Public Gloucestershire Integrated Care Board Meeting

To be held at 2.30pm to 4.00pm on Wednesday 27th September 2023

The Green Room, Churchdown Community Centre Parton Rd, Churchdown, Gloucestershire GL3 2JH

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.30 – 2.32pm	**Welcome and Apologies;** Martin Holloway	Information	**Chair**
2.	2.32 – 2.32pm	**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.	2.32 – 2.34pm	**Minutes of the meeting held 26th July 2023**	Approval	**Chair**
4.	2.34 – 2.35pm	**Action Log & Matters Arising**	Discussion	**Chair**
		Business Items		
5.	2.35 – 2.40pm	**Questions from members of the public**	Discussion	**Chair**
6.	2.40 – 2.55pm	**Patient Story** demonstrating the value of quality improvement approach (warmth on prescription)	Discussion	**Hein Le Roux** **Neil Penny**
7.	2.55 – 3.05pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
8.	3.05 – 3.30pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Mark Walkingshaw** **Tracey Cox** **Marion Andrews- Evans** **Cath Leech**
		Decision items		
9.	3.30 – 3.55pm	**One Gloucestershire Workforce Strategy**	Approval	**Tracey Cox**
		Information Items		
10.1	3.55 – 4.05pm	**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 3rd August 2023 & latest approved Committee Minutes.		**Colin Greaves**
10.2		**Chair's verbal report on the Quality Committee** held on 17th August 2023 & latest approved Committee Minutes.	Information	**Prof Jane Cummings**
10.3		**Chair's verbal report on the Resources Committee** meeting held on 7th September		**Prof Jo Coast**
10.4		**Chair's verbal report on the People Committee** & latest approved Committee Minutes.		**Prof Jane Cummings**
10.5		**Chair's verbal report on the Audit Committee**		**Julie Soutter**
11	4.00 – 4.02pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on 29th November 2023, in the Boardroom, ground floor Shire Hall

Gloucestershire Integrated Care Public Board Meeting

To be held 2.00pm to 4.23pm on Wednesday 26th July 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 & Care NHS Foundation Trust
Deborah Lee	**DL**	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Ellen Rule	**ER**	Deputy CEO/Director of Strategy and Transformation, NHS Gloucestershire ICB
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
Mary Hutton	**MH**	Chief Executive, NHS Gloucestershire ICB
Christian Hamilton ***(Deputising for Mark Walkingshaw)***	**CH**	Associate Director of Commissioning, Elective Care, NHS Gloucestershire ICB
Siobhan Farmer	**SF**	Director of Public Health, Gloucestershire County Council
Prof Sarah Scott	**SS**	Sarah Scott, Executive Director of Adult Social Care, Wellbeing and Communities, Gloucestershire County Council
Tracey Cox	**TC**	Director of People, Culture and Engagement, NHS Gloucestershire ICB
Participants Present:		
Ann James	**AJ**	Director of Children's Services, Gloucestershire County Council
Benedict Leigh	**BL**	Director of Integration, NHS Gloucestershire ICB & Gloucestershire County Council
Carole Alloway-Martin	**CAM**	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council
Deborah Evans	**DE**	Chair, Gloucestershire Hospitals NHS Foundation Trust
Helen Goodey	**HG**	Director of Primary Care & Place, NHS Gloucestershire ICB
Graham Russell	**GR**	Vice Chair, Gloucestershire Health & Care NHS Foundation Trust
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Mark Cooke	**MC**	Director of Strategy & Transformation, NHSE
In attendance:		
Ryan Brunsdon	**RB**	Board Secretary, NHS Gloucestershire ICB
Christina Gradowski	**CGi**	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Becky Parish	**BP**	Associate Director, Engagement and Experience, NHS Gloucestershire ICB

Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire ICB
Hannah Norman *(Agenda Item 6)*	**HN**	Voluntary, Community & Social Enterprise (VCSE) Impact Manager, Healthy Communities and Individuals Team, NHS Gloucestershire ICB
Josie Houghton *(Agenda Item 6)*	**JH**	Director – Let's Cook with Josie, Community Interest Company (CIC)
Mindy Pickering *(Agenda Item 6)*	**MP**	Co-Director – Let's Cook with Josie, Community Interest Company (CIC)
Will Chapman *(Agenda Item 6)*	**WC**	Associate Director, (Prevention & VCSE Partnerships) Healthy Communities and Individuals Team, NHS Gloucestershire ICB
Holly Beaman *(Agenda Item 10)*	**HB**	Lead Commissioner - Learning and Physical Disabilities. Gloucestershire County Council

1. Welcome and Apologies

1.1 Apologies were received from Mark Walkingshaw (MW), Dr Jo Bayley (JB) , Dr. Olesya Atkinson (OA) and Dr. Paul Atkinson (PA).

1.2 There were two members of the public attending the meeting.

2. Declarations of Interests

2.1 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. The meeting was declared to be quorate.

3. Minutes of the meeting held on 31st May 2023 and 28th June 2023

3.1 The Minutes of the meeting held on 31 May 2023 were approved as a true and accurate record of the meeting subject to amending Item 9.7 where the word 'legal' should read 'media'. This has now been corrected. The minutes from the Extraordinary Board meeting held on 28th June 2023 were approved as a true and accurate record of the meeting.

4. Action Log and Matters Arising

4.1 The Chair had intended to meet with CGi to discuss the management of the Action Log a date for that meeting has been scheduled for September. There were no further matters arising.

5. Question from member of the public

5.1 There was one question from the member of the public:
How is Gloucestershire Integrated Care Board assured, and reassured, that it is actively reaching people from Black Asian and Minority Ethnic communities to promote employment opportunities across health and social care now, and for the future? What measurable evidence does the Gloucestershire Integrated Care Board have for this happening, along with the measures to demonstrate impact?

Response from Tracey Cox
As an ICS we seek to genuinely embrace diversity in all of its dimensions and aim to ensure that our workplaces are free from discrimination and that our workforce at all levels is representative of the populations we serve. This extends beyond legally protected characteristics into social deprivation. As an ICS we have made a commitment to ensuring that the principles of Equality, Diversity and Inclusion are embedded as the personal responsibilities of all members of staff.

The ICS track a range of metrics, over the last three years on ED&I across the ICS by sharing data and information on each organisation's Workforce Race Equality Standard, Workforce Disability Equality Standard, the Gender Pay Gap audits and staff survey data. The ICS look at that information in detail at our People Committee. The specific metrics that the ICS monitor tell us how we are performing in relation to the employment of people from Black, Asian and Minority Ethnic communities are the WRES Indicator 1 which measures BME representation in the workforce overall, and in clinical and non-clinical pay bands and we compare our position against the local South West and national position.

The ICS also monitors the relative likelihood of individuals from a BME background being appointed from shortlisting across all posts. We have over the past two to three years, implemented a range of EDI initiatives and programmes across the ICS that aim to improve recruitment of those with protected characteristics, and to provide a positive working environment in which staff can thrive, free from discrimination and prejudice.

Tracey Cox explained that the list of schemes and work undertaken in this space was listed in the full response. It was acknowledged that there was much more to do to increase representation within the workforce.

On 8th June 2023, a national Equality, Diversity and Improvement Action Plan was published which set out six high impact actions that the providers and system should undertake to address the widely known intersectional impacts of discrimination and bias. Action 2 specifies that providers and systems should focus on overhauling the recruitment processes and to embed talent management processes with six identified success metrics. The metrics are set out in the formal response.

Whilst the EDI Action Plan builds on existing programmes of work that the ICS was undertaking, the position was being re-assessed against this new EDI Action Plan to understand the opportunities to further strengthen the approach.

5.2 The Chair stated that a more substantial response would be given, recognising that this was taken very seriously across all the partner organisations.

5.3 The Chair stated that a second question had been received from a member of the public that had come in rather too late for a response to be given, and this would be picked up through the normal mechanisms following this meeting.

6. <u>Patient Story - 'Let's Cook with Josie' (VCSE)</u>

6.1 WC gave a brief overview of the work of the Healthy Communities and Individuals Team, which sat within the Strategy and Transformation Directorate of the ICS, which aimed to promote health equity across Gloucestershire. The team worked alongside the communities of Gloucestershire to tackle inequality and to empower them to bring about change.

6.2 Let's Cook with Josie' was a voluntary, community and social enterprise (VCSE) organisation that taught cookery skills to children from disadvantaged backgrounds. Josie Houghton provided an overview of her work with children; previously she had approached the Parish Council and asked

for a very small sum of money which enabled her to go into the schools and work with the children to encourage and support them to cook. She had set up a Community Interest Company (CIC), which was also helpfully supported with some ICB funding.

6.4 JH discovered areas of poverty in Cheltenham and Charlton Kings where children also needed support. Over the course of a year, 24 children had attended four-weekly sessions in Josie's home from various demographic backgrounds, and age groups. There were also quite a high proportion of looked after children included in the scheme.

6.5 JH talked through the benefits of this work to the children, which included:

- Learning about making healthy food choices;
- Learning where food comes from (air miles, carbon footprint, locally grown/seasonal produce);
- Learning to cook healthy meals at home;
- Learning about the reduction of food waste;
- Improving life chances and life skills;
- Engaging with others through small group classes, feeling included in the project/community no matter their background/disability.
- Actively engaging with the community through trips to the local community allotment.

6.6 JH explained that the children enjoyed the cookery sessions and the benefits to them could not be underestimated. Feedback was incredibly positive, and their skills developed quickly over the four-week period. They were much more likely to try different foods, were able to show their parents what they could achieve and became more knowledgeable and confident around food handling and preparation.

6.7 JH hoped that she would receive further funding for next year in order to continue to reach other children as well as those who might want to return in order to reinforce their skills further.

6.8 The Chair spoke about a conversation at the Partnership Forum about childhood obesity and that this linked with that conversation while presenting some innovative opportunities. CAM reflected that there was a willingness to do something widespread which could incorporate all the statutory, voluntary and local authority organisations. JH stated that she also worked with adults helping to support them with cookery skills in St. Paul's and Springbank, which had been enthusiastically attended and had been successful in bringing people together.

6.9 There was a query from HG about whether JH could work on site in educational settings which could capture a bigger audience. JH did explore working with schools but there was insufficient flexibility around the school curriculum and in some schools insufficient catering facilities. All the classes with children JH organised were delivered from her own home. HG felt that investment in the smaller projects brought benefits to people and helped others to think about the wider opportunities. JH and WC were thanked for their time and for the differences JH had made to the community.

