commissioned the review. Meanwhile, select committee inquiries are part of the parliamentary scrutiny process and enable the legislature to identify deficiencies in the policies of the

executive and to set out how they should change them to make them more effective. The Health and Social Care Select Committee is largely concerned with examining the work of the DHSC in terms of spending, policies and administration, as well as the arm's-length bodies (ALBs) that 'sit under' the department. The Autonomy and Accountability inquiry was initiated when the now-Chancellor Jeremy Hunt was chair of the committee.

The Hewitt review was published very early in the life of ICSs, seeking to support the significant changes envisaged under the Health and Social Care Act 2022 which demand a high level of commitment from central government and the wider health and care system.

Analysis

We welcome the government's response to the Hewitt review, which is a clear indication of the government's support for ICSs and a commitment to a model of devolved decision-making alongside appropriate accountability. This message was reinforced in the keynote speech by the Secretary of State for Health and Social Care at NHS ConfedExpo: "For me the opportunity is to devolve much more and to trust local decision-makers. In return to expect more meaningful transparency."

The response is also an endorsement of the shift of resources to preventative care to deal with the challenges that the health and social care system faces today and in the future. This approach is a key priority for our members to support the changing health needs of their communities.

We recently set out the key priorities of ICS leaders for implementing the Hewitt review recommendations and we are pleased to see that many of these have been accepted, at least in part, in the government's response.

Although the government has not committed to the Hewitt review recommendation to increase the total share of NHS budgets at ICS level going towards prevention by at least 1 per cent over the next five years, this does not preclude progress on this front locally. The government's commitment to work with ICSs to support investment in prevention, including locally defining preventative healthcare spending and baselining, will support ICSs to make progress in this important area.

Fewer national targets with parity with local priorities will unlock much-needed devolution, empowering local leaders to deliver improvements to patient care. This more flexible approach is reflected in the government's new NHS mandate and we will continue to work with the government and arm's-length bodies to ensure interactions with ICSs are aligned with this new approach, in line with the behaviours and ways of working described in the review, inquiry and NHS England's operating framework.

Enhanced local autonomy will be matched by appropriate accountability, including through the CQC. We are encouraged by the approach DHSC and the CQC are taking to developing ICS assessments and taking time to finesse their approach to ratings. We welcome the decision not to create additional mechanisms for individual MPs to hold ICSs to account (as was suggested in recommendation 18 of the Health and Social Care Select Committee inquiry), which would circumvent parliament, go against the spirit of the Hewitt review and move towards fewer national targets, missives and directives.

The government has committed to rolling more funding into allocations, avoiding the 'drip, drip' of small pots. This will let local leaders plan and make best use of the funding available to them. We will work with NHS England, DHSC, and the Treasury to ensure in-year settlements or ringfencing are limited to situations where it is absolutely necessary, as committed to in the response.

The government has also committed to an urgent review of capital spending to ensure there are no further delays to funding reaching new hospitals, improved diagnostics and digital technology. We look forward to seeing the government's planned next steps and hope these include a rapid review of the capital sign-off process to ensure that existing budgets are reaching projects quickly and best used to meet local needs.

The government has decided not to enable flexibility to choose between payment mechanisms within the current NHS Payment Scheme, which will make it more difficult for ICS leaders to increase efficiency and

achieve a shift in prevention. However, the government has opened the door to learning from international payment mechanism to shape future payment schemes.

We also have concerns about the planned scale of cuts to ICSs' Running Cost Allowance, which risks hindering capacity to deliver improvement and distract from ICSs' core purposes. It continues to be the case that expenditure on NHS management is undervalued, despite all the evidence suggesting that the NHS is under-managed compared to international health systems. These latest cuts to management costs risk impeding progress against ICSs' primary objectives. In particular, the scale of the immediate cuts to NHS running costs will distract from driving forward improvements in care, reducing waiting times and improving access to care for the public.

Finally, given the urgency of the social care workforce crisis, our members and their local communities will be disappointed that the government is not committing to a social care national workforce plan to complement the NHS workforce plan. We will not fix the problems in the NHS without tackling head-on the challenges in social care.

We look forward to working with the government and key partners including NHS England, the CQC and the LGA to support a collaborative approach to implementation with a focus on the priorities which are most important to ICS leaders. In the meantime, we will work with our members and partners to carry forward recommendations where we can to help local health and care systems to achieve their mission, including in developing a national leadership support offer, building on our peer review offer, and agreeing a common approach to co-production.

Recommendations and responses

Below are tables summarising the government's response to each recommendation of the Hewitt review and of the Health and Social Care Select Committee inquiry on ICSs, and our interpretation of the extent to which each has been accepted.

Government Response to the Hewitt Report		
1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1 per cent over the next five years. To deliver this the following enablers are required: a) DHSC establishes a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention. b) Following an agreed framework, ICSs establish and publish their baseline of investment in prevention.	Accepted in part	To support investment in prevention, NHS England and DHSC will work closely with ICSs, local government partners and NICE to develop practical information and evidence to support local investment decisions. This will include considering the methodologies for developing an appropriate definition for preventative healthcare spending and exploring options for local baselining. Once this process has concluded we will make an assessment on publishing this information. However, we do not agree with imposing a national expectation of an essentially arbitrary shift in spending.
2. The government leads and convenes a national mission for health improvement. DHSC should publish, as soon as possible, the proposed shared outcomes framework.	Accepted in part	Given that policies affecting many of the underlying drivers of health are the responsibility of departments other than DHSC, we have established the Health Mission Working Group to provide a forum for working with other departments to explore opportunities for cross-government action to drive progress on the health mission and support common interests. In the coming months we will publish a toolkit that will support all places to develop local shared outcomes frameworks.
3. A national Integrated Care Partnership Forum is established.	Accepted in principle	More work needs to be undertaken consider the most effective way of meeting this recommendation.
4. The government establishes a Health, Wellbeing and Care Assembly.	Rejected	There are already a range of forums available to ICSs to facilitate learning and sharing of best practice, such as the ICS Network and Public Health Integration Forum.
5. NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all	Principle accepted but already doing this	Currently, NHS and publicly funded adult social care organisations in England must have regard to information

Joined up care and communities

ICSs in order to improve interoperability and data sharing across organisational barriers.		standards. We have been working to support interoperability, which is detailed in Data Saves Lives.
6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the Data Saves Lives strategy (2022).	Accepted – considering this approach	We will engage further this year to determine the best approach. This may include revising the regulations, which would proceed subject to the parliamentary timetable.
7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.	Accepted	NHS England will work with system representatives to review the membership of the board and understand how best to involve digital and data leaders from across systems.
8. Building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.	Accepted	As we continue to develop the NHS App we are committed to continuing this approach of open sourcing elements of the code that are most useful for others to have access to.
9. The government should set a longer-term ambition of establishing Citizen Health Accounts.	Accepted – planned changes aligned with this approach	Work is ongoing to consider further changes to the NHS App and explore the legal and commercial implications of implementation.
10. Health Overview and Scrutiny Committees (HOSCs)(and, where agreed, joint HOSCs) should have an explicit role as system overview and scrutiny committees. To enable this, DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.	Accepted	DHSC will work closely with local government and ICSs to identify how to support HOSCs to carry out their roles in a way that supports outcome-focused, balanced, inclusive, collaborative and evidence-informed overview and scrutiny of ICSs. This support could include providing necessary resources, guidance and expertise to HOSCs.
11. Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.	Accepted – already in train	ICSs should be enabled to set a focused number of locally co-developed priorities and we have already taken meaningful steps towards this approach. For example, recent reforms to the Commissioning for Quality and Innovation (CQUIN) 2023 to 2024 guidance from wholly national targets to identifying a small number of clinical priority, are allowing local areas to also prioritise locally co-developed priorities and targets.

11. In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this, support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement.	Accepted – already in train	The principle of this recommendation closely aligns with the approach taken by NHS England in the existing NHS oversight framework.
12. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.	Accepted – already in train	CQC is continuing to work with NHS England in developing its approach to ICS assessment, to ensure alignment with NHS England's annual assessments of ICBs, including sharing evidence and information. CQC will test working arrangements with NHS England during its pilot assessments.
13. A national peer review offer for systems should be developed, building on learning from the LGA approach	Accepted	A national peer review offer should be developed by partners within the system, moving towards a more bottom-up, autonomous model of improvement and agreeing that this should build on learning from the approach developed by LGA.
14. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.	Accepted	NHS England will work with ICB leaders to consider how to best support ICBs to mature, building on the co-design approach that has been used to support the development of ICSs so far.
15. An appropriate group of ICS leaders should work together with DHSC, Department for Levelling Up, Housing and Communities (DLUHC), and NHS England to create new high accountability and responsibility partnerships.	Accepted in principle	DHSC supports the intent behind the recommendation and will undertake further work as ICSs mature to understand how it could be implemented in practice.
16. During 2023 to 2024 financial year, further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10 per cent cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.	Accepted in part	NHS England has set out its policy intent with respect to the delegation of services to ICBs and the transfer of associated budgets. In 2023 to 2024, NHS England completed the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services to all ICBs. This is accompanied by a transfer of funding, as well as a transfer of staff and functions from NHS England to

		ICBs. In 2024 to 2025, the intention is to begin formal delegation of specialised commissioning services and NHS England will continue to explore the delegation of further services and functions into the future where it is agreed that ICB-level commissioning is the optimal commissioning model. As part of the Creating a New NHS England programme (following the merger of NHS England, Health Education England and NHS Digital), NHS England is also making significant reductions in the size of regional and national teams over 2023 to 2024 and 2024 to 2025. The 10 per cent cut in ICB RCA planned in 2025 to 2026 forms part of the 30 per cent real-terms reduction per ICB by 2025 to 2026, which has been agreed with government and which forms part of NHS financial plans.
17. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.	Accepted – already in train	DHSC is working closely with NHS England on the development of a new very senior manager (VSM) pay framework that will ensure that senior manager pay is set at the right level. The new framework aims to improve consistency and transparency of VSM pay-setting processes and will be made publicly available.
18. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.	Accepted – already in train	NHS England continues to work closely with ICBs to design the arrangements for delegating further commissioning functions from regional teams to ICBs, following the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services.
19. NHS England should work closely with the LGA, NHS Confederation and NHS Providers to further develop the leadership support offer.	Accepted	We accept the value of having a national leadership programme across health, care and wider sectors.
20. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS	Accepted – already in train	A senior advisory group across health and care has been brought together to advise and help to plan a three-year roadmap of leadership and management support and development in response to this and other reviews.

21. Ministers should consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than ten national priorities.	Accepted and actioned	We also recognise the benefit of the centre focusing on a small core set of priorities, which has been reflected in the reduction to 31 national NHS objectives within the 2023 to 2024 priorities and operational planning guidance and will be reflected in the forthcoming mandate to NHS England.
22. NHS England and ICBs need to agree a common approach to co-production, working with organisations like the NHS Confederation, NHS Providers and the LGA.	Accepted – already in train	In the [operating] framework, NHS England describes its aim to co-create and secure co-ownership of strategy, priorities and plans both within the NHS and with wider partners, building on the close partnership working that already exists, as demonstrated through the establishment of ICSs and in developing the most recent planning guidance.
23. As part of CQC's new role in assessing systems, CQC should consider within its assessment of ICS maturity a range of factors (set out on page 58 of the Hewitt review).	Accepted	We support the vision set out in the Hewitt review (paragraphs 3.117 and 3.118) and will consider the best approach regarding ICS ratings. This would build on existing plans and development work led by CQC and include ratings on the quality of services within the ICS across the key domains of care and ICS leadership; and we agree that the highest ratings would not be given to a system where the financial position is not being well managed. DHSC and CQC will work with NHS England and other partners to develop these measures and CQC will start to test the ratings as suggested by the Hewitt review (paragraphs 3.117 and 3.118) in 2024 to 2025. DHSC and CQC will also consider the factors listed on page 58 of the Hewitt review.
24. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high-quality data required for the purposes of improvement and accountability. In particular: a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests.	Accepted – already in train	DHSC supports the spirit of this recommendation and is already making progress in several ways e.g. data alliance partnership, five promises on data.

b) Data required in real time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis. c) Data collection should increasingly include outcomes (including, crucially, patient reported experiences and outcomes) rather than mainly focusing on inputs and processes. d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government. e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within three months		
25. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.	Accepted – already in train	Over the course of 2023 to 2024, the government and NHS England will engage with the profession, patients, ICSs and key stakeholders to build further on the Fuller stocktake report. We want to work with the profession and engage on the development of the future general practice contract.
26. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.	Rejected	People at the Heart of Care and Next Steps document cited as government's approach to social care.
27. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.	Accepted	Healthcare regulators have existing standards and guidance on the delegation of healthcare tasks. DHSC will bring together the relevant regulators to review this existing guidance and to consider options for reform.
28. Currently the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised	Rejected	The Agenda for Change framework does currently allow for certain flexibilities, such as the use of recruitment and retention premia (RRPs), which can either be applied nationally or locally, where market pressures would otherwise prevent the employer from being able to recruit and retain staff.

analytical and intelligence. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible		
29. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA), to develop a consistent method of financial reporting.	Accepted	We will establish a working group, including NHS England, system partners and local authorities, partnered with CIPFA, to provide recommendations to the Secretary of State on how to improve the ability of NHS England and local authorities to track and report on collective spending on key areas of expenditure. DHSC expects that part of this project will include how systems define spending on a particular area, understanding what data already exists and how it can be improved.
30. Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms: a) Ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements. b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this. c) National guidance should be further developed providing a default position for payment mechanisms for inter system allocations.	Accepted in part	Significant improvement will continue to be made to reduce the prevalence of in-year funding, particularly where it entails substantial and potentially onerous reporting requirements on systems. We recognise the importance of providing systems with certainty, often providing funding on are current or multi-year basis, such as the commitments regarding the building of new hospitals. The introduction of ICSs has provided systems with greater freedom and autonomy to determine how best to deploy their resources to meet local needs and, with this in mind, in-year funding should be limited to situations where it is absolutely necessary. DHSC agrees in principle that systems should be provided with sufficient flexibility to determine allocations for services and appropriate payment mechanisms… In the context of ensuring flexibility, we agree that ringfencing and hypothecation should be limited, but again note that ringfencing is necessary in some circumstances to secure adequate funding for a particular priority, for instance the Mental Health Investment Standard. NHS England believes that there is already a high degree of specificity/defaults for inter-system payment arrangements.

31. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).	Accepted	We will work together across government to align the publication of allocations for social care, local government, public health and the NHS as much as possible, and to give as much notice as is feasible of allocations for future years.
32. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.	Accepted – already in train	Review underway as promised in the integration white paper.
33. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.	Accepted – already in train	It is critical that ICSs are able to draw on a range of resources to support and incentivise improvement. As part of its role in supporting ICBs to deliver their plans, NHS England already makes a wide range of resources available to ICBs to enable systems to identify and realise productivity opportunities.
34. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.	Accepted	We recognise the importance of best practice in implementing innovative payment models across the country. As part of the NHS Payment Scheme development process, NHS England undertakes a significant programme of engagement with ICBs and other organisations in England, seeking to understand best practice and effective payment models. NHS England is also looking at international comparisons of different payment mechanisms and the resulting impacts they have.
35. There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024	Accepted	We agree with the need for a review, particularly with respect to areas that were not already covered in detail by the 2021 review - specifically setting an overall strategic direction for NHS capital, considering how the current capital regime operates for primary care, clarifying the position on new private finance and improving the data held and management of the NHS estate. We will set out next steps in due course.
Responses to the Health and Social Care Select Committee inquiry		

3. Targets for ICSs set by DHSC and NHS England should be based on outcomes. There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.	Accepted	Given that policies affecting many of the underlying drivers of health are the responsibility of departments other than DHSC, we have established the Health Mission Working Group to provide a forum for working with other departments to explore opportunities for cross-government action to drive progress on the health mission and support common interests. In the coming months we will publish a toolkit that will support all places to develop local shared outcomes frameworks.
5. DHSC should explain the mechanisms that will ensure that progress is made against local priorities. It should set out how this compares to mechanisms used to measure progress against national priorities, alongside an assessment of whether this balance will support ICSs to meet their four main objectives.	Accepted in part	ICSs should be enabled to set a focused number of locally co-developed priorities and we have already taken meaningful steps towards this approach. For example, recent reforms to the Commissioning for Quality and Innovation (CQUIN) 2023 to 2024 guidance from wholly national targets to identifying a small number of clinical priority are allowing local areas to also prioritise locally co-developed priorities and targets.
6. DHSC should publish, as soon as possible, the proposed shared outcomes framework and more information about how and when ICSs should expect it to be implemented.	Accepted in part	In the coming months we will publish a toolkit that will support all places to develop local shared outcomes frameworks. We will work closely with other government departments to make sure that central ambitions for local outcomes are joined up, especially where departmental responsibilities intersect.
8. NHS England should provide an update on whether it intends to refresh its 2019 NHS Long Term Plan and, if so, when. Any update to NHS England's NHS Long Term Plan must put prevention and long-term transformation at its heart, empowering ICSs to pursue these priorities and giving them the confidence that they have the necessary backing from the government and NHS England. This should also apply to the government's pending Major Condition's Strategy.	Accepted in part	The overall aims of NHS England's NHS Long Term Plan remain the right ones and these strategic aims are reflected in planning guidance, service-specific plans and work with systems. DHSC and NHS England continue to work together to monitor commitments in the plan on an ongoing basis. The government is building on the commitments in the NHS Long Term Plan through the delivery plan for tackling the COVID-19 backlog of elective care, the delivery plan for recovering urgent and emergency care services, and the delivery plan for recovering access to primary care, as well as

		the soon-to-be-published Long Term Workforce Plan and the major conditions strategy.
10. To guarantee a continual focus on the prevention agenda, all integrated care boards should ensure they include a public health representative, such as a public health director or public health lead. In 12 months, DHSC should conduct a review to understand the extent to which this is happening. If necessary, further steps should be taken to mandate the inclusion of a public health representative so the focus on prevention is not lost.	Rejected	We agree that there should be a continual focus on the prevention agenda. ICBs are expected to ensure that directors of public health and their teams have defined positions at an ICS and place level, ensuring that ICB decision-making is made with public health input to take account of joint local health and wellbeing strategies in which the directors of public health have a key role in the design and/or sponsorship. While public health is and should remain a crucial role of local government, and may have been included through the recruitment of partner members on ICB boards, systems have the autonomy to appoint members based on their area's priorities… It is important to grant ICSs the freedom to create the architecture and governance for their ICP and ICB that enables them to best serve their population.
12. We welcome the Minister's comments about giving ICSs information about the funding that will be available to them further in advance. DHSC must set out how it intends to do this, and any decision to give that information must be made in plenty of time to support ICS preparations for winter 2023/24.	Accepted in part – already in train	The allocation of funding to ICBs to support them in commissioning services for their local population is one of the key duties of NHS England. NHS allocations, which are published during the NHS planning process, are distributed using an independent 'fair shares' formula. NHS England published allocations for 2023 to 2024, to 2024 to 2025 on 27 January 2023. In advance of the publication of the 2023 to 2024 local government finance settlement (LGFS), DLUHC published a policy statement in December setting out forward notice of the measures to be included in the 2023 to 2024 provisional LGFS and those expected to be maintained into 2024 to 2025. The government's intention was for this to support councils' budget-setting processes by giving them additional, multi-year certainty over their funding levels. For social care, this included setting out the adult social care precept referendum principle