6.10 AJ was pleased to hear the reference to some of the more vulnerable groups of children stating that the more that could be done to spread JH's skills and help lay down those patterns to help support children growing into healthy young adults and going on to live healthier and longer lives. AJ suggested that there was an opportunity for the Integrated Care Board (ICB), that she and Josie could speak further following the meeting.

6.11 SF thought that a further discussion following the meeting might help other communities to see JH's story, and to enable others to run innovative and supportive community schemes. SF referenced the roll out of the Childhood Weight Management programme where more funding would go into the community enabling some work around pathways for those who might need extra support from the specialist services already being provided.

RESOLUTION*: The Board noted the verbal update from Josie Houghton's Patient Story.*

7. Board Assurance Framework (BAF)

7.1 TC informed the Board that the BAF presented current strategic risks that have been aligned to the agreed ICS Strategic Priorities / Objectives 2022-2023. The Urgent Care risk had been reduced and related to the work which had been undertaken on the Urgent and Emergency Care (UEC) transformation process and the mobilisation of the Programme Board.

7.2 Risks around mental health transformation, particularly the Eating Disorder service, workforce transformation and financial sustainability retained the same risk score as previously reported as had Elective Care and the Health Inequalities risks. The risk score around transition arrangements had been reduced. TC suggested that the risk related to the transition to an ICB / ICS (BAF 9) would need to be removed as system working was becoming more embedded and the ICB/ICS was operating within a business-as-usual context.

7.3 The 2023/2024 objectives were being examined in terms of phraseology and wording and the BDO's review of the governance arrangements suggested that a more succinct approach to the BAF strategic objectives and hence risks could be taken. This was noted to be a work in progress, but the next version of the BAF that the Board would see will reflect the proposition around what a refreshed BAF would look like for 2023/2024.

7.4 JSo had met earlier that day with CL and RB and discussed the Corporate Risk Register/BAF, with a view to making this easier to read, more user friendly and with a cap on the number of descriptive words. It was agreed to progress work on the Corporate Risk Register/BAF with the Audit Committee and include the feedback from Chairs of the sub- Committees over the course of the next year, to encompass work on the strategic objectives. JSo had given some notes to CL and RB from recent meetings where organisations had talked about their top risks and priorities. JSo would work with the Audit Committee and TC would engage with CL in ensuring this work was on track to deliver.

7.5 MC raised two points: that there may be a risk to the ICB in terms of the future running cost allowance reductions which ICB will need to implement, and which may impact on the delivery of programmes and secondly, consideration of further delegation of commissioning responsibilities by NHSE to ICBs. Both of these things may create risks to a well-performing organisation and its ability to sustain performance in a challenging environment which could be reflected in the wording.

7.6 JSo was hoping that in October, the Audit Committee could examine the strategic and look at the individual risks that underpin those objectives together with some of those risks which cut across priorities. The comments that MC made could be picked up in as part of that discussion.

7.7 **RESOLUTION*: The Board noted the BAF and further work to be undertaken by the Audit Committee on reviewing the strategic risks aligned to the strategic objectives / priorities for 2023-24***

8. Chief Executive Officer Report

8.1 MH provided an overview of the current key programmes and initiatives over the past 2 months since the last CEO report in May.

8.2 MH explained that with regard to work around the Quality Improvement Initiatives, a further £950k had been secured for 2023/24. Primary Care Networks (PCNs) had been developing their proposals, based on their population, for how they plan to spend the funding. Partners from six Integrated Locality Partnerships (ILPs) would deliver a range of projects to promote health and wellbeing, seeking to tackle health inequalities and supporting people to live well at home. It was felt to be important to join up the work across the whole system and link it into the work being undertaken at a clinical programme level.

8.3 There was an encouraging update on Creating Active Schools in Gloucestershire. The aim was to identify and support those schools which required the most support. The *We Can Move* charity had been granted £740,000 capital and revenue funding which would be used to open school facilities for wider communities, commencing with Barton and Tredworth, where there was greater need.

8.4 The acute respiratory infection hubs that were established in Cheltenham and Gloucester had completed an initial evaluation, revealing promising results in both patient and clinician satisfaction, with potential impact to reducing attendance in emergency departments with respiratory illness. The evaluation was ongoing, with plans in place to continue the clinics this winter.

8.5 The Eye Health Clinical Programme Group (CPG) was nominated for an award at the NHS Parliamentary Awards for their work on the Community Ophthalmic Link. The team was selected as Regional winners of the award. Gloucestershire was the first in the Country to support community optometrists with access to hospital eye images, diabetic screening, and referral information. This programme reflected successful collaboration across the whole system and improving the service offer to the local population.

8.6 The Voluntary and Community Sector (VCSE) and Clinical Programmes event took place on 13th July 2023 and was very well attended with over 120 delegates from a wide range of VCSE organisations across Gloucestershire who were keen to link some of their work with the ICB and HWP. Outputs and themes would be shared in a future report.

8.7 MH reported that from next year it had been agreed that ICBs would take delegated responsibilities for specialist commissioning. Specialised commissioning budgets would be delegated i.e., specialised commissioning spend would become part of the ICB and ICS financial position (with agreement that the ICB should consider some form of regional risk sharing arrangement). It was proposed that the joint committee made up of ICBs and the regional team in the South West continued into 2024/25 ran by the NHSE specialised commissioning team, from the newly established Collaborative Commissioning Hub.

8.8 Gloucestershire ICB would be asked to assess its readiness against an updated Pre-Delegation Assessment Framework (PDAF) and the Board would be required to sign off the ICB's State of Readiness in the autumn (with the process to be completed by December). Members of the Board would have an opportunity to be involved in any discussions around delegation.

8.9 The Chair made an observation of the importance of the ICB being aware of how much money was spent on people who needed specialist commissioning services, because data showed that the nearer people were to a specialist centre, the more specialist treatment that population received. It

was important that the people of Gloucestershire were not disadvantaged but at the same time, decisions should not be made which might damage the infrastructure of existing tertiary providers. This would need considerable thought about getting the right balance of services and being able to continually sustain them for the South West.

8.10 The GP Patient Survey collected data from January to March 2023 which provided information about patient experiences of their GP practices. Gloucestershire had a 39% response rate to the survey. It was encouraging to see good use of online services with people less likely to use NHS 111. Gloucestershire reported a 93% of needs met which was positive. There was more access to private dentistry in Gloucestershire and less people on waiting lists than in other areas. The Primary Care team within the ICB was developing a Dental Strategy to address access to NHS dentistry and patient experience of dental services. This was monitored via the Primary Care and Direct Commissioning Committee.

8.11 The Chair noted that Out Of Hours (OOH) was one of the more vulnerable areas and a new specification would be drawn up and tendered out to the market at an appropriate time. This would be an opportunity to think about incorporating a more dynamic model for the OOH service.

8.12 **RESOLUTION:** ***The Board Noted the contents of the Chief Executive Officer report.***

9. Integrated Finance, Performance, Quality and Workforce Report

9.1 CH provided an overview of the performance elements of the report. The Eating Disorder service had made good progress in reducing waits across both adult and children and young people's waiting lists.

9.2 Good progress had been made in reducing the number of patients waiting over 62 days for cancer treatment or for cancer to be ruled out. The percentage of those being treated within 62 days continued to be above the national average and the continued achievement of the fast diagnosis 28-day standard was supporting the ability to make progress against the early diagnosis targets for cancer. This continued to be above target and Gloucestershire was noted to be one of the few areas nationally and regionally to be consistently achieving this and had been for some time.

9.3 UEC performance continued to be on an upward trajectory. The handover delays trajectory was missed by a very small margin due to some hours unfortunately lost on one day.

9.4 Elective Care had been significantly impacted by industrial action. Nationally the decision had been made to reduce the Elective Recovery Fund (ERF) target by 2% in response to industrial action and the impact on Gloucestershire was under review.

9.5 Deterioration in diagnostic performance had seen the proportion of patients waiting more than six weeks increase to above the interim 2023/24 target of 15%. This was predominantly driven by endoscopy and echocardiography. A task and finish group to support endoscopy had been formed and was beginning to meet in July to determine an action plan. While additional capacity in echocardiography had begun in the community diagnostic centre.

9.6 The Chair noted the improvement in the Eating Disorder service and the significant improvement in access. The Chair extended thanks to DB and his team for all the hard work that had been undertaken to move this forward for the system.

9.7 DL spoke about industrial action by junior doctors and the impact on consultant colleagues who were very demoralised and were still trying to reduce backlogs from the pandemic whilst managing to work incredibly hard. The impact on patients had been very well managed compared to the region, with fewer inpatient and outpatient procedures having been cancelled due to consultant activity being maintained. DL was very concerned about potential divisions across the NHS and the need to support staff to deliver good quality care.

9.8 The Chair recognised a very worrying trend where trainee doctors avoided certain specialties and the inability of NHS organisations to fill training posts. This would impact on services in a fairly short space of time. DL commented that Gloucestershire was doing comparatively well, and this was a workforce planning issue around getting the right recruitment at the right times and making those roles more attractive. ICSs needed to lobby Government as this was crippling the NHS, our patients and colleagues. The Chair considered that more discussion time would be needed around workforce issues in the forthcoming months to fully understand the workforce gaps and potential solutions.

9.8 ER stated that all the comments made in relation to workforce applied to UEC and staff were very fatigued. However, progress was being made in a sustained way. UEC was in a good position and hard work undertaken by operational and clinical colleagues across all the metrics around the strike action across all partner organisations. Transformation programme resources were being built up together with the Newton team and it was hoped that there would be a launch of the 'test and learn' pilots in September which would bring changes in line with the vision for diagnostics.

9.9 TC spoke about the Workforce element of the report. A number of surveys will go out to primary care staff to ascertain what made them come to Gloucestershire, what would make them stay so that there was clarity about framing the first phase of the recruitment campaign, with the ultimate aim of attracting more people into the area. Due to the lack of clinical placement capacity, some 55 GP training placements across the South West have been deferred until February 2025. This was a national and regional problem. TC explained that the regional team was aware of this problem with a discussion about possible solutions for Gloucestershire, but this was a multi-factorial problem. HG reflected it boiled down to money and capacity, explaining that for the first time ever, there was now a locum pool in Gloucestershire due to the cost-of-living problems for Practices.

9.10 Work was ongoing around the allocation of workforce transformation funding to the system. Some good bids for funding had been submitted. TC requested to check alignment in some of the priority areas such as Mental Health and Frailty and agreed to follow up with BL. Work was underway across the system to review how the ICS worked with schools and promoted career opportunities within the NHS. The People Committee agreed last week that the approach should be re-modelled going forward. TC confirmed that she would be speaking to BL about mental health and frailty workforce transformation funding.

9.11 The Chair noted that at the recent Health and Wellbeing Partnership there had been an integrated report on workforce which talked about apprenticeships, and some of the opportunities with the County Council. There was enthusiasm from the voluntary sector to engage. CAM agreed that there was real energy and insight at that meeting and it was encouraging to see people looking for engagement opportunities.

9.12 MAE delivered the Quality element of the report and informed the Board that the Warning Notice had been lifted from PPG, the Out of Hours provider. PPG would remain on enhanced supervision until a full inspection had been carried out to ensure improvements were being made.

9.13 The implementation of the Patient Safety Incident Response Framework (PSIRF) will take place soon, as a system-wide approach to examining Serious Incidents (SI) and learning from these, as opposed to investigating them all. There had already been one raising awareness session held, which will be followed by a detailed training session across the system.

9.14 Recruitment for clinical posts in Mental Health was in a more positive position which was good news, more staff meant that people were receiving better care.

9.15 The Standardised Hospital Mortality Indicator at Gloucestershire Hospitals NHS Foundation Trust (GHFT) has remained within expected levels for Oct to Dec 2022 following a period of being an outlier between June 2022 to Sept 2022. This continued to be monitored.

9.16 Some outstanding work has been completed around falls prevention at Charlton Lane and this will be taken to the System Quality Group which was a forum in which to share good practice.

9.17 The Patient Transport Advice Centre which dealt with the calls for those booking non-urgent patient transport for outpatient appointments, was experiencing difficulties with longer waiting times than would be expected around call answering, and a deep dive into the reasons for this would be conducted. An improvement plan had also been requested.

9.18 There was recent adverse media coverage around services at Wotton Lawn Hospital (some of which was out of date and had already been addressed), particularly relating to discharge of patients and patients going absent without leave. Following a Rapid Review Meeting, services at Wotton Lawn Hospital entered a period of enhanced surveillance and quality monitoring with a standing item on the System Quality Group agenda. A really good action plan had been drawn up with monthly meetings in place to monitor progress. There were also actions for the ICB to instigate around the Advocacy Service.

9.19 MAE spoke about Maternity services and the improvement plan. The Local Maternity and Neonatal System (LMNS) and GHFT were undertaking a gap analysis regarding the actions for 'Ockenden 2'. Insight visits led by the LMNS were being undertaken with the regional team. There remained concerns around workforce issues and as Maternity remained a very high profile area, the Maternity Support Programme remained in place.

9.20 MAE noted that industrial action had clearly affected the quality of service for the local population as well as having an impact on the workforce. Midwifery was about 20% down on staff and industrial action was not encouraging people to come into the healthcare sector, which was of concern and will need to be addressed.

9.21 The Chair noted that a Maternity Report had been received roughly nine months ago and as this was a high priority area, it was suggested to link this together with Women's Health Strategy due to the new initiative with Women's Centres and Hubs etc. It would be the job of the Chief Nursing Officer to chair any Local Maternity and Neonatal System (LMNS) meetings.

Action: Maternity/Women's Health Strategy to be placed on a future Agenda and linked in to other women's services. MAE

9.22 CL gave a finance update. There had been an overspend for the year to date of just under £700,000 which related to costs of industrial action in the NHS. Gloucestershire Health & Care NHS Foundation Trust (GHC) had been impacted but to a much lesser degree than GHFT. Whilst the system was forecasting a break-even position, this would not be achievable without quite significant actions, and this presented a high risk for the system as a whole.

9.23 It was noted that workforce pressures were leading to high expenditure on agency and locum staff and there were steps being taken to tackle this and the region was helping to support with those measures.

9.24 There was a reduction in the elective recovery target of 2% which was very welcome and was there to help fund the costs of industrial action for April and May. As a system a different approach had been adopted as the industrial action costs were a pressure to the ICB. Elective recovery was behind plan as were NHS providers, but the independent sector was on plan. Other pressures included the pay award and children's placements.

9.25 A financial recovery plan was already in place within GHFT and there have been requests from other partners and region to support some actions. As a system, the ICB and GHC were looking at ways that could help offset, mitigate and influence any of the actions. The system was now formally in a recovery position and the system would need to ensure that no short-term actions were taken which would have a longer-term detrimental effect on that recovery.

9.26 A medium-term financial plan was in development and would underpin the Joint Forward Plan (JFP). The ICB must show how it planned to break even in 2024/2025 and how a recurrent financial balance could be achieved across that period. The timescale will be challenging and there was a huge amount of work being undertaken which would come back to the Board and committees across the system in September 2023. There was a break-even of capital forecast against the plan and there will be some work undertaken on the leases which had already started. CL stated that quality and finance should be balanced.

9.27 JSo asked whether a re-forecast would need to be completed for this financial year regarding the work mentioned for September on the medium-term financial plan (MTFP). CL stated that forecasting for 2023/2024 was ongoing; this was a rolling forecast within the organisations and across the ICS. The medium-term plan would be dependent on achieving the 2023/2024 plan recurrently. JSo also asked whether there was a formal re-forecast for the year to NHSE at the end of September 2023. CL confirmed this was reported to NHS on a monthly basis.

9.28 MC informed the Board that NHSE would be focusing on the MTFP, driven by a government desire to look at productivity across all government departments, particularly in the NHS. There had been an increase in workforce cost, but a reduction in activity and MC felt that it might be helpful for the ICB to look at this now. CL stated that this was being actively examined and GHFT had quite a significant programme of analysis, which pinned productivity down to division and specialty level; some of this probably needed to be revisited in these meetings.

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

10. Gloucestershire Health and Social Care Framework

10.1 BL explained that this was a Framework that covered the majority of care delivery which was not bed-based; including supported living, domiciliary care, floating support for children and young people, supported extra care housing and support in people's own homes when there were complex physical health needs. It was a demand driven budget and support was purchased mainly from the private, independent and voluntary sectors to deliver services to those people whose needs have been assessed.

10.2 The Framework helped with consistency and contractual discussions and allowed focus on moving beyond that transactional relationship with local providers, into one which is much more around

treating those crucial parts of the system in delivering support, care and health to people in Gloucestershire.

10.3 The sum involved over the life of the contract is not likely to be more than c£80M over eight years and would support some of the most vulnerable people in the community from a range of organisations. The Framework would be useful to help build up local organisations who can deliver complex, health focussed support for people to be able to stay in their own homes. It would also enable the ICB to deliver responsibly against the amount of public money it has to support people.

10.4 CAM informed the Board that this proposal was supported by GCC Cabinet who were significantly challenging around the preparation of the document, ensuring it was robust. A positive decision was made but there was potential for call in of that decision within 28 days. CAM had spoken to members at the Council and the document had been very positively accepted.

10.5 IB spoke about there being hyper-localised domiciliary care plans in County which had been successful in other areas. IB wondered whether this re-shaping of the market would deliver the impact that is very much needed.

10.6 BL responded that he was 100% confident that the Framework would allow re-shaping of the market and would enable domiciliary care agencies to support it and see themselves as part of that health and social care solution. The increase in workforce capacity was driven by agencies seeing themselves as partners in delivering care. Domiciliary Care agencies were not reporting any issues in capacity; however, there was still a lot of work needed in supporting the workforce as true partners in the system. BL was confident in successful delivery and the right elements were being put in place to allow this to happen.

10.7 IB drew to the Board's attention the really hard work that Holly Beaman and her team had put into developing the Framework and building that important relationship with providers. Holly was thanked for her contributions and the Chair stated she would like to see some of the components brought back to a future Board meeting as the Framework was implemented, particularly on Continuing Healthcare. JC would like to see some future evaluation.
Action: Gloucestershire Health & Social Care Framework elements (e.g., CHC) and evaluation to be brought back to a future Board meeting.

10.8 **RESOLUTION*: The Board unanimously approved the Gloucestershire Health and Social Care Framework.***

11. ICB Governance Report

11.1 As part of the internal audit work programme, the ICB had worked with BDO UK to examine the effectiveness of governance arrangements. This was an advisory report which has drawn upon the perspectives of Board members to make the assessment in the ICB's first year of operation as well considering national and local good practice. In response to the question posed to ICB Board members about the effectiveness of the governance structures, Gloucestershire ICB scored an average of 7.7/10. There was some positive feedback about collaborative partnership working, the quality of relationships and behaviours as well as acknowledgement on the transformational work the ICB had undertaken in its first year.

11.2 There were a number of improvement recommendations which were all being implemented including.

- Establishing a skills matrix for Board and Executive members

- Reviewing the composition of the Board including around the VCSE
- Review the BAF and ensure that the strategic risks were concise and clearly linked to ICS strategic priorities / objectives.
- Link the One Gloucestershire ICS strategy with individual strategies.
- Produce a comprehensive Board papers/reports forward plan.

11.3 The report addressed the inclusion of VCSE; noting that the ICB had robust arrangements for including the VCSE on the ICP and Healthwatch and the VCSE was invited to ICB Board meeting to present as they choose on patient stories, which they wish to bring to the attention of the Board. After some discussion, the Chair and members concluded that the recommendations were being implemented and would be taken forward by the Audit Committee which will monitor their implementation.

11.4 **RESOLUTION*: The Board noted:***

- ***The Governance Review 22-23***
- ***That the Audit Committee will monitor implementation of the management action plan.***

12. Overview of NHS Workforce plan and implications for the ICB

12.1 TC presented the NHS Workforce plan which consisted of three main themes :

- **Train:** Substantially growing the number of doctors, nurses, allied health professionals and support staff.
- **Retain**: A renewed focus and major drive on retention, better opportunities for career development and flexible working options, alongside reforms to the pension scheme, aiming to retain 130,000 staff working in the NHS for longer.
- **Reform**: Working differently and delivering training in new ways.

12.2 It was noted that while the plan was a national one, there were many elements that needed local response and action, and there was a critical role for ICSs to work to connect local partners in delivery with the short-term focus being on recruitment and retention. There was a commitment to refresh the plan at least every two years.