		for 2024 to 2025 and reiterating the increase in grant funding as set out at the Autumn Statement.
14. The government and NHS England should set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders.	Accepted	We accept the value of having a national leadership programme across health, care and wider sectors.
16. Following engagement with ICSs and being conscious of the space required for local priorities, DHSC and NHS England should issue guidance with additional detail on what ICSs are expected to achieve within each of the four core purposes. As we have said previously, the focus here should be on outcomes and not dictating to ICSs how they achieve the goals.	Rejected	As set out above, the combination of the mandate to NHS England, NHS England's planning guidance and system planning provide a complementary and aligned set of processes to deliver on the four core purposes of ICSs. This will allow for the right balance between clarity of national requirements and local innovation and flexibility.
18. The Secretary of State should set out further detail about how he intends to empower MPs to hold their local ICSs to account and what performance measures he envisages being available to support this.	Rejected	It continues to be the case that local leaders are best placed to make decisions about their local populations with fewer top-down national targets, missives and directives. That is why ICSs have greater devolved responsibilities than their predecessors. ICSs are accountable to the individuals and communities they serve. In addition, there are formal accountability arrangements for different partners of ICS that are defined in legislation and other supporting guidance, with local authorities held to account through local democratic processes and NHS organisations accountable to NHS England, which is in turn accountable to government and to parliament.
20. NHS England should provide more clarity about what ICSs should expect in terms of the monitoring of partnership working and how this will be assessed in ICB annual assessments.	Rejected	As part of the NHS England ICB annual assessment process, there is an expectation that ICB partnership arrangements will be discussed as part of ongoing support and oversight relationships with consideration of how these are working. This is informed by feedback from stakeholders including health and wellbeing boards. NHS England does not have a remit to assess the partnership working across the wider ICS. Effectiveness of partnership

		working across the wider ICS will be assessed by CQC through its new role undertaking ICS assessments.
21. DHSC, working with ICSs, should clearly set out what action could be taken, be that by the CQC, NHS England or others, to resolve issues of poor partnership working, in particular with adult social care.	Rejected	CQC will play an important role in assessing systems as a whole. The development activity for these assessments is underway and CQC plans to pilot its approach later this year, before beginning formal ICS assessments by the end of quarter four of the 2023 to 2024 financial year. CQC assessment reports will clearly set out required improvement and best practice. Following the report, system partners (ICBs, local authorities, providers, provider collaboratives and place partnerships) are expected to come together through a local system improvement summit to review assessment findings and publish action plans, which CQC will monitor. NHS England holds the regulatory powers to take necessary formal enforcement action if an ICB or NHS provider has failed or is at risk of failing to perform their duties or meet required standards and this includes duty to cooperate as placed by NHS Act 2006. ICBs are accountable to NHS England via the oversight framework.
23. DHSC should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise, by 1 October 2023.	Rejected	ICBs are required to publish their constitution, which includes a list of ICB board members, in accordance with the Health and Care Act 2022. ICBs have made board member information, including members' expertise and knowledge, publicly available on their websites. Keeping records of ICB membership centrally with DHSC will be duplicating efforts as all the information is publicly available. Where the ICB proposes a change to its board membership, this will be discussed with the NHS England regional team as part of the constitutional amendment approval process.
24. Once the data is gathered, DHSC should review it with a view to understanding whether the policy of keeping mandated representation to a minimum is producing the intended results and whether any specialties are especially underrepresented.	Accepted in part	The Health and Care Act 2022 sets out membership requirements of the ICBs that include representatives from NHS trusts, primary care and local authorities. However, the local areas can go beyond the legislative minimum requirements in order to address their local needs. Most ICBs

They should report the outcome of this work, and whether any further mandating is required, to the House.		have used this discretion and appointed additional members such as members for public health, VCSE representatives and others based on their local area needs. DHSC will continue to work closely with NHS England and ICBs to ensure that the current arrangements are working.
27. DHSC should therefore review the funding and commissioning arrangements for Healthwatch, with a view to ensuring they are fit for purpose within the context of new ICSs, and support Healthwatch to have a clear voice. The outcome of this review should be reported to the House.	Accepted in part	The government is committed to a health and social care system that listens to and acts upon the feedback of its users and we work closely with Healthwatch England to understand the important insights that their work can offer. We are in regular contact with Healthwatch England about the challenges the Healthwatch network faces and how they can improve their impact. We will continue to explore options for improvement and in doing so, the value of a formal review of Healthwatch is something that the government will keep under consideration.
29. DHSC should urgently provide the CQC with its decision on ratings and any priorities it would like the CQC to focus on. It should also communicate to ICSs what methods will be used to address any areas of concern that assessments might raise. ICSs should be given fair notice about this, and the CQC may need time to incorporate this into their approach, so it is imperative that this clarity is provided before the bulk of the CQC's assessment work begins.	Accepted in part	We support the vision set out in the Hewitt review (paragraphs 3.117 and 3.118) and will consider the best approach regarding ICS ratings. The Secretary of State has now set objectives and priorities for both CQC's assessment of local authorities' exercise of their Care Act functions and of ICSs.
30. DHSC and NHS England should review existing regulatory assessments for ICSs with a view to ensuring there is as little duplication as possible. We recommend this work is done alongside the Department for Levelling Up, Housing and Communities, given its role in local authority assurance.	Accepted – already in train	CQC is continuing to work with NHS England in developing its approach to ICS assessment, to ensure alignment with NHS England's annual assessments of ICBs, including sharing evidence and information. CQC will test working arrangements with NHS England during its pilot assessments.

AUDIT COMMITTEE 27th June 2023

ASSURANCE REPORT

Part I

Area	Assurance	Actions	Notes
Annual Report and Accounts	G	G	All requirements met.
Service Auditor Reports	G	G	Some recommendations for service providers to implement - ICB has own sufficient mitigating controls
External Audit	G	A	Noted unqualified audit opinion on both sets of accounts Apr-Jun 22 CCG and Jul-Mar23 ICB Review of year end controls and processes to take place to inform next year's planning VFM work – very positive final report with no significant weaknesses and only minor recommendations. Board to receive in July.
Internal Audit	G	G	Annual Report and Head of Internal Audit opinion – moderate for CCG and substantial assurance for ICB. Noted strength of controls and work done by ICB Advisory report on Governance – positive and will monitor implementation recommendations. Primary Care Commissioning – Training Hub – substantial assurance Data Security & Protection Toolkit – moderate assurance. Further work required to complete requirements. Noted again work done by ICB with remaining issues to be addressed by submission end June
Risk Management and BAF	G	A	Risk register reviewed with actions required on updates, evidence and reporting. New system in use with some further improvements to come – extra resources in place. BAF improving with some further refinement and future workshop discussed. Executive updates noted. Some excellent examples. Further work to refine system risks required following on from Board development
Counter Fraud	G	G	Overall Green rating for annual return. Annual Report and 23/24 workplan agreed
Procurement	G	G	Noted improvements to Conflict of Interest training for procurement – new material ready by end July
Financial Management	G	G	Noted reports Losses & Special Payments, Debts Written Off and Debtors Reports

Part 2

Area	Assurance	Actions	Notes
Risk management	**A**	**A**	Corporate risk register reviewed. Management actions for high rated risks reviewed. Primary Care pressures to be reflected as recognised national issue
Information Governance/ Cyber Security	R	A	Cyber security rated red nationally due to heightened level of threat. Overall risk levels in countywide report support risk rating with some local issues in Data Security Protection compliance Long running capacity issues in countywide service – being addressed albeit slowly. Patching/upgrades etc affected with deadlines missed. ICS wide cyber exercise in May – lessons learned report and follow up planned More training sessions and comms planned Joint work with Internal Audit to follow

Gloucestershire Integrated Care Board

Audit Committee
Part I
Minutes of the Hybrid Meeting Held at 9:30am on 16th March 2023

Members Present:		
Julie Soutter	JS	NED, Chair
Colin Greaves	CG	NED, Deputy Chair
Marcia Gallagher	MG	Member
In Attendance:		
Christina Gradowski (*Agenda Item 9)*	CGi	Associate Director of Corporate Affairs
Gerald Nyamhondoro (*Agenda Item 10)*	GN	Corporate Governance Officer (taking minutes)
Cath Leech (*Agenda Items 16, 17)*	CL	Chief Finance Officer
Lee Sheridan (*Agenda Item 7*)	LS	Head of Local Counter Fraud Service
Andrew Davies (*Agenda Item 6*)	AD	Audit Manager, Grant Thornton LLP
Justine Turner (*Agenda Item 5)*	JT	Audit Manager, BDO LLP
David Porter (*Agenda Items 11, 12, 13)*	DP	Head of Procurement
Adam Spires (*Agenda Items 5)*	AS	Partner, BDO LLP
Ryan Brunsdon (*Agenda Item 8)*	RB	Board Secretary
Helen Goodey (*Agenda Item 18)*	HG	Director of Primary Care & Place

1. Apologies

1.1 Apologies were received from Claire Feehilly and Dr Jo Bayley.

1.2 The Chair confirmed that the Audit Committee meeting was quorate.

2. Declarations of Interests

2.1 There were no interests declared other than those presented by way of Register.

3. Minutes of the Last Audit Committee Meeting Held

Approved

3.1 Minutes of the meeting held on Thursday 26th January 2023 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 closed.**

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 closed.**

4.3 **17.11.22, Item 5.3.3** HFMA Financial Sustainability. AS explained the auditors' role in assessing the ICB's utilisation of performance metrics when measuring financial sustainability. **Item closed**

4.5 **16.01.23, Item 5,2.1** Internal Audit Follow-Up Report. AS summarised overdue recommendations including those related to Personal Health Budgets (PHB). Members emphasised commitment to the deadline of 31st March 2023 for the issue of PHB financial pathway to be concluded. **Item closed.**

5. Internal Audit Report

5.1 Progress Update

5.1.1 The update report was taken as read and AS added that in terms of delivery against plan, work relating to governance was nearly complete and the indicative Head of Internal Audit Opinion issued meant that the preparation of the ICB Annual Governance Statement would not be prejudiced.