12.2 The One Gloucestershire People Strategy would be brought to the Board in September and the publication of this Plan had given an opportunity to sense check what was being described and to ensure alignment between the national workforce strategy and the Gloucestershire workforce strategy. This ensured that there was synergy on views and ambitions and to highlight priorities. NHS employers had started to provide a helpful guide on what action was needed and this was being worked through to obtain an initial check to compare this with other actions that were in train.

12.3 DB commented about the mismatch between placements and existing numbers. The funding streams needed to support direct backfill costs for apprenticeships which was a good way of getting a long term, committed workforce. This would be a better approach rather than trying to pick up the pieces of placement capacity from the universities.

12.4 The Plan contained some big assumptions around improving retention of staff from 55,000 to 128,000 which was the aim within the plan. The leaver rate for staff was around 8.7% which was the number of those having left the NHS within the last 12 months. It was noted that there was significant work required around staff retention.

12.5 The Chair stated that she would like the People Committee to think about whether there were things that could be made available to the local social care workforce. Unification was the way forward and there were opportunities to use resources once in a much more dynamic way in order to benefit people. Work was being undertaken around the needs of the workforce in the independent sector. The Chair noted that the work needed to benefit the whole system and not just one part of it.

12.6 **RESOLUTION***: The Board noted the contents of the NHS National Workforce Plan and the implications for the ICB.*

13. Hewitt Report – Implications for Gloucestershire ICB (Confed Report)

13.1 MH informed board members that overall, the response to recommendations was positive with the majority of recommendations across both the Hewitt Review and Select Inquiry accepted. There was continued support for ICSs with a commitment of devolution to local systems, with meaningful transparency. There was a commitment to fewer national targets and parity to local priorities to help unlock devolution alongside a commitment to support the development of Health Overview and Scrutiny Committees (HOSC).

13.2 Although Government did not go as far as approving the 1% of spend to be moved into prevention over the next five years it had committed to supporting systems in making their own local decisions in this area. The response included a commitment to rolling more funding into allocations rather than drip-feeding funding through individual funding pots. This was alongside an urgent review of capital spending to ensure there were no further delays in funding reaching local systems.

13.3 There were 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.

13.4 The Chair noted that there was not a systematic way of evidencing how much was spent on prevention across all partners and until this was understood, by partner, it would have been very difficult to pin down what that 1% was from in monetary terms. SF had carried out some benchmarking work on prevention, which would be shared with the Board within the next few months. This would be fundamental to the ICB in working out what the direction was, and interest has been shown across all the ICSs but there was no standard methodology or definitions as yet. MH commented that the ICB under-reported what was spent on inequalities and targeted work and this was also something being looked into as part of that review.

13.5 **RESOLUTION**: ***The Board noted the Government response to the Hewitt Review and House of Commons Select Inquiry.***

14. Committee Updates

14.1 Chair's verbal report on the Audit Committee meeting held on 27 June 2023

14.1.1 JS noted that in terms of External Audit actions shown in the report. The Audit Committee had looked at the Mental Health Investment Standard and the audit tender for that which was now completed.

14.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 1 June 2023 and last set of approved minutes.

14.2.1 CG referred to the minutes of the meeting from 17th April 2023 (Item 7) and informed the Board that Tetbury Surgery Business Case which had been approved, was subject to planning approval permission from Cotswold District Council which was a longstanding requirement.

14.2.2 The meeting on 1st June 2023 approved the Business Case for Hucclecote Surgery which had been an area of concern for a number of years and this Surgery, in partnership with the County Council, was expected to be completed in the summer of 2025.

14.3 Chair's verbal report on the System Quality Committee Workshop meeting held on 20th July 2023

14.3.1 A Quality Workshop was held on 20th July 2023 which was well attended by Non- Executive Directors from the ICB and partner organisations as well as Executives. There was representation also from region. The aim was to strengthen the assurance role and to ensure that the Quality Committee concentrated on the things that were most important to the system.

14.3.2 Each of the partners were able to identify their system risks and priorities and the agenda for the Quality Committee was reviewed to ensure that there was good two-way communication. There were good links between the System Quality Group and the System Quality Committee, and the partner organisations held each other to account but could also escalate issues that only the system could deal with. The next Quality Committee agenda would reflect some of the feedback from a recent quality workshop and overall, it was a very positive and useful workshop.

14.4 Verbal report on the People Committee meeting held on 20th July 2023 and last set of approved minutes.

14.4.1 JC reported that the recent People Committee discussed the workforce plan, the One Gloucestershire People Strategy and had more of a deep dive on Primary Care workforce trends which was interesting to see and quite daunting in terms of some of the pressures and the reductions in partners.

14.4.2 The Committee also looked at strengthening the approach to Careers and Engagement which was useful.

14.4.3 Two policies were approved, these were on Domestic Abuse and Lone Working and the Social Media policy was being reviewed which would be updated and approved.

14.5 Chair's verbal report on the Resources Committee meeting held on 6th July 2023 2023 and last set of approved minutes

14.5.1 There was a Board Development session on Health Economics and after exploring what came from that session, some of the resources had been shared via email.

14.5.2 Processes were also discussed for monitoring and evaluating in terms of Benefits Realisation.

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

15. Any Other Business

15.1 There was no other business to discuss.

Time and date of next meeting

The next Board meeting will be held on Weds 27th September 2023 from 2.00 to 4.30pm

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.

(Commercial in confidence discussions)

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log

September 2023

Open actions only

Meeting Date Raised	Reference	Action	Due	Updates	Status
25/01/2023	**Min 6.13, 6.15 & 6.16 Patient Story**	The Board asked for an update on the actions being taken to address the use of electronic cigarettes (vaping) (increasingly replacing smoking) in adults and children and young people	**July-23**	**Actions completed**: • 29/03/23: Briefing on Vaping in CYP in Gloucestershire February 2023 was circulated to ICB Board members. • The results of the pupil Wellbeing Survey availablehttps://www.gloucestershire.gov.uk/inform/children-and-young-people/pupil-wellbeing-survey-formerly-online-pupil-survey/ • South West statement on vaping of nicotine products https://www.adph.org.uk/networks/southwest/wp-content/uploads/sites/18/2023/06/SW-ADPH-Position-Statement-on-Nicotine-Vaping-1.pdf • 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. • The Tobacco Control Steering Group is producing an action plan and engaging with relevant stakeholders around vaping among children.	**Recommendation for the Board to consider this closed**
29/03/2023	**Min 8.9 BAF**	The Board asked for further work to be undertaken to review the risk mitigations within the BAF	**May-23**	**Actions completed**: • On-going discussions and at the Audit Committee and Resources Committee on improving the risk mitigations plans in the BAF, which have been reflected in various iterations of the BAF presented to the Board. • The BAF will be updated with the current ICS strategic objectives for 23-24 and presented to the Board in November.	**Recommendation for the Board to consider this closed**
29/03/2023	**Min 12.11 Health Inequalities**	The Board asked that the issue about people from different groups and those with protected characteristics reluctance to disclose information be looked into	**May-23**	**Actions completed:** Healthy Communities and Individuals and the Care Programme Group teams are addressing these issues as part of the ICB/ICS work on health inequalities.	**Recommendation for the Board to consider this closed**

ICB Board Action Log – September 2023

31/05/2023	**Min 12.11 Digital Strategy**	The Board asked that Healthwatch and GHFT were linked up around digital inclusion	**July-23**	**Actions completed:** A resourced plan on digital inclusion is in place and this includes engagement with Healthwatch ..	**Recommendation for the Board to consider this closed**
31/05/2023	**Min 12.11 Digital Strategy**	The Board requested that AI and Healthcare be included in a future board development session.	**July-23**	**Actions completed:** An item on AI & Healthcare has been added to the ICB Board Development session forward plan. Action to be closed.	**Recommendation for the Board to consider this closed**
26/07/2023	**Min 9.21 Maternity**	Maternity to be placed on a future Agenda and linked in to other women's services.	**July 23**	**Actions completed:** An item on Maternity had been added to the Board / Board development plan.	**Recommendation for the Board to consider this closed**
26/07/2023	**Min 10.7 Glos H&S Care Framework**	Gloucestershire Health & Social Care Framework to be brought back to a future Board meeting.	**July 23**	**Actions completed:** Gloucestershire Health & Social Care Framework had been added to the Board / Board development plan	**Recommendation for the Board to consider this closed**

Warmth on Prescription

Dr Hein Le Roux - Deputy Medical Director, NHS England South West

Neil Penny – Integrated Commissioning Manager, NHS Gloucestershire ICB

@One_Glos
www.onegloucestershire.net

Gloucestershire Strategic Housing Partnership

- District Councils, County Council, ICB/ASC, PH, local health trust and social landlords
- Aim is to collaborate and maximise resources to improve health outcomes through the home
- Opportunity to grow Warm and Well to include targeted insulation (Park Homes Programme), energy advocacy and Warmth on Prescription
- Over £12m in external grants awarded due to partnership approach of Warm and Well
- Oncology project increasing benefits awarded for people receiving treatment, >£1m per year

Health Impact

INSTITUTE of HEALTH EQUITY

FUEL POVERTY, COLD HOMES AND HEALTH INEQUALITIES IN THE UK

Impacts of cold

- increase in heart attacks and strokes
- respiratory conditions worsen
- asthma increases
- infants fail to gain weight
- complications related to diabetes increase
- exacerbation arthritis symptoms
- more hip fractures
- poorer mental health

Warmth on Prescription

- Helping people keep their houses warm
- Install smart meter or similar
- Voucher for heating costs
- Potential to refer to Warm and well for insulation etc.

Warmth on Prescription

- People with long term conditions – Respiratory etc.
- Improve health and maintain independence
- Aiming to reduce admissions, appointments
- Referral via GP or social prescribers

Warmth on Prescription

- Pilot in Forest of Dean and Gloucester
- Jan – March 2022
- 28 households
- Well received

Here's what patients thought about it

"I normally end up in hospital in sort of the colder months, I tend to get pneumonia, pleurisy, flu and stuff, which does land me in hospital. The last time it almost landed me in intensive care.

This year, I didn't actually need to see the doctor at all... So that was a big relief because having to try and find someone to have the kids while I get rushed into hospital is never easy."

"Yeah it's made all the difference to him, I mean I don't usually see my husband cry and it's made him cry, so you know it's been fantastic."

"It's made a massive difference to us and you don't feel weighed down by the amount of clothing you have to have."