5.2 Internal Audit Follow-Up Report

5.2.1 AS stated that a comprehensive audit premised on Healthcare Financial Management Association (HFMA) financial sustainability recommendations had been employed to deliver targets. AS also stated that a finance procedure should be developed and fused with PHB financial pathways. He added that the auditors acknowledged the work and efforts applied in implementing Personal Health Budget (PHB) recommendations.

5.2.2 AS explained that follow-up actions on recommendations relating to Lessons Learnt from Covid-19 pandemic were still outstanding but there was a plan in place to ensure the progressing of actions recommended. AS stated that auditors felt it reasonable that Covid-19 pandemic recommendations, factoring in Business Continuity Planning and Training needs, be deferred to the succeeding year.

5.3 Conflicts of Interest Report

Approved

5.3.1 AS presented the report and explained that the Governance Team applied commendable effort in mitigating risk and the controls put in place were found to be sufficient. AS clarified that the ICB had two Registers for declarations of conflict of interest; one for non-decision makers and another for Board and Senior Staff Members. AS explained that although there was no statutory requirement for maintaining a Register for non-decision-making staff, the ICB maintain this for further assurance.

5.3.2 CGi explained that NHS England was reviewing online conflicts of interest training and it would subsequently issue revised guidance. CGi reassured that although no provisional guidance had been issued by NHS England to cover the transition period, the ICB continued to provide effective online training based on its own initiative. AS stated that BDO LLP gave both the design and effectiveness of the ICB management of interest system a substantial rating.

5.4a Readiness for Pharmacy, Ophthalmic and Dental (POD) Delegation

5.4.1a JT presented and described the report as aiming toward adding value to best practice in POD services. JT highlighted the benefits of POD delegation and joint commissioning with the Regional Commissioning Hub (CCH) as follows:

- ability to work closely with local pharmacists, opticians, dentists and other organisations to transform and improve outcomes and deliver the ICS strategic aspirations;
- retention of expertise within the CCH to support the ICB;
- cross regional working, with workshops and forums to discuss pertinent issues including wider strategic issues.

5.4.2a Members discussed mitigation of risks associated with working in partnerships. MG raised a concern that there could be disparities in the level of risk awareness. This could impact both transitional phase and subsequent operation of POD services. MG emphasised on need to assess the impact of direct commissioning of POD services and the system's financial position.

5.4.3a CL explained the need to put controls in place to keep POD services within budget. Members acknowledged that Primary Care & Direct Commissioning diligently worked on mitigating POD risks. Members rated POD Assurance Red and management action Green.

5.4b Indicative Internal Audit Annual Report and Annual Statement of Assurance

5.4.1b JT presented the report and explained that NHS England requested and early site of Head of Internal Audit Opinion, and on 10th March 2023 BDO LLP delivered to NHS England a preliminary report which gave substantial assurance opinion. JT added that the probability of the final report deviating significantly from the report submitted to NHS England was deemed low.

5.5 Internal Audit Annual Plan for 2023-24

5.5.1 JT presented the Annual Plan and reiterated that the Plan was first presented before the Committee in January 2023 and subsequently revised to consider contributions and suggestions from members and executive management. JT explained that the scope of the Plan now extended

Approved

to Continuous Health Care (CHC), Business Continuity & Emergency Planning and Cyber Security. As a result, an increase in volume of work was expected.

5.5.2 JT requested approval of the Audit Plan but highlighted that further amendment to the Plan was possible. Members discussed, amongst other things, the strengthening of Cyber Security and the monitoring of service provider performance. CL stated that Cyber Security was an area receiving attention and a Business Continuity Cyber Security exercise was planned for the month of May 2023. CL suggested that the County-wide Cyber Team and other cyber sub-groups be encouraged to work with BDO LLP to develop Key Performance Indicators (KPI) and nurture progressive Cyber Security performance.

5.5.2 CL added that she would investigate as part of supporting the assurance process, the progress made in finalising Service Level Agreement (SLA). MG reiterated the importance of elevating Cyber Security assurance within the system. MG expressed the importance of liaison between the system's Audit Chairs to reinforce Cyber Security and assurance. Members discussed the report and rated (apart from POD delegation discussed in paragraph 5.4.3a above) Assurance Green and management action Green.

5.6 RESOLUTION: The Audit Committee:

- **Noted the Internal Audit Progress report.**
- **Noted the Internal Audit reports on Conflicts of Interest and POD – Readiness for Delegation.**
- **Noted the Internal Audit Follow-up report.**
- **Approved the Internal Audit Plan for 2023-24.**

6. External Audit Report

6.1 AD presented the report and explained that the audit work covered two periods: starting with a three-month period running from 1st April 2022 to 31stJune 2022 and ending with a nine-month period running from 1st July 2023 to 31st March 2024. AD reassured members that the auditors were working hard to finish the three-month audit and minimise overlap of the three-month audit with the nine-month audit as overlap would exacerbate resource pressure.

6.2 Members acknowledged that the county system did not produce Consolidated Accounts, but partners worked closely together. It was also confirmed that the auditors treated the ICB as a single entity for audit purpose. AD and CL explained that the audit scope covered, amongst other things, how the system impacted management of the ICB's financial governance, accounting and value for money regime. After further discussion members rated both Assurance and management action Green.

6.3 RESOLUTION: The Audit Committee noted contents of the External Audit report

7. Counter Fraud Report

Approved

7.1 LS presented the report and stated that Local Counter Fraud Service (thereafter "Counter Fraud") continued to work with the ICB Governance Team to improve fraud, bribery and corruption risk mitigation. LS stated that Counter Fraud favoured the tailoring of the ICB risk scoring process without deviating from national guidance. LS reiterated that the risk scoring process sought to identify control measures that mitigated the ICB risks as much as possible. LS succinctly outlined the rationale behind the scoring process.

7.2 LS explained that progress made in refining Counter Fraud processes provided confidence to consider adjusting risk Assurance from the current Red to Amber by the time of submitting the Annual Return. LS re-emphasised Counter Fraud's role in unearthing fraudulent activities that impacted the ICB. LS presented before members, the draft Counter Fraud, Bribery and Corruption Annual Report for year 2022-23. LS also presented the Workplan for year 2023-24 and relevant performance metrics. Members discussed contents of the report and rated Assurance Red and management action Green.

7.3 <u>RESOLUTION</u>: The Audit Committee:

- **Noted the progress report.**
- **Noted the performance metrics.**
- **Approved the draft Counter Fraud Bribery & Corruption Annual Report 2022-23.**
- **Draft annual Workplan 2023-24.**

8. Risk Management Report

8.1 RB presented the report and stated that 4Risk which is the ICB Risk Management System had recently migrated to a new version and a few problems associated with the migration were being rectified. CGi added that one of the challenges her team was facing was that Risk Leads and Risk Owners were still not used to the new 4Risk version. CGi reassured that training was being provided.

8.2 RB explained that there was a total of 55 risks highlighted across all directorates as reflected by the Corporate Risk Register (CRR). RB described the Board Assurance Framework (BAF) and the CCR of the ICB and highlighted that the Governance Team had discussed with Operational Executive the need for BAF to only recognise strategic risks with 15 scores and above.

8.3 RB requested closure of the following risks:

1. Risk of backlog of CHC eligible individuals requiring a Deprivation of Liberty (Risk 1078).
2. Risk of delays to completion of CHC, Fast track and FNC Reviews (Risk 1085).

RB stated that it was hoped that each committee of the Board should have oversight of risks which fall under its domain, with the Audit Committee being charged with universal oversight of risks faced by the organisation.

8.4 Members discussed contents of the report. CG was of the view that risk management should be designed with tools that allowed demonstrable evidence of all Board committees' diligence in managing risks in their respect domains. Members held the view that system level risk mitigating tools required further development, and they emphasised a need to invest more in models and

Approved

tools that captured system level risks. JS further suggested that committees should focus more on high level risks in the BAF whilst the rest of risks would be managed by Operational Executive but be brought before the Audit Committee twice a year.

8.5 Members concurred that that was the best way to drive forward risk assurance processes. They expressed a concern that the content heavy nature of operational risks could limit the effectiveness of assurance process and undermine management of strategic risks. Members requested CGi and RB to take members' concern to Operational Executive and convey the approach favoured by members. **Action: CGi and RB to take members' suggestions to Operational Executive.** Members rated Assurance Amber and management action Amber.

8.6 **RESOLUTIONS: The Audit Committee:**

- **Approved the closure of Risk 1078.**
- **Approved the closure of Risk 1085.**
- **Noted contents of the CRR.**
- **Noted contents of the BAF.**
- **Acknowledged the developmental work of the 4Risk platform.**

9. Draft Annual Governance Statement

9.1 CGi presented the draft Statement and reminded that the draft was prepared ahead of year end, therefore it was subject to further amendments. CGi clarified that more input was expected from the committees, cyber security teams and other departments. CGi demonstrated with another example of Attendance Registers of the Board and committee members. These Registers were still open and could not be closed before end of year.

9.2 **RESOLUTION: The Audit Committee noted contents of the Draft Annual Governance Statement**

10. Management of Conflict of Interest

10.1 Members stated that they had read the report ahead of the meeting and agreed to take the report as read. GN added that the ICB was required by NHS England to have a Conflict-of-Interest Guardian. GN explained that the Chair of the Audit Committee was the Conflict-of-Interest Guardian and all employees had access to the Conflict-of-Interest Guardian. GN described the duties of the Conflict-of-Interest Guardian as being those of:

- acting as a conduit for members of the public who have any concerns in regard to conflicts of interest;
- providing a safe point of contact for whistle-blowers within the organisation for issues pertaining to conflicts of interest;
- supporting the rigorous application of conflicts of interest principles and policies;
- providing advice on minimising the risks of conflicts of interest.

Members requested that a meeting be arranged for the Conflict-of-Interest Guardian to meet ICB staff. **Action: GN and CGi to make arrangements for the Conflict-of-Interest Guardian to**

Approved

meet staff. Members commended the effort and outcome of conflict-of-interest management in the ICB. Members rated Assurance Green and management action Green.

10.2 **RESOLUTION: The Audit Committee noted contents of the Management of Conflict of Interest**

11. Procurement Decisions Report

11.1 DP presented the report which related to the decision to award a contract to Doccla Ltd for the provision of a virtual ward in Gloucestershire. The value of the contract was £698,000 including VAT. Members discussed the report and rated Assurance Green and management actions Green.

11.2 **RESOLUTION: The Audit Committee noted contents of the Procurement Decisions report.**

12. Waiver of Standing Orders

12.1 DP presented the seven waivers of Standing Orders requested and approved by the ICB Executive. DP further described the waiver process. Members examined the ICB's use of waivers and rated Assurance Green and management actions Green.

12.2 **RESOLUTION: The Audit Committee noted the Waivers of Standing Orders report.**

13. Media Advertising

13.1 DP presented and described the review conducted by the ICB Communications Team to determine the most cost-effective advertising. It was concluded that the *Local Answer* publication continued to provide the widest possible in-county coverage and represented best value for money. Members discussed contents of the report and rated both Assurance and management actions Green.

13.2 **RESOLUTION: The Audit Committee noted contents of the Media Advertising report.**

14. Losses and Special Payments Register

14.1 No report was presented on this item.

15. Debts Proposed Write-offs

15.1 No report was presented on this item.

16. Aged Debt Report

16.1 CL presented the outstanding debt as of 28th February 2023. CL explained that the outstanding debt as per the Sales Ledger was £3,714,801 of which £3,073,969 was NHS and £640,832 was non-NHS. Members discussed the individual items constituting the outstanding debt and the

Approved

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.

16.2 RESOLUTION: The Audit Committee noted contents of the Aged Debt report.

17. Annual Accounts

17.1 Year End Timetable, 2022- 23

17.1.1 CL presented a report which provided an overview of year end timetable informing posting of the 3-month CCG final Accounts ending 30th June 2022 and audit for the ICB 9-month Accounting period. CL clarified that the reporting dates for the ICB Accounts for the 9-month period ending 31st March 2023 were similar to those in operation in the previous financial years. CL stated that the audited Accounts for both sets of Accounts needed to be submitted to NHS England by 9:00am on 30th June 2023.

17.2 Going Concern

17.2.1 CL stated that a review had been carried out by Grant Thornton LLP to determine whether the ICB is a Going Concern. The review concluded that the ICB is a Going Concern and that the ICB's Accounts should be prepared on such basis. Members discussed contents of the Annual Accounts report and rated both Assurance and management actions Green.

17.3 RESOLUTION: The Audit Committee:

- **Noted the plans in place and the timescale for ICB to prepare and complete the final accounts for 2022-23.**
- **Reviewed the information provided and confirmed that the ICB is a Going Concern.**
- **Agreed that it is appropriate for the accounts to be prepared on Going Concern basis.**

18. Primary Care Delegation: POD Services

18.1 HG delivered a verbal presentation summarised as follows:

- there were still outstanding issues relating to decision making framework and Memorandum of Understanding;
- the managing of risk during the transition of POD services from NHS England to the ICB was being collectively managed by both the ICB Primary Care Team and NHS England Regional Team;
- the outcome and approach to managing transition and POD services risks would be brought before the Audit Committee in June 2023. **Action: Helen Goodey, and Jo White to deliver report to members.**

Members discussed contents covered by the presentation and rated both Assurance and management action Amber.

Approved

18.2 **RESOLUTION: The Audit Committee noted contents of the Primary Care Delegation: POD report.**

19. Any Other Business

19.1 The Chair directed that arrangements be made for members who are NEDs to meet separately the external auditors and internal auditors on bi-annual basis for periods not exceeding 30 minutes. **Action: GN and CGi to facilitate the meetings.**

The meeting ended at 11:55am.

Date and Time of Next Meeting: 9th May 2023 at 09:30am (Hybrid).

Minutes Approved by the Audit Committee: Signed (Chair): Julie Soutter Date:27th June 2023

Approved

NHS Gloucestershire Audit Committee, Part 1

Tuesday 9th May 2023, 09.30am

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

Members Present:		
Julie Soutter	JS	NED, Chair
Colin Greaves	CG	NED, Deputy Chair
Marcia Gallagher	MG	Member
Participants Present:		
Cath Leech	CL	Chief Finance Officer
In attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer
Ryan Brunsdon	RB	Board Secretary
Shofiqur Rahman	SR	Deputy Chief Finance Officer

1. Introduction and Welcome

2. Apologies for Absence

2.1 Apologies were received from Jaki Meekings-Davis and Dr Jo Bayley.

2.2 The Chair confirmed that the Audit Committee meeting was quorate.

3. Declarations of Interests

3.1 There were no interests declared other than those presented by way of Register.

4. Annual Accounts

4.1 CL presented the report and described the uniqueness of the 2022-23 Accounts which lay in that the 12-month period which would normally have one set of Accounts had two sets. The first set covered a 3-month period from 1st April – 30th June 2022. The second set of Accounts covered a 9-month period starting from 1st July 2022 and ending on 31st March 2023. CL emphasised that the two sets of Accounts resulted in tight timescales and workforce pressures.

4.2 CL further stated that the two sets of Accounts were intertwined and the closing balances for the CCG formed opening balances for the ICB. SR added that there was a change to the way dilapidations provision was accounted for in the two sets of Accounts. This was a result of updated guidance issued by NHS England. CL described the IFRS16 and its adoption as a key change to accounting which resulted in the removal of the distinction between operating and finance leases.

Approved

4.3 CL stated that the 9-month Accounts showed a position that was consistent with in-year performance reports presented to the Board. CL added that the ICB performed within the set key targets. SR presented the 9-month unaudited Accounts of the ICB which showed a small in year surplus of £19,000 and a cumulative surplus of £13,957,000. SR further presented the ICB Accounts as follows:

- revenue resource limit was £951,324,000 which included £10,684,000 running costs;
- net operating cost was £937,367,000 which included £10,181,000 running costs;

SR summarised notes to the Accounts.

4.4 CG commended the Finance Team's commitment and hard work. JS directed that more information on IFRS16 and associated literature be circulated to members; or alternatively, be incorporated into the report to aid the oversight role. **Action: CL and SR to circulate to members.** **CL & SR**

4.5 CL presented deadlines for the submission of Accounts and the supporting documents, and she explained that on 27th June 2023 the ICB planned to present its Accounts to members to seek recommendation for approval to the Board of its audited Accounts. If recommended, the Accounts would be presented before the Board on 28th June 2023 to seek approval and if approved, the ICB would submit on 29th June 2023 the audited Accounts and reports as signed and dated by the Accountable Officer and appointed auditors as one composite document.

4.6 CL stated that International Accounting Standard 1 (IAS1) required the ICB to assess its ability to continue operating as a Going Concern. Management thus reviewed available evidence and could not find evidence or conditions that could cast doubt on the ICB's ability to continue as a Going Concern.

4.7 <u>RESOLUTION</u>: The Audit Committee:

- **Noted contents of the unaudited Accounts.**
- **Assessed and confirmed that the ICB was a Going Concern and that it was appropriate for the Accounts to be prepared on such basis.**

5. Head of Internal Audit Opinion

5.1 CL presented the report and described the role of internal auditors as being that of providing informed opinion regarding the adequacy and effectiveness of the internal control systems to support attainment of objectives. CL clarified that the report was still its draft form, and it was subject to further amendments. CL reiterated the auditors' positive view regarding the effectiveness of controls in place for the 9-month period starting on 1st July 2022 and ending on 31st March 2023.

5.2 CL stated that the preliminary position of the auditors was that there was a sound system of internal controls applied consistently and designed to meet the ICB's objectives. CL re-emphasised that the ICB displayed strong controls in relation to key financial systems. CL highlighted that the ICB continued to develop and enhance its controls to support more effective assurance and oversight arrangements.

Approved

5.3 **RESOLUTION: The Audit Committee noted contents of the Head of Internal Audit report.**

6. Annual Report 2022-23

6.1 RB presented the report and explained that this was still a draft and should thus be deemed work-in-progress. CL reassured that a completed report would be ready by 27th June 2023, and it would be submitted before the Audit Committee. Members assessed the report and requested that the final report be made available to them prior to the 27th June meeting. **Action: RB and CGi to circulate the Annual report ahead of the June meeting.**

6.2 **RESOLUTION: The Audit Committee noted contents of the 2022-23 Annual Report.**

7. ISA3402 Service Auditor Report

7.1 CL presented the report and stated that the Commissioning Support Unit (CSU) provided a range of services to ICBs. CL clarified that CSU only provided payroll and non-clinical procurement services to Gloucestershire ICB. CL explained that the outsourcing of these services to the CSU impacted the ICB's internal controls. Therefore, to deliver assurance over CSU's internal controls, NHS England engaged service auditors to test and report on the controls put in place by CSU.

7.2 CL explained that the service auditors had found one of the controls to be operating less effectively although overall CSU controls were of acceptable standard. CL added that CSU was developing an action plan to remedy the weakness identified by way of audit. CL reassured that the ICB had developed supplementary controls. JS stated that in future members would be happy to receive an abridged version of the service auditor report unless they request a full report ahead of, or after the relevant meeting.

7.3 **RESOLUTION: The Audit Committee noted contents of the ISA3402 Service Auditor Report**

8. Any Other Business

8.1 There was no other business.

The meeting ended at 11:55am.