"It's just life changing, as silly as that sounds, but to have a warm home is great."

NHS

2022-23 Warmth on Prescription

- Offered to more people
- 150 in county, 25 per district
- Offer of £600 towards bills from Household Support Fund
- Patients with acute respiratory conditions
- Refer to Severn Wye Energy Agency

Reaction and 2023-24

- Very well received
- Hoping to show reduction in admissions
- International media interest and government discussions
- Planning 2023-24 – 300 households
- Expand to those using expensive medical devices at home

Feedback

'This project has been a godsend to me, I have been on it twice now and I promise you that I would have been in hospital if it hadn't been for your help, in two years being on the scheme I have not had to enter hospital once'

Evaluation

Films:

https://www.youtube.com/watch?v=iIrkc7bx5Os

https://youtu.be/lZPPEXvlPZY

For more information or any questions:

Neil Penny – neil.penny@nhs.net

Agenda Item 7

NHS Gloucestershire ICB Board, Public Session

Wednesday 27th September 2023

Report Title	**Chief Executive Report**			
Purpose (X)	**For Information** X		**For Discussion**	**For Decision**
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.			
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer.			
Key Issues to note	This report covers the following topics: • **Gloucestershire chosen as case study site for national evaluation of social prescribing link workers** • **New Fit and Proper Person's Framework following Review Recommendations** • **Extension of the Procurement Strategy** • **Update: Introduction of the Provider Selection Regime** • **Delegation of Specialised Commissioning Update** • **ICB Annual Assessment Summary** • **Sexual Safety in Healthcare – Organisational Charter**			
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)	New regulations are being introduced following the Kark review to implement a more comprehensive Fit and Proper Person Test. Section 4 describes the provider selection regime (PSR)which set of new rules for arranging healthcare services in England by organisations termed relevant authorities
Impact on Health Inequalities	N/A
Impact on Equality and Diversity	See section 4 on Sexual Safety in Healthcare addressing sexual abuse in the workplace
Impact on Sustainable Development	N/A
Patient and Public Involvement	Not referenced in this report
Recommendation	The Board is requested to: • Note the contents of the CEO report • Approve the extension of the ICB Procurement Strategy until 31st March 2024 • Agree the Sexual Safety in Healthcare Organisational Charter and the 10 principles and actions to achieve this.
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

27th September 2023

1. Introduction

1.1 This report summarises key achievements and significant updates by the Chief Executive Officer of NHS Gloucestershire to the Integrated Care Board. This report is provided on a bi-monthly basis to Board meetings held in public.

2. Gloucestershire chosen as case study site for national evaluation of social prescribing link workers

2.1. There will be a national evaluation of social prescribing link workers, delivered by Applied Research Collaboration and funded by National Institute for Health and Care Research. The research will be led by colleagues from the University of Manchester, along with academics from the Universities of Bristol, Newcastle, Edinburgh and Glasgow.

2.1. As part of the study, they are including eight 'case-study' sites from across three English regions and Scotland, to explore the approaches being taken to the use of social prescribing link workers. After meetings with researchers to discuss our approach to social prescribing, Gloucestershire has been chosen as one of these sites. They will be looking at our commissioned Community Wellbeing Service (co-commissioned with Gloucestershire County Council) and will also conduct a deep dive of Social Prescribing Link Workers in one of the Primary Care Networks.

2.1. This will give us great insight into how social prescribing is working in Gloucestershire and how we can work to make it even more effective.

3. New Fit and Proper Person's Framework following Review Recommendations

3.1. NHS England recently published a new Fit and Proper Person's Framework in response to the recommendations from the 2019 Kark Review which examined the scope, operation and purpose of the Fit and Proper Person Test and how it applies to Board members of NHS organisations. The Kark review and its recommendations are particularly important and timely given the recent outcome of the Countess of Chester trial.

3.1. The Framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member and applies to Executive and Non-Executive Directors of Integrated Care Boards, NHS Trusts and Foundation Trusts, NHS England and the Care Quality Commission for both permanent and interim appointments. From the 30 September 2023 new and more comprehensive requirements come into place which include: -

- An Annual individual Board member declaration process (self-attestation) reviewed by

the Chair & CEO (aligned to the annual appraisal process)

- Annual Board declaration process relating to all Board members signed off by Chair and submitted to the Regional Director
- A prescribed format and reference template for all Board member references for new appointments to be used after a conditional offer is made.
- Completion and retention of a Board member reference for leavers (to be completed even if the individual is not moving to another Board role).

3.1 We have written to individual Board members to inform colleagues of the new requirements and will begin to consider the modifications needed to the annual appraisal process for both Executive and Non- Executive Directors. For Partner members we will be relying on the application of the framework by the host employer and will be seeking assurances relating to partner members processes. We note that similar processes do not exist for Local Authority members and we will work with GCC to agree a process to seek appropriate assurance.

4.1 **Update: Introduction of the Provider Selection Regime**

The Provider Selection Regime (PSR) is a set of new rules for arranging healthcare services in England by organisations termed relevant authorities. Relevant authorities will be NHS England, integrated care boards, NHS trusts and foundation trusts, and local or combined authorities. The PSR will not apply to the procurement of goods or non-healthcare services, irrespective of whether these are procured by relevant authorities. Subject to parliamentary processes, the Department of Health and Social Care aims to introduce the PSR by the end of 2023.

4.2 The PSR aims to introduce increased flexibility and transparency to the procurement of healthcare services and support greater integration and the establishment of stable collaborations. However, the PSR will still require organisations to comply with various processes to evidence decision-making, including record keeping and the publication of transparency notices. Competitive tendering will also remain an important tool for organisations to use when it is of benefit.

4.3 The PSR will be introduced by regulations made under the Health and Care Act 2022. Once the PSR is in force, it will replace the Public Contracts Regulations 2015 and the Procurement, Patient Choice and Competition Regulations 2013 for the procurement of healthcare services by relevant authorities.

5. **Extension to the Procurement Strategy**

5.1 In February 2021, the UK government published a White Paper entitled Integration and Innovation: Working Together to Improve Health and Social Care for All. This paper proposed changes to public sector procurement regulations which will use legislation to remove much of the transactional bureaucracy that has been a barrier to sensible decision-making.

5.2 The new legislation will introduce a bespoke health service provider selection regime (to be known as the Provider Selection Regime) that will give commissioners greater flexibility in how they arrange services than at present. These changes are likely to remove the mandatory requirement to seek competitive tenders for all health care services and will encourage procurement staff to seek competition where it is in the best interests of the health service and of the patients that we serve. The legislation will replace the Public Contracts Regulations 2015.The updated regulations are now at the 'Consideration of Amendments' stage at the House of Commons and are expected to become law from 1 January 2024.

5.3 Once the legislation has completed its passage through Parliament, a comprehensive revision of the ICBs procurement strategy will be necessary to incorporate the new planned procurement processes and procedures.

5.4 It should be noted that extending the procurement strategy does not impact on the ICBs ability to deliver its existing procurement work programme. All procurement activity will continue to be conducted in accordance with the Public Contracts Regulations 2015 until the legislative changes have been enacted.

5.5 An update on the proposed legislative changes was provided to the Audit Committee on 26 January 2023. The Board is asked to approve the extension to the ICBs procurement strategy of 6 months from 1 October 2023 to 31 March 2024.

6. **Delegation of Specialised Commissioning: Update**

6.1 As discussed at July Board, we have now formally responded to NHS England on the delegation timeline for Specialised Commissioning. This led to Gloucestershire along with 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 the newly appointed independent chair).

6.2 In summary then, in supporting the draft Pre-Delegation Assessment Framework we have signalled:

- a commitment to the direction of travel and eventual delegation of specialised commissioning to ICBs;
- that the PDAF accurately represents the joint working arrangements in place and currently under further development;
- that the PDAF accurately represents the risks of delegation, including remaining unquantified and unmitigated risks.

6.3 We have confirmed that it would not be possible at this stage for the ICB to make a formal acceptance decision that would satisfy its own statutory duties and internal audit requirements given the extent of information currently unavailable and further financial diligence required. Although NHS England's national PDAF process does not ask ICBs to make this decision, it is noted that the PDAF submission is the only opportunity which the ICB has to formally feed into the NHS England Board decision in December 2023 on whether to delegate specialised services

for April 2024. To avoid a situation where the NHS England Board is not fully aware of ICB positions when making its own decision, it is appropriate for the ICB to give an indication of intent.

6.4 The ICB therefore indicates that a continuation of joint working in 2024/25 and a deferral of formal delegation until 2025/26 is vital for the following reasons which are addressed in further detail throughout the PDAF submission:

1. There is insufficient information on future allocations and financial framework for the ICB to properly begin financial diligence on these issues.
2. The diligence requirement, including internal audit review or signoff is unlikely to complete in good time to make a formal delegation decision in time for April 2024 noting competing operational pressures.
3. ICBs have limited capacity to engage with the existing NHSE England team on the specialised portfolio and a continued focus on formal delegation for April 2024 would severely limit any further meaningful engagement on service or pathway issues in the meantime.
4. The business processes to support delegation, including risk management, clinical oversight and day-to-day operational decision making are only now beginning to be developed and the ICB does not have capacity to support and engage in this development and to undertake pre-delegation diligence simultaneously.
5. Attempting to proceed with delegation before these steps are completed creates a very significant risk of short- and mid-term disruption which will both increase diligence and assurance requirements, and slow down the long-term delivery of delegation benefits.
6. Overall, NHS England's stated aims of pathway integration and improved patient care would be better served with a continuation of existing joint working followed by later delegation once operational processes have been stress tested, and ICBs have an understanding of the specialised portfolio gained through experience working with and alongside the existing NHS England specialised services team.

7. ICB Annual Assessment Summary

7.1 As Board members are aware the ICB is assessed annually. The attached letter sets out a summary assessment of the ICB's performance against the specific objectives set by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2022/23 financial year.

7.2 The assessment is structured in a way which assesses our role in providing leadership and good governance within your Integrated Care System as well as how we have contributed to each of the four fundamental purposes of an ICS.

7.3 The assessment identifies many areas of good practice, as well as setting out some of the challenges we face.

8. **Sexual Safety in Healthcare – Organisational Charter**

8.1 On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024. NHS Gloucestershire ICB is presenting the charter to the ICB Board to agree the 10 principles and actions to achieve this.