Date and Time of Next Meeting: 27th June 2023 at 09:30am (Hybrid).

Minutes Approved by:

Signed (Chair): Julie Soutter   Date: 27th June 2023

Approved

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Part 1

Monday 17th April 2023, 09.00-11.00am

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

Members Present:		
Colin Greaves	CG	Chair & Non-Executive Director
Dr Andy Seymour	AS	Chief Medical Officer
Ellen Rule (part-meeting)	ER	Deputy Chief Executive Officer
Prof Jane Cummings	JC	Non-Executive Director
Dr Marion Andrews-Evans	MAE	Chief Nursing Officer
Mary Hutton (part- meeting)	MH	Chief Executive Officer
Shofiqur Rahman (deputising for Cath Leech)	SR	Deputy Chief Finance Officer
Participants Present:		
Becky Parish	BP	Associate Director of Engagement and Experience
Helen Edwards	HE	Deputy Director of Primary Care and Place
Helen Goodey	HG	Director of Primary Care & Place
Jo White	JW	Deputy Director of Primary Care and Place
Nigel Burton	NB	Healthwatch Representative
Ryan Brunsdon	RB	Board Secretary
In attendance:		
Ayesha Janjua	AJ	Associate Non-Executive Director
Cherri Webb	CW	Primary Care Development and Engagement Manager
Declan McLaughlin	DM	Senior Primary Care Project Manager
Andrew Hughes (Agenda Items 6 & 7)	AH	Associate Director, Commissioning
Dr Peter Hill (Agenda Item 7)	PH	GP Partner
Tim Scruton (Agenda Item 7)	TS	Practice Professional Advisor Lead

1 Introduction & Welcome

1.1 CG welcomed AJ to the meeting who was due to join the Integrated Care Board (ICB) as an associate non-executive director with a responsibility for Primary Care & Direct Commissioning (PC&DC).

2 Apologies for Absence

2.1 Apologies were noted from Dr Olesya Atkinson and Cath Leech.

2.2 It was confirmed that the meeting was quorate.

3 Declarations of Interest

Approved

3.1 No declarations of interest were received during the meeting.

4 <u>Minutes of the Previous Meeting</u>

4.1 The minutes of the previous meeting held on Thursday 2nd February 2023 were approved as an accurate record of the meeting.

5 <u>Action Log & Matters Arising</u>

5.1 There were no open actions or matters arising.

6 <u>Questions from the Public</u>

6.1 The following question was received on the 11th of April 2023 from a member of the public, and read out by AH;

"In light of the above, does the GICB Board acknowledge that this narrative, established by trusted and powerful medical staff within the Phoenix Group (a GICB Member Practice), has exerted a significant undue influence or coercion infecting the Planning Process, leading many residents (26% of Support Comments) and politicians (for a whole Town Council) to support Planning Approval, formally submitting written comments to CDC, citing the fear of service relocation as one of their significant reasons?"

6.2 The response to the Public Question was sent to the member of the public via email. A copy has been posted on the ICB website https://www.nhsglos.nhs.uk.

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7 <u>Business Case for New Surgery in Tetbury (Phoenix Group)</u>

7.1 CG welcomed AH, PH and TS to the meeting who presented the business case which set out the case for change and preferred option for the development of Primary Care (PC) services in Tetbury. The business case had been sent to voting members in advance of the meeting.

7.2 AH reiterated that the development in Tetbury had been a priority for over seven years. He acknowledged that the Practice had progressed the business case through a challenging financial and commercial context. In order to make it affordable, the Practice had had to move from a GP led-scheme to a third party led-scheme.

7.3 AH highlighted the key drives for the development of the surgery, which were found within section 3.4 of the report. Key drivers included;

- Suitable facilities for current number and future expected number of patients
- Facilities can respond to PC service strategies
- Facilities available for developing training services
- Taking into account any operational issues

7.4 AH identified that there had been an extensive options appraisal, with the preferred option being identified to develop a new Phoenix Tetbury Medical Centre as a purpose-built facility on Cirencester Road on the edge of Tetbury approximately 0.9 miles distance from the existing surgery. The planning application was to be considered by the Cotswold District Council on 26th April 2023.

7.5 The net recurrent investment would be £242,920 after deducting existing rent and rates reimbursement, which would be sourced from the delegated primary care budget premises

Approved

reserve. In addition, it was proposed that: the ICB would provide £84,200 fee support to cover appropriate legal costs, monitoring surveyor fees and Stamp Duty Land Tax (SDLT).

7.6 AH confirmed that the revenue consequences within the business case were included within the financial framework developed in partnership with the ICB Finance Team. Non-recurrent fees would be funded from the slippage found within the financial framework.

7.7 Subject to approval, planning approval and successful tender, the plan was for construction to commence in September 2024 with the facility expected to be available in Spring 2025.

7.8 PH reported to the Committee that the landlords of the current building had requested the building back and they would be helpful in supporting the practice move into a new premise. Secondly, the current estate was presenting issues to the practice. PH noted that twelve different sites had been previously explored.

7.9 CG advised that the District Valuer (DV) had forwarded the interim report to the Committee but it had not been included in the papers due to commercial sensitivity. It was noted that the DV's assessment was the scheme presented good value for money. CG confirmed that he had seen the details on the nineteen sites for considered and the rationale for the preferred option.

7.10 JC commented on the design and wondered how this had been future-proofed in terms of what a PC setting might provide in the future. An example given was room for additional therapy or community midwives. TS confirmed that the design incorporated different room sizes, which could be modified and had been modelled on similar newbuilds. PH commented that the Practice needed to take Tetbury Hospital into consideration with future developments. AH added that development included expansion space which had not been fitted out. Recommended space size had been adhered to as suggested by NHS England (NHSE).

7.11 It was noted that work with Primary Care Networks (PCNs), which looked at additional roles within PC and the impact these would have, would be shared with PCN Leaders. An early quantification of additional roles could influence the space and room size required in premises development.

7.12 CG highlighted that section 6.2.2 reported building costs of £230 per square metre, but the majority of new builds cost more than this figure. AH clarified that the DV has discussed this with the practice team and himself and agreed a supplementary payment. This was expected to be a small payment between 5-10%. This payment would support paying any additional increases, and confirmed that when the practice opened they would receive £230 plus an additional £17. After a three year period, the supplementary payment would dissolve. CG acknowledged that additional fees are sometimes covered, and these had been included within the case.

7.13 SR queried if the finance team had been included in discussions with the premises reserve, and in particular the £242k. AH confirmed he had and that the net amount was included within the financial framework. One-off fees were to be paid from the budget. CG explained that money is set aside each year for PC development.

Meeting Outcome: The Committee

- ***Agreed to the recurrent annual investment of £321,814 to fund the delivery of a 3rd party Developer led new Tetbury Surgery to cover rent (including actual rent, a supplementary payment, car parking and VAT) and rates costs. Based on existing levels of reimbursement this would be a net annual investment of £242,920;***

Approved

- ***Agreed to make available one-off financial support amounting to £84,200 towards fees and SDLT;***
- ***Supported the allocation of £198,585 excluding VAT from the GPIT capital budget to fund GPIT and HSCN requirements.***

8 Practice Merger Application – Acorn Surgery/Walnut Surgery

8.1 JW introduced this item of a practice merger application and explained that the ICB had received the application of a merger to take place from 1st October 2023 made up from Acorn Medical Practice and Walnut Tree Surgery. It was explained that there was already a relationship between the practices.

8.2 JW informed the Committee that Acorn had two partners, one of which was retiring in July 2023 and the Practice felt in terms of future resilience, a merger was appropriate. It was noted that Care Quality Commission (CQC) ratings for these practices were good and outstanding respectively.

8.3 JW described that there was little financial impact with a merger and suggested that there would be a potential 0.1% per annum. It was added there may be an increase in Quality Outcome Frameworks (QOF) income if best practice was shared..

8.4 CG questioned if there was any potential for staff redundancy post-merger. JW confirmed that the practices had already been working together with practice management and nursing already shared. She did not think there would be any redundancies.

8.5 HG commended the PC team with regards to the completion of due diligence. It was recognised that support for the merger needed to be continued and that resilience and sustainability was demonstrated should a merger be agreed. Robust follow-ups for all mergers would be routinely conducted.

8.6 MAE expressed the importance of merged practices have outlined the set of policies, procedures and practices clearly along with who was responsible for running the new merged practice. Practices who had merged in the past had sometimes failed CQC inspections for not having this outlined. MAE highlighted the importance of keeping CQC advised throughout the entire procedure.

8.7 It was confirmed that a supportive site visit would be conducted.

8.8 HG confirmed that this was solely a General Medical Service (GMS) contract merger.

Meeting Outcome: The Committee approved this request to merge contracts from Acorn Practice and Walnut Tree Practice.

9 Primary Care Risk Report

9.1 RB provided a verbal update on the risk report provided for this meeting in the absence of Christina Gradowski. The Committee were advised that the 4RISK system had the ability to assign risk to specific Executive Committees. It was noted that significant developmental issues within the system had been experienced and this remained a work in progress.

9.2 CG commented that a risk found within the confidential risk register in reaction to sustainability for general practice and contended that this risk should appear within the public risk register. It was requested that HG reviewed this risk for the public session of PC&DC. **HG**

Approved

9.3 AH suggested that sense checking NHSE board papers may provide a comparable view of how this risk could be presented.

Meeting Outcome: The committee noted the content of the Risk Register.

10 Primary Care & PCN Highlight Report

10.1 JW provided an update on the Primary Care & PCN highlight report. JW reported to the Committee that: the Learning Disability (LD) annual health check had improved to 86.5% against a target of 75%; and the Severe Mental Illness (SMI) health checks was 61.37%. Last year's achievement was 51%.

10.2 HG commended and thanked MAE's team with assisting with these checks. It was added that teams had been working in a more integrated way with Gloucestershire Health & Care NHS Foundation Trust (GHC).

10.3 HG noted the big team effort for this performance, and further acknowledged JW for the work on reporting performance and being able to directly target GP practices.

10.4 MAE advised that Making Every Contact Count was key and fundamental to the success of this. An example provided was through vaccination clinics and offering blood pressure checks, which had identified people who needed to see a GP. AS congratulated practices for the hard work and described the issues over the winter to suspend QOF and felt that this achievement further demonstrated the approach and resilience due to the support of the Integrated Care System (ICS).

10.5 Further work developing the healthy wellbeing hubs continued with the vaccination service been in the position to invest within these services. These hubs will continue to support PCN population wellbeing. JC thanked all teams involved for their participation in this work.

10.6 AS acknowledged that for many practices QOF had been set-up for these checks to be completed in Quarter Four (Q4), which led to an uneven distribution.

10.7 CG questioned when the Primary Care Strategy was last updated. HG confirmed that this was due for an update. It was proposed that a PC strategy development group was set up. Work of the transforming neighbourhood group would also be integrated into this strategy. Discussions with the dental strategy group were also being undertaken. HG proposed that it would take approximately six months to complete and noted that a bottom-up approach was needed.

10.8 AJ requested further understanding as to how patient and public engagement would be conducted, and more particularly, how hard to reach patients and health inequalities would be addressed. BP advised that the recruitment for a new Peoples Panel was ongoing, and this looked to recruit people representing demographics within the County across the Core 20 + 5 areas. It was suggested that BP and AJ discussed this offline.

10.9 HG expected that the core 20 + 5 areas would have an increased focus within the strategy being developed. It would be embedded as a key theme throughout the strategy.

10.10 CG recognised that the Committee did not have data available as noted within the PCN dashboard. The highlight report described a point in time.

10.11 CG commented that the quote around the delegation agreement for MH for Pharmacy, General Ophthalmic, and Dental (POD) was to be amended to say signed via digital route on 24th March not the 29th of March. It was acknowledged that the work on POD within the

Approved

report was a work in progress. HG commended the PC team on the turnaround of work for POD.

10.12 CG noted that access to embedded documents during the signing off delegation were not accessible. Moving forward, more information on the risks and mitigations was requested for the next PC&DC Committee. **HG &JW**

Meeting Outcome: The committee noted the Primary Care & PCN Highlight Report.

MH joined the meeting at this point and ER left the meeting.

11 Primary Care & PCN Performance Report

11.1 JW presented the PC & PCN performance report. JW drew attention to appointment data. It was acknowledged that Gloucestershire was 23% above the baseline, and this was the highest across the Southwest. The baseline was set at pre-Covid rates.

11.2 CG recognised that the data was open to interpretation, however, he was impressed by the trend of the data. HG acknowledged that there was variation across practices and that variation can sometimes be explained. Data was also correlated across patient satisfaction surveys. It was known that practices had struggled with recruitment, vacancies, and coding.

11.3 MH noted that level of delivery was unsustainable, and capacity did not match demand. There was a need to understand why Gloucestershire was seeing an increase. HG recognised that practices within Gloucestershire, dealt with patients who were expected clinical intervention on that day. New access requests needed to be considered so this did not disrupt the commitment within Gloucestershire. It was felt that there was a need for demand management across practices, especially within the Core 20+5 areas.

11.4 AS reported that the national PC recovery plan was still awaited and he was hopeful that this would enable the good work being undertaken within practices to continue.

11.5 JW confirmed that work continued with the Additional Role Reimbursement scheme (ARRs) and the new contract had resulted in new roles were being made available in PC. HG added that the workforce team had been working with individual practices and noted challenges in urban areas with recruitment and nervousness around the status of the PCN contract.

11.6 HE added that individual conversations with PCNs and practices were focused on additional support to maximise recruitment potential. Conversations with other organisations remained ongoing around supporting the placement of recruits.

11.7 CG felt that funding was disconnected to the recruitment cycle and suggested that the ICB should be driven by need rather than funding.

11.8 CG expressed concern around issues with recruitment Mental Health (MHe) practitioners. It was understood that there had been issues around the Agenda for Change (AFC) banding for these members of staff. HE confirmed that Gloucestershire was ahead of other organisations within the Southwest in terms of recruiting MHe practitioners and conversations with GHC colleagues were ongoing

11.9 JC felt that banding should be primarily based on the role being undertaken and whether any national guidance provided influenced this. MAE agreed with this comment and wanted the Committee to be aware that MHe practitioners often worked in isolation. It was also felt that more peer-support would be needed for these roles.

Approved

11.10 MAE acknowledged that career progression also needed to be considered and suggested that this would be reviewed within an upcoming progress report.

Meeting Outcome: The committee noted the Primary Care & PCN Performance Report.

12 Primary Care Quality Report

12.1 MAE introduced the Primary Care Quality Report which had been circulated and read prior to the meeting.

12.2 MAE reported that a designated Doctor for safeguarding had started within the ICB. Named GP sessions had been increased for safeguarding due to demand from PC.

12.3 MAE highlighted the risk that there was no Doctor for Children in Care (CIC) and no Doctor for child death reviews, as the recruitment for these posts had been unsuccessful.

12.4 BP confirmed to the Committee that as part of the Research Hub which looked at qualitative data on patient experience for services within the County, the ICB would be facilitating a session for Research for Gloucestershire, due to be held 2nd May 2023. BP agreed to advise the Committee on the detail. **BP**

12.5 MAE noted that the Community Pharmacy Consultation Service was now able to prescribe treatment for Urinary tract Infection (UTI) which should result in patients not requiring a GP intervention.

12.6 MAE advised that there had been an increase in norovirus. There had also been an increase in C-Difficile (C-Dif) and work with patient management in primary care is due to be undertaken. It was added that that ICB had employed an Infection Prevention and Control (IPC) Nurse for Primary Care, and visits amongst PCNs were ongoing to review IPC arrangements. It was noted that a project on the use of Personal Protective Equipment (PPE) within Primary Care had started which looked to decrease the amount of PPE used, specifically, gloves. CG commented on additional data on C-Dif would be helpful and would provide context.

12.7 MAE confirmed that vaccinations and spring boosters remained ongoing. The hard work delivered by PCNs was acknowledged with vaccination work being frontloaded.

12.8 MAE reported that site assurance visits had been completed across all vaccination sites which reviewed Standard Operating Procedures (SOPs). It was highlighted that these were welcomed, and actions had been identified.

12.9 MAE reported that Julie Zatman-Symonds (JZS) had been working with the PPG, who had been providing the Out of Hours (OOH) service and had supported them in implementing their action plan. They were also due a repeat visit from CQC.

12.10 MAE confirmed that members of her team had been working with region on POD ensuring an appropriate assurance process was in place. This was noted to be a work in process.

12.11 MAE concluded that the Migrant Health Team remained busy, with an additional two hotels due t to be opened imminently.

12.12 JC confirmed that the Quality Paper was presented at the System Quality Committee in April, and there were discussion around how ICB quality and PC quality is reflected and ensuring the content within the report was directly linked to PC. A workshop for Quality

Approved

Committee was to be arranged to look at the content and level of granularity. MAE advised that she was working on the Terms of Reference (TOR) for both committees.

Meeting Outcome: The committee noted the Primary Care Quality Report.

13 Financial Report

13.1 SR provided a verbal update regarding the financial position. SR gave an update as at month eleven (M11) position and confirmed that month twelve (M12) had also been finalised. It was confirmed that as of M11, the financial underspend was £319k with a forecast out-turn of £24k overspend.

13.2 SR reported that there was a £644k underspend on PCNs which related to ARR recruitment, which had been offset by underspends on the global sum of £393k.

13.3 Sustainability Transformation Fund (STF) was reported to be fully spent.

13.4 SR updated the Committee that the M12 position finished with a yearend position of £147k overspend for the year. Maternity underspend as highlighted within the paper did not equate to £200k as stated. There was also a premises underspend.

13.5 HG reemphasised that PC budgets were complex and complicated and that there had been many changes made recently within the finance team and noted that it took time to understand the PC budget. HG commended her team on the work supporting the finance team to help better understanding.

13.6 MH queried what the entire overspend was for the ICB. SR reported that the ICB had a surplus position of £22k for end of year.

13.7 HG assured the committee that PC had supported the organisation and system covering a number of projects and suggested that this support could have influenced the financial position.

Meeting Outcome: The committee noted the verbal financial update.

14 Tewksbury Newent & Staunton (TWNS) Primary Care Network (PCN) Evaluation of Health & Wellbeing Quality Improvement (QI) Project

14.1 CG explained to the Committee that this item had been pulled from the agenda to support the PCN and would be presented at a future meeting.

15 ICS Transformation Programme & ILP Highlight Report

15.1 CG welcomed HE who provided an update on the ICS Transformation Programme and ILP Highlight Report. HE highlighted that £150k non-recurrent strengthening local communities grant had been made available for the ICB for use in 2023/24. This was the third time the budget would have been made available and would align with ILP strategic priorities.

15.2 HE confirmed that the grant would support increasing voluntary and community capacity locally and provide funding to smaller organisations. A report covering funding for all ILPs would be written and shared with the committee.

15.3 HE advised that the ICB hosted an event for NHS Confederation virtually. Work from West Cheltenham was showcased during this event. The ICB was also expected to host a visit from NHSE Southwest Region, however this had been cancelled.

Approved

15.4 HE reported that there was a focus on evaluation and measurement within work being undertaken. The PC team were expected to participate in a future ICB Board Development session along with Business Intelligence (BI) colleagues to demonstrate how data had influenced priorities and projects.

15.5. HE drew attention to the new Transforming Neighbourhood group as previous mentioned in the meeting. A third meeting was booked for end of April. The group had looked at Community and Wellbeing Hubs, vaccinations, workforce models and building in Clinical Assessment Hub at Rosebank surgery.