8.2 Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

8.3 **As signatories to this charter, NHS Gloucestershire ICB commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:**

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

8.4 These commitments will apply to everyone in our organisation equally. Where any of the above is not currently in place, NHS Gloucestershire ICB commit to work towards ensuring it is in place

by **July 2024.**

8.5 The ICB Board is asked to approve the 10 principles and actions as outlined above.

9 **Recommendation**

9.1 The Board is asked to

- note the CEO report
- Approve the extension of the Procurement Strategy for another 6 months until 31 March 2024
- Agree the Sexual Safety in Healthcare – Organisational Charter and the 10 principles and actions to achieve this.

To: Mary Hutton (CEO)
cc. Dame Gill Morgan (Chair)

Elizabeth O'Mahony
Regional Director
South West
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

19th September 2023

Dear Mary,

Gloucestershire Integrated Care Board Annual Assessment High-Level Summary for 2022-23

I am writing to you pursuant to Section 14Z59 of the NHS Act 2006 (Hereafter referred to as "The Act"), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making an assessment I have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that my team and I have had with you and your colleagues throughout the year.

This letter sets out my assessment of your organisation's performance against those specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2022/23 financial year.

I have structured my assessment to consider your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS. For each section of my assessment (see below), I have summarised examples of those areas in which I believe your ICB is displaying good practice and also provided examples of programme/workstream themes in which I feel further progress is required, and any support or assistance being supplied by NHS England to facilitate improvement towards meeting the statutory duties.

In making my assessment I have sought to take into account the relative infancy of ICBs, having only been statutory bodies for nine months of the 2022/23 financial year. I am also mindful of the developing local strategic aims of ICS' set out in the Integrated Care Strategy for your system and articulated through your recently published Joint Forward Plan.

I would like to thank you and your team for all your work over the 2022/23 financial year in what remains challenging times for the health and care sector, and I look forward to continuing to work with you in 2023/24.

Yours sincerely,

E O'Mahony

Elizabeth O'Mahony
Regional Director, NHS England – South West

Summary 2022/23

SECTION 1: SYSTEM LEADERSHIP

The ICB leadership remained largely unchanged following ICS establishment, which has supported stability in transition. Gloucestershire ICB has a lead SRO for Health Inequalities – a jointly held position for the ICS, shared between Siobhan Farmer (Director of Public Health) and Douglas Blair (CEO, Gloucestershire Health, and Care). Health inequalities and population health are 'golden threads' throughout the annual report and the draft Integrated Care Strategy. The ICB has strong partnerships and a good ICS Strategy and JFP.

Gloucestershire ICB chose to conduct their own ICB governance review in 2022/23 and the draft report has recently been shared with NHSE. Whilst you acknowledge there is room for further improvement, it is noted that the ICBs governance arrangements are strong and in line with guidance to facilitate effective decision-making.

SECTION 2: IMPROVING POPULATION HEALTH AND HEALTHCARE

Elective services throughout 2022/23 - the ICB, system, and trust performance achieved the national ambition of zero >104ww and >78ww and continue to maintain this position. The system has worked closely with the independent sector to obtain capacity and offer choice. In addition, the use of the Cheltenham site as an elective 'hub' and the reconfiguration of some of their community sites has assisted in the pace of elective recovery. They ICB have monthly Planned Care Boards with attendance from the acute provider, IS and NHSE. The Elective Care Hub (ECH) offers reassurance to people on the elective waiting list and support while they are waiting. This includes the promotion of wellbeing services and social prescribing. The roll out of additional capacity in the community diagnostic hub has commenced. Focus on diagnostic recovery has led to significant reductions in the number of patients waiting over 6 weeks in all modalities, particularly echocardiography which has now cleared its backlog.

Urgent and Emergency Care Services - the ICB acknowledges that it has faced several UEC challenges and national core standards have not been achieved consistently. The ICB however recognise the issues that need to be resolved and commissioned a helpful system wide review to better understand the way UEC services are operating today and look for opportunities to improve outcomes. Progress has been made, a number of new pathways and services have been operationalised in 2022/23 to support timely care in the most appropriate setting: for example, the Community Assessment and Treatment Unit (CATU) supporting frail patients who would otherwise have had an acute admission, non-specific symptoms pathway for suspected cancer, and falls service expansion to cover both injurious and non-injurious falls.

Overall performance across UEC metrics has been improving throughout 2022/23, with significant decreases in time lost to handover delay and Category 2 response times notable towards the end of the year. The system continues to focus on delivery commitments for 23/24 with ambitious improvement targets set particularly for ED waiting times and reducing long stays in acute hospitals.

Cancer Services - the system and provider have had a strong focus on screening, diagnostics, and treatment delivery. The faster diagnosis standard (FDS) continues to be delivered above national milestones. Cancer treatment activity has remained high throughout 2022/23; this has been achieved by protecting cancer services during periods of operational pressure and continuing service redesign. Primarily breaches of the treatment

target have been for Lower GI and Urological cancers, where specialties and diagnostic provision are still recovering from disruption during the pandemic.

Primary Care - across the county, around 70% of appointments are in person (face to face) with a clinician. The remaining 30% are conducted by phone or virtually. The increased availability of online appointments in primary care has been beneficial to many patients where it suits their lifestyle and needs. NHS Gloucestershire is continuing to provide support to primary care, particularly around areas such as recruitment, appointments and booking systems. Despite significant pressure, primary care metrics are all performing well with rates of appointments, rates of GPs workforce, rates of direct patient care staff, and experience of making a GP appointment all benchmarking in the top quartile compared to other ICBs across England. Gloucestershire ICS is ranked 1/42 systems for both rate of GP appointments conducted and for experience of making a GP appointment (in July 2022). Appointments in general practice have continued to increase above plan levels and the 2019/20 activity baseline following sustained demand for services.

Mental Health Services - improvements in access to services and wider support for people with Serious Mental Illness have been seen throughout 2022/23, with many more people having a full physical health check (over 56% of the SMI register) and taking up subsequent interventions to manage their health across primary care and community mental health. Over 2022/23, the eating disorder team has significantly reduced the urgent adolescent assessment waiting list numbers and waiting times and focussed on providing alternative support to those who are waiting, in collaboration with voluntary sector partners. National dementia diagnosis performance dropped during the pandemic, with Gloucestershire performance mirroring the trends seen across the country. National reporting has been suspended; however, prior to October 2022 performance had stabilised and the system is working to improve diagnosis rates in line with the 2023/24 operational plan. It is noted that the system is not meeting the Talking Therapies (IAPT) access metric (10,740 against local target of 13,936 and national ambition of 17,738). IAPT referral volume continues to be below the level needed to meet this target, and higher than expected drop out levels in Q4 also contributed to the lower than planned access rates. Recovery performance continues to be on target, with March performance at 51.5% patients entering recovery, and the target met in all but two months in 22/23. National ambitions around access have been revised down to reflect challenges in workforce recruitment and retention as well as lower demand for the service.

SECTION 3: TACKLING UNEQUAL OUTCOMES, ACCESS, AND EXPERIENCE

Gloucestershire ICB has sought to restore services inclusively to support the reduction of health inequalities with further work to do around One Gloucestershire, moving through into 2023/24. Gloucestershire Hospital Foundation Trust (GHFT) has launched an Elective Care Hub that offers reassurance to people on the elective waiting list and support while they are waiting. Targeted analyses to review the waiting lists for elective care and cancer have been conducted with further areas for review identified.

Acute respiratory infection hubs have been set up in areas of highest deprivation in the county. Evaluation is being conducted to determine future model, with benefits around reduced attendance and admission and support for long term conditions. Over the past four years Gloucestershire has been an early adopter and pilot system for a new digital model of personalised self-care across multiple pathways.

Gloucestershire ICB manages digital exclusion through the digital exclusion group, which brings together diverse communities and ensures users of care are heard. The Digital Divides project analyses data and community assets to ensure equal digital access and

opportunity across Gloucestershire. However, the System efficiency target was not met, with particular concern about the delivery of recurrent efficiencies.

In respect of workforce, it is noted the Gloucestershire ICB staff survey scores are all either above median or the same as median. I would like to congratulate you for achieving the highest recommendations from staff as a place to work, this was the best score out of all 42 ICBs. It is good to see that the ICB is leading the development of a system wide People Strategy that is based around the seven People Promises.

The ICB has taken full advantage of opportunities through HEE to develop a range of projects to support, develop and train its workforce. Examples include additional training for community optometrists in the clinical domains of; Independent prescribing, Glaucoma, Medical retina, Low vision.

The ICB has also developed an education framework to support the development of new and existing clinical roles across the system to support in the delivery of respiratory strategic priorities. The ICB continues to run training and development for primary care staff (with separate forums now established for nursing and non-clinical receptionist and administrative staff).

In respect of digital development priorities including sustainable models of healthcare; the ICB has increased remote consultations and developed a digital literacy programme jointly with GCC, to enable better access to digital services by a wider range of the population. In order to meet accessibility needs, the system has developed the NHS Gloucestershire Personal Health Records Strategy: Personal Health Records (PHRs) are digital health tools that allow people to do specific tasks, including viewing their medical record, booking appointments, and uploading their own health information.

SECTION 4: ENHANCING PRODUCTIVITY AND VALUE FOR MONEY

The ICB and system achieved their planned revenue positions, and the ICB achieved its efficiency plan. However, the system under-achieved on both its efficiency target and its target for efficiencies achieved recurrently.

The ICB is leading the development of a system-wide People Strategy that is based around the seven People Promises. The ICB continues to run training and development for primary care staff and has begun to scope a training and development plan for clinical leaders working to support its 10 Clinical Programme Groups, and other priority areas, having completed a training needs analysis in February 2023.

With regards to digital there are ongoing programmes of work supporting the development of clinical pathways in particular virtual wards. PHRs are noted in section 3, above and the digital exclusion group brings together diverse communities and ensures users of care are heard. The Digital Divides project analyses data and community assets to ensure equal digital access and opportunity across Gloucestershire.

SECTION 5: HELPING THE NHS SUPPORT BROADER SOCIAL AND ECONOMIC DEVELOPMENT

One Gloucestershire's Integrated Care Strategy has a dedicated section for articulating commitments to health equity and outlines the use of the population intervention triangle, as a framework for action, thus describing the role of Gloucestershire's anchor organisations as

well as the Core20Plus5 approach and the potential for PHM, as a tool to better target interventions to those who need them most.