15.6 HE highlighted work that was ongoing within Localities. Exercises classes had started within Stroud and Berkeley Vale in Scarlett House care home for six weeks and work was ongoing with Care Grow Live who provide drug and alcohol services, and a recovery member of staff was being recruited to support priorities within Forest of Dean (FOD).

15.7 CG requested that a routine report from the Transforming Neighbourhood group be presented to the PC&DC committee.

Meeting Outcome: The committee noted the ICS Transformation Programme and ILP Highlight Report

16 <u>Any Other Business</u>

16.1 AJ thanked the Committee for being so welcoming and reflected that the meeting was well chaired and structured. It was felt to be positive, however noted the challenges around succession planning and resilience.

16.2 NB commented on how well Gloucestershire had been progressing within Primary Care.

The meeting closed at 10:34am.

<u>Date and Time of next meeting:</u> Thursday 1st June 2023, 14.00-16.00 to be held Virtually and at Sanger House.

Minutes Approved by:
Signed (Chair):Colin Greaves Date:01st June 2023

Approved

System Resources Committee

Minutes from the meeting held on
Thursday 4th May 2023; 14:00 – 17:00

Initials	Name	Job Title	Organisation
Present			
JC	Joanna Coast *Chair*	Non-Executive Director; System Resources	ICS
CaL	Cath Leech	Chief Financial Officer	ICB
ClL	Clive Lewis	Non-Executive Director; Renumeration	ICS
ER	Ellen Rule	Deputy Chief Executive & Director of Strategy and Transformation	ICB
MH	Mary Hutton	Chief Executive	ICB
MW	Mark Walkingshaw	Director of Operational Planning and Performance	ICB
SBe	Sandra Betney	Deputy Chief Executive & Director of Finance	GHC
In attendance			
HG	Hannah Gorf	Commissioning Development Manager; Social Prescribing and Creative Health	ICB
JS	Julie Soutter	Non-Executive Director	ICB
JY	Jess Yeates	ICS PMO Coordinator	ICB
KD	Kat Doherty	Senior Performance Management Lead	ICB
MAE	Marion Andrews-Evans	Chief Nursing Officer	ICB
MG	Mark Golledge	Programme Director for PMO and ICS Development	ICB
ML	Melanie Lyddon	Systems and Planning Manager *(observing)*	ICB
SP	Steve Perkins	Deputy Director of Finance *(on behalf of Karen Johnson)*	GHFT
SR	Shofiqur Rahman	Interim Deputy Chief Finance Officer	ICB
Apologies			
AP	Angela Potter	Director of Strategy and Partnerships	GHC
KJ	Karen Johnson	Director of Finance	GHFT
SBr	Steve Brittan	Non-Executive Director	GHC
SL	Simon Lanceley	Director of Strategy and Transformation	GHFT

Item	Details	Owner
1.	**Introduction, Welcome and Apologies**	
	JC welcomed the group and noted the apologies as listed above.	
2.	**Declarations of Interest**	
	No new declarations were noted.	
3.	**Minutes and Action Log from the meeting held on 12th January 2023**	
	The minutes from the last meeting were taken as read and approved as a true reflection of the meeting. One amendment required: CaL to be referenced correctly throughout the document.	

	Action: JY to update the document. The action log was updated accordingly.	**JY**
4.	**Matters Arising**	
	Terms of Reference Review It was agreed to defer this item to September meeting. The group agreed to review annually due to the frequency of the committee meeting.	
	Health Economics	
5.	**Preparation for the June ICB Development Session**	
	JC advised the group that there are plans for a 'Board Development' session, to be held in June, focusing on Health Economics. The group were asked to discuss this and bring ideas for the session forward, including any particular items to be covered and what they would like to see achieved. JC noted the importance of consistent terminology and the approach Health Economics brings to objectives and constraints, which may highlight and help the executives think about utilising resources across the system to meet these objectives. MG presented the slides shared with the group ahead of the meeting. MG confirmed the committee have been tasked to plan, coordinate and facilitate a 90 minute session on 28th June 2023. In particular, the committee were asked to consider the following questions: • How can we focus more on the totality of spend in Gloucestershire rather than marginal spend? • How can we further ensure that we live within our means as a system – recognising funding limitations? • Is the funding we allocate in line with the needs of the population (current and future) – and how can we increasingly move funding towards prevention? The group noted the importance of clarifying and standardising the definitions used, as this will add a lot of value to the work going forward. The group noted the importance of future analysis and how this will be carried out, to ensure the correct approach is used to carry out the work. The group acknowledged the need to focus on 'prevention' to equip the system well going forward and lead to a healthier population. One item to be considered at the Board Development session is how to address and deliver preventative schemes, whilst also running schemes that are about addressing	

	the here and now pressures. How does the system resource and fund schemes that are preventative, without disadvantaging or disinvesting from existing schemes that are addressing the more immediate pressures across the system? SP noted a previous piece of work carried out to analyse health outcomes compared to spend per head, which could be an approach utilised in programmes going forward. It was noted that throughout the session, there must be a link to health inequalities. The group agreed on 3 objectives for the Board Development Session: • To give people an understanding of what future demographic changes are happening and what that would potentially mean for One Gloucestershire, as a system. • To help the Board understand the different terminology being used around health economics and how we would apply that in practice. • To generate ideas, reflections on how we address the current pressures, but also resource prevention activity, whether that is to have a short-term impact or long-term impact. It was noted that locality and demographic information should be made available to the board members – including future population growth in those over the age of 65 as this was going to increase significantly. It was agreed to make the session as interactive as possible – utilising breakout rooms or smaller working groups within each item to be discussed. It was agreed for MG to use these comments to structure a draft plan and share with members of this group for further comment if required.	
Evaluation *"How can we better understand the impact that our investment is having across the system?"*		
6.	**6.1 Presentation: Evaluating the impact of work in cultural commissioning**	
	HG presented the slides titled 'Creative Health: Capturing value'. HG provided an overview of the work carried out by the Creative Health team and how this links to the wider determinants of health. HG explained the approach taken to evaluation, including the value for the individual, value for the system and value for money. This focusses around co-production, co design and continuous monitoring, from all partners. It was noted the template utilised for this process is adapted from a Public Health England evaluation.	

	HG highlighted how the evaluation process collects and utilises data on a regular basis. The group were shown examples of how the work has developed and evolved to fit the need of the population more closely. This included the data analysis, feedback obtained by service users and experiences of the staff delivering the service.	
	6.2 Reflection: Our Approach to Evaluation	
	MAE advised the group of the previous ways of evaluating programmes within the system, including an 'Evaluation Steering Group' and a 'Technical Advisory Group' to support them. These groups provided advice and guidance to programme leads on how they evaluate their work and provide various options to be followed, depending on the type of work being conducted. These had been stood down during COVID and hadn't yet been re-established but there were now plans to establish an evaluation task and finish group to support programmes with their approach to evaluation. It was agreed that the task and finish group should prioritise schemes of where there was significant strategic importance – including schemes that had received substantial investment. It was acknowledged that the business case template now includes an area for evaluation so this could be utilised by the evaluation task and finish group. The group acknowledged the need for programmes to be given guidance, to learn from others and use this to define the shape of their own evaluation. One concern raised was 'familiarity bias' when programmes are asked to evaluate their own work. This enhances the need for an independent, system wide group to be available to assist when required. **Action: It was agreed to set up an Evaluation Task and Finish Group.**	**MAE**
	6.3 Discussion: What can we learn in order to further develop our approach to evaluation?	
	The group discussed and considered the following points: 1) What currently works well / what could we be better at? What does "good" look like? • Schemes being clear on benefits at the outset • Ensuring that stated benefits are measurable • Schemes showing a range of benefits • Effective monitoring of the benefit of schemes • Giving visibility of whether benefits are / have been delivered • Programmes able to demonstrate the impact schemes are having on wider programme benefits	

	2) How can we strengthen our approach to this as a system - building on what is already happening? It was noted the system should provide the tools and resources required, along with an agreed approach to evaluation.	
7.	**Performance Report 2022/23 Stock Take and 2023/24 Areas of Focus**	
	MW presented the Performance Report showing the end of March 2023 position. MW referred the group to the report shared prior to the meeting, highlighting some of the programme areas detailed and provided a Year End Summary. It was noted that this report includes reflections in terms of performance within the system. One focus of the previous year was to stabilise the Urgent and Emergency Care as well as continued work to reduce the elective backlog. MW highlighted how the report includes areas where the system is in a challenged position and there are a number of national targets in place. This challenge is expected to continue into the new financial year with a number of operational plan commitments agreed with NHS England for 2023/24. For most areas (such as urgent care, elective recovery, mental health and cancer) we are forecasting an amber/green position. MW highlighted the importance of the Committee in monitoring delivery of the commitments stated in the plan. MW noted the strong engagement from systemwide colleagues throughout the operational planning process and thanked partners for their support.	
8.	**Financial Position**	
	CaL presented the Finance Report, noting that the end of year financial position for 22/23 was draft and as yet unaudited. CaL outlined some of the challenges faced over the last financial year and the mitigations taken. Recurrent pressures were noted by the group and CaL highlighted the work that was going to be needed on the Medium Term Financial Plan as a system to ensure long-term financial sustainability. CaL highlighted that for 23/24 we have put in a break even revenue position although recognised the different challenges in organisations. CaL also highlighted that there is a balanced capital plan for 23/24. CaL shared the framework / protocol that had been developed through Executive teams on a financial risk share proposal. The framework would set out how a deficit position in one organisation would be managed and handled across the system. It was agreed that there was a need for a clearer financial framework on financial deficits.	

	Action: It was agreed that a further update on the financial risk share proposal would come to the Committee.	**CaL**
9.	**Any Other Business**	
	CaL provided an update to the group on the Pharmacy, Ophthalmic and Dentistry budget position for 23/24 now that it has been transferred to NHS Gloucestershire ICB.	