The ICB had formal feedback from the Gloucestershire Health and Wellbeing Board, which demonstrated excellent partnership. It is clear that ICB partner organisations have been key contributors to the local anchor organisation work, with some excellent practice around employment and workforce development, carbon reduction and procurement emerging. The ICB has also recognised its significant role in reducing inequalities in access to, experience of and outcomes from, health care interventions it delivers. A strong locality focus and involvement of local communities also aligns with the asset-based approach of the JHWS.

CONCLUSION

In assessing Gloucestershire ICB's performance, I have reviewed the collective data and feedback from NHSE and the ICB's stakeholders.

For the year 2022/23, I am pleased to confirm that Gloucestershire ICB is considered to have been working in compliance with its statutory duties. Please continue the good work that has been identified throughout this assessment, as part of your sustainable ICB development journey.

The assessment process has shown that the ICB remains in a strong position with regards to system leadership, and highlights where the ICB has improved its integrated approach to prevention and patient care, including by developing partnerships with those working on broader social and economic development. The ICB and system achieved its planned revenue positions, and the ICB achieved its efficiency plan. However, the system under-achieved on both its efficiency target and its target for efficiencies achieved recurrently. Progress is also required in 2023/24 to improve dementia diagnosis rates in line with the 2023/24 operational plan and to improve IAPT access. The ICB's focus on ambitious improvement targets for ED waiting times and reducing long stays in acute hospitals is welcomed and recognised.

The ICB is currently in NHS Oversight Framework segment 2, and the areas highlighted above will be part of considerations for the ICB to potentially move to segment 1 in the future.

This high-level summary of the 2022/23 ICB Annual Assessment can be shared with your leadership team and the ICB should consider publishing this, alongside your annual report, at your Annual General Meeting. NHSE will also publish a national summary of all ICB annual assessments as part of its 2022/23 Annual Report and Accounts.

Agenda Item 8

NHS Gloucestershire ICB Board, Public Session

Wednesday 27th September 2023

<table>
<tr><td>Report Title</td><td colspan="4">Integrated Performance Report</td></tr>
<tr><td>Purpose (X)</td><td colspan="4">For Information | For Discussion: X | 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 September 2023.

The report brings information together from the following four areas:

• Performance (supporting metrics report can be found here)
• Workforce (supporting metrics report can be found here)
• 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. In November the Board report will incorporate further measures and trajectories for 23/24 as confirmed in operational planning and as set out in the Joint Forward Plan, details are outlined within the metrics report.

We will also be giving visibility to the Board of delivery against longer-term outcomes through joint work with public health. This will be shared with the ICB every 6 months commencing from the Autumn.</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>

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	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. Our performance also feeds into the NHS Oversight Framework and influences 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.
Management of Conflicts of Interest	None
Resource Impact (X)	**Financial** [ ] **Information Management & Technology** [ ] **Human Resource** [ ] **Buildings** [ ]
Financial Impact	See financial section of the report.
Regulatory and Legal Issues (including NHS Constitution)	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.
Impact on Health Inequalities	See Performance section of the report.
Impact on Equality and Diversity	See Performance section of the report.
Impact on Sustainable Development	None
Patient and Public Involvement	The Integrated Performance Report (Quality section) currently provides information on patient and public feedback.
Recommendation	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

Author	**Performance:** **Kat Doherty** **Workforce:** **Tracey Cox** **Finance:** **Chris Buttery** **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

September 2023

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Supporting Performance and Workforce Metrics – see document here.	

System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	7th September 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
In Year (2023/24) Financial Position	Limited	Committee received an update on the in-year financial position and the key risks to delivery. Pressure areas in particular for the ICB and GHFT were discussed (in particular on cost containment for the run rate in GHFT as well as Prescribing /Medicines costs in the ICB) and the work being undertaken on the financial recovery plan to mitigate these pressures.	There was agreement from the Committee to move (as part of the financial process) to move from organisational to system recovery. Work was being undertaken to quantify the impact of all the actions in the Financial Recovery Plan	September 2023
Medium-Term Financial Plan	Limited	Committee discussed the first draft submission on the Medium Term Financial Plan and the work that had been undertaken to close the underlying deficit over the next few years. The Committee heard about the expected financial position for the next few years. Further work was going to be needed throughout September to ahead of re-submission and to support delivery of schemes in the plan.	Further work being undertaken on the Medium Term Financial Plan to support re-submission at the end of September 2023.	September 2023
Performance	Limited	Committee received an update on performance and in particular discussed performance in urgent care (including the work underway on winter planning) as well as the impact of industrial action on planned care performance.	Continued support to, and monitoring of delivery through programme boards. Work is being undertaken to incorporate the full range of metrics as stated in the Joint Forward Plan into the performance report for the ICB.	Ongoing
Committee Risks	Limited	Committee considered the risks that had been assigned to the System Resources Committee. Some risks re-allocated to other Committees.	Further work to be undertaken on the risk report – to be picked up outside the Committee	December 2023
Health Economics & STAR Programme	N/A	Committee discussed feedback from the Board Development session. Work had been undertaken with Midlands and Lancashire CSU for COPD and consideration was being given to how this approach could be used in other pathways.	Follow on Board Development session on health economics planned for October 2023. Further work being undertaken on adopting the STAR approach within Gloucestershire.	November 2023

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

Issues referred to another committee

Topic	Committee
None	None

People Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	20th July 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 current industrial action by consultants and junior doctors, and the impact this was having on services. GHC had (consultant) secured cover for services though no slack existed in the organisation. Junior doctor cover situation was less secure. Agency staff were able to be used for cover, because of recent high court ruling, this will not be a option for the future. GHFT managing to cover critical services.	Plans for further industrial action - which includes overlapping dates for Consultants and junior doctors in September – are being developed.	September 2023
National EDI Action Plan	Limited	Committee was informed of recently published National EDI Improvement action plan, which has added to existing national (e.g. WRES/WDES) plans and local plans	Mapping and alignment of national and local EDI action plans	Sept 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
Workforce Development and CPD Funding	Significant	Confirmation of funding received (comparable to previous years). Trusts and system reviewing which schemes should be funded.	Funding allocation to be distributed based on agreed schemes delivery	Remainder of 2023/24

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	17th August 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Maternity	Limited	Section 29A remains in place from 2022. A large number of varied action plans were in place and will be collated into one overall action plan. Staffing remains the most significant risk. The Regional Chief Midwifery Officer for England visited GHFT and has attended the Maternity Group Delivery meeting. This was an encouraging visit with an offer of help and support to the Trust.	GHFT have advised that they will be able to deliver further assurance on improvements following CQC action at the next meeting. An integrated action plan has now been developed. Follow up actions to be implemented following ICB / region insights visit .	October
Wotton Lawn Hospital	Limited	Good progress has been made with staffing challenges by putting in place Band 5 staff as a proxy measure. Other grades are now well recruited to. Successful internal recruitment work had been helped by the University of Gloucestershire.	Ongoing monitoring through SQG and Quality Committee.	October
Primary Care	Limited	The meeting discussed GP Patient Satisfaction Survey results and whether more could be done to help those Practices and PCNs in areas of higher deprivation where inequalities were greater and where outcome improvements were most needed.	The meeting Chair to discuss the allocation of funding in areas of deprivation at a future development session.	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”
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Issues referred to another committee

Topic	Committee
None	N/A

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Summary of Key Achievements & Areas of Focus

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- The UEC programme has achieved the majority of planned commitments going into July – with reductions in the numbers of long stay and no Criteria to Reside Patients in the acute hospitals, and good performance against the 2hr Urgent Care community response target.
- Imaging performance remains strong – with no patients waiting more than 6 weeks for CT or MRI at GHFT in July. Diagnostic imaging performance in Gloucestershire is ranked 1st for all ICBs nationally.
- Despite the challenges of industrial action, the Elective recovery fund (ERF) position for Q1 is on plan, with achievement at 105%. Pathways avoided are an important contributor to the achievement of this target, and additional investment is allowing performance issues around the haematology advice and guidance service to be resolved with outsourcing for 6 months while a sustainable solution for long term provision is developed.
- Total primary care activity remains above plan, and provision continues to benchmark well nationally.

Areas of Focus

- The ongoing industrial action continues to impact the system, with mitigations for industrial action put into place repeatedly – this takes focus away from other areas of work, including UEC transformation. There have been significant numbers of cancellations of elective procedures and appointments, which although has not yet caused the ERF position to drop, is impacting on the system's ability to attract additional funding for elective work.
- Industrial action is also constraining options for patients likely to breach the 78 week wait for elective treatment – we may see breaches of this target in the coming months due to less capacity across the system.
- Hot weather early in September has been causing performance issues – particularly for SWAST (ambulance trust). Increased demand has been seen across all systems in the South West (and ambulance trusts more widely across the country), with knock on impact to Category 2 response times and handover delay performance.
- Endoscopy recovery remains below plan – dedicated Task and Finish groups have begun working at a system level and within GHFT focussing on operational delivery and transformation to ensure the service can sustain demand going forward.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

ICS People Strategy Development

- Final draft of ICS People Strategy written and submitted to ICB board for final review and approval (27th Sept).
- System Workforce KPI interactive dashboard developed.

NHSE Funding:

- £350k business case approved for International Recruitment for domiciliary care sector.
- £310K Workforce Development Funding - PIDs locally reviewed, submitted to and approved by NHSE office and allocated across five projects across the system.
- £145k received to support the AHP workforce.

Health and social care career promotion:

- ‘We want you’ outreach project scoping completed, strategic priorities set and delivery commenced (plan to work with 19 schools).
- “Be in Gloucestershire recruitment campaign” stakeholder engagement underway via 1:1s and survey – focus on GP recruitment, campaign to commence in 2024.

System-wide Development Programmes

- Applications for Systems Thinking masterclass cohorts 3 and 4 received.
- Reciprocal Mentoring cohort 1 commenced and mid-point evaluation being undertaken.
- Long-term evaluation for Flourish Programme undertaken.
- Inclusion Allies cohort 2 commenced.

Areas of Focus

ICS People Strategy

- Further engagement with Countywide Health and Wellbeing Partnership planned focusing on areas for wider collaboration in implementing the strategy.

Staff Health and Wellbeing

- Development of a county-wide Health and Wellbeing strategy, building on the previous vision work.
- Development of system-wide health and wellbeing early starter conversations (supporting retention efforts)

Temporary Staffing

- Focus on increasing (more cost-effective) bank staff usage over agency staff usage.

System-wide Development Programmes

- Reciprocal Mentoring Cohort 2 planning (2023) for delivery in 2024.
- Systems Thinking masterclass cohort 3 delivery scheduled for October and November.
- Leadership and Management training needs and gap analysis to commence.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality

Key Achievements

- Healthcare Leader's analysis of the NHS's monthly performance statistics for June 2023 has revealed that for all cancers, only two ICBs are working above the target:
  - Kent and Medway ICB (95.32%)
  - Gloucestershire ICB (94.77%)
- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has remained within expected levels since November 2022.
- System Partners have agreed a provisional timescale of the switch from the Serious Incident Framework to the Patient Safety Incident Response Framework.
- Waiting times for the Patient Transport Advice Centre have shown some early signs of improvement.
- GHT are one of the national pilot sites for supporting patients to request a second opinion if they have concerns about treatment.

Areas of Focus

- Weekend Mortality rates show some statistically higher rates of mortality. A 'Task and Finish' group has been set up to review causes.
- Use of 'freedom to speak up' as part of the ICB review into mortality and serious incidents
- The introduction of the new patient safety reporting framework.
- Saver staffing reviews are commencing across the ICS, starting with GHT. This will take the form of a full comprehensive review, service by service to better understand staffing establishments and comparative analysis.
- Maternity services staffing concerns and impact on mother's access to services especially the midwifery-led birthing units.

Finance and Use of Resources

Finance

- The ICS finance position as at month 5 2023/24 is:

	Year To Date (£k) (Overspend)/Underspend	Forecast Outturn(£k) (Overspend)/Underspend
GICB	(335)	0
GHFT	(2,438)	0
GHC	(1)	0
Total Surplus/(deficit)	**(2,774)**	**0**

- The ICS continues to face a number of significant financial pressures and there remains a high risk of non-delivery of an overall system breakeven position. The financial pressures include:
  - ICB prescribing item and price increases.
  - Workforce pressures leading to high expenditure on agency and locum staff.
  - Medicines division pressures within GHFT.
  - Impact of industrial action on operating costs and activity levels.
  - Ongoing inflationary pressures – pay and price and demand and growth pressures, including recurrent pressures from 22/23 built into the 23/24 plan. There is growing evidence that suggests inflation in specific areas will continue.
  - Slippage in the delivery of savings plans.

- A proportion of current pressures are being mitigated through non-recurrent savings, slippage in investments and non recurrent measures. Chief Executives are looking at bringing forward plans to deliver recurrent savings in year in addition to extra non recurrent savings.

- Year to date capital expenditure has a variance of £11.8m against budget for the year, mainly relating to early year slippage against schemes. The forecast is for this slippage to be recovered by year end and work is ongoing to ensure system capital expenditure remains within the system capital allocation. Some capital funding sources outside of the system capital allocation are yet to be confirmed.

- Agency costs in month 5 are above the straight line value of the agency cap for the system. Actions are underway to reduce the expenditure within both Trusts, however, Industrial Action is one of the factors impacting on this spend. This is one of the system performance measures.

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

- August overall performance across all ED sites was 72.7% (patients seen and treated/admitted or discharged within 4 hours) a drop from July's performance predominantly due to challenging periods at the GRH site in August (including the temporary changes to respond to industrial action), with GHFT discharging/admitting 56.9% of patients within target. MIIU performance against the 4-hour target remains strong at 99.8%. SWAST Cat 1 average response time was 9.5 minutes, and Cat 2 average response time was 29.8 minutes – which meets the national ambition for 23/24 to achieve a 30 minute average Cat 2 response time. Handover delays have increased slightly – at 2687 hours lost against a target of 1933, reflecting a steady increase in resource hours lost as the month progressed (seen in Gloucestershire but also across the whole SWAST patch).

- Hot weather early in September has been causing performance issues – particularly for SWAST (ambulance trust) with increases seen in terms of ambulance incidents and ED attendances. Increased demand has been seen across all ambulance and ED systems in the South West (and more widely across the country), with previous increases in heatwaves due to heat related exposure and breathing difficulties. The majority of these additional calls have been able to be closed with Hear and Treat outcomes and have not resulted in increased conveyance to ED.

- Following Further industrial action is planned throughout September and October with junior doctors and consultants aligning dates in many cases. The cumulative impact of industrial action on staff resilience, as well as the continued high cost of using agency support to mitigate staffing levels is putting the system under considerable strain.

  Future industrial action dates:
  - 19 September - Consultants will deliver Christmas day levels of staffing, while junior doctors will work as usual.
  - 20 September - Both junior doctors and consultants will deliver Christmas day levels of staffing (only emergency care will be provided).
  - 21 and 22 September – Junior doctors industrial action (no care provision by junior doctors taking part). Consultants will return to work as usual.
  - 2 - 4 October - Junior doctor and consultants will deliver Christmas day levels of staffing only.

- The system has shown good progress against planned commitments for UEC in 23/24 throughout Q1 of the year despite the challenges of the industrial action – with the majority of targets being met. Particular improvements have been seen in the % of patients remaining in hospital with no criteria to reside (NCTR) which has reduced to 151 in the most recent week. ED performance against the 4 hour target was on target through to July, however the dip in performance seen in August means that Type 1 ED waiting time improvements have declined and are below target.

Improving Services & Delivering Outcomes

Elective Care

- In July 2023 the overall waiting list size has dropped slightly to 80,522 (a reduction of ~500 patients). This is the first reduction in waiting list size seen since December 2022. Overall RTT performance has reduced to 67.2% (waiting list under 18 weeks) for all ICB patients.
- There has been an increase in overall 65 week waits for the ICB to 690 in July from 613 in June (11.2% increase) – no area saw a particularly significant increase. Overall increase in 65 week waits may be as a consequence of industrial action impacting the service. GHFT accounted for 576 of the total 65 week waits (83.4%). In July there were 16 (down from 17 in June) over 78 week waits for the ICB with all waiters being located OOC (out of county).
- Year to date (M1-3) performance for Elective Recovery is 105%, thus achieving the new revised target of 105% but still below the submitted plan of 109%. At Provider level overall GHFT are almost achieving 19/20 levels (97.3% recovery) but are impacted by cancellations due to Industrial action. OOC NHS providers are recovering to 86.8% for 19/20 against an ambition of 95% recovery. The Independent Sector providers continue to provide extra capacity, particularly for day case activity, which has a significant contribution to ICS recovery position. Pathways avoided are contributing around 4% on top of activity recovery.
- Industrial action has had a significant impact on elective recovery. There were a total of 2,155 cancellations across April to June due to Industrial action which equates to an additional £980,450 value weighted activity when average tariffs are applied. Including this activity would put the YTD (M1-3) ERF position up from 105% to 107.6% (including pathways avoided). Further industrial action will have a similar impact – as yet there is no decision on whether ERF targets will be altered centrally again.
- The new Chedworth Day Surgery Unit in Cheltenham will provide a protected day surgery environment in Cheltenham through winter to allow continuity of elective capacity – in particular this will boost the daycase activity in specialties currently below plan, such as gasterenterology and urology.
- 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. Additionally, focussed work on understanding the waiting list increases in the system, and ensuring that patients are supported while they wait is continuing to take place with cross organisational working groups.
- Role out of the Patient Initiated Digital Mutual Aid System (PIDMAS) remains planned for October in line with national commitments – patients waiting over 40 weeks with no first appointment planned in the next 4-6 weeks will be written to with a link to review other options within a minimum of 100 miles. This will be a significant challenge to all systems due to increased administrative burden and a lack of realistic alternative options for many specialties.
- The haematology outsourcing project to consultant connect (for 6 months) to clear backlog is about to go live, this will allow focussed work on developing an ongoing internal service to take over once the 6 months is complete.

Improving Services & Delivering Outcomes

Cancer

- 2 week wait performance also achieved the 93% target with 96.8% of patients seen within 2 weeks of referral on a cancer pathway. Treatment target waiting times were missed narrowly for 31 day treatments with 93.3% patients beginning treatment within 31 days of a decision to treat. 62 day treatment targets were missed for all referral routes with Lower GI and Urology breaches the drivers of low performance as the backlog for these specialties continues to be worked through. With endoscopy performance still extremely challenged – it is likely Lower GI performance will be affected for some time.

- July performance against operational planning commitments for cancer waits has met the majority of targets, with the number of patients waiting more than 62 days reducing at GHFT to 178 (July average, against a target of 180 set in operational planning). Recovery plans in urology and Lower GI have delivered large reductions in their backlogs and there is ongoing work to prevent new patients tipping over 62 days. The 28 Day Faster Diagnosis standard was achieved with performance at 79.7% in July. Compliance with FIT testing for Lower GI referrals has been high in Gloucestershire, with the best regional performance in 22/23 (SWAG region). Latest performance shows 75% of referrals are submitted with a FIT result – ahead of the trajectory to reach 80% by the end of the year.

- Non specific symptom (NSS) referrals remained stable at 29 in July 2023, against a target of 48 – this under performance is expected due to the consistency of GP referral into cancer pathways prior to the launch of the NSS pathway, The pathway is now fully open to all PCNs, with NSS clinicians having visited all PCNs to promote it. A regional evaluation of the service is underway, with the cancer CPG and service considering whether there is value in diverting other referrals from 2ww services where a NSS referral could be beneficial.

- 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.

- Strong system working particularly around the interface between primary and secondary care for cancer and suspected cancer patients continues – the cancer team is developing a newsletter for practices to advertise opportunities such as masterclasses, webinars and other education events.

Improving Services & Delivering Outcomes

Primary Care

- There continues to be significant public demand on primary care, with 352,531 appointments carried out in July 2023 – the total year to date activity is 93,000 appointments above planned levels for 23/24. Total activity is now 18.1% above pre-pandemic levels in 2019, with a 24% increase in same day appointments booked compared to 2019 (both above the national average). In July Gloucestershire offered 7.7 more same day or next day appointments per 1000 population than the national average.

- The primary care team are continuing to engage with practices, PCNs and ICB colleagues to ensure that the Delivery plan for recovering access to primary care is progressing as required. This includes, but not limited to, online bookable appointments., digital telephony solutions, self-referral pathways and GP improvement programmes. PCNs are continuing to implement their Capacity and Access improvement plans which support the delivery plan for recovering access to primary care.
- 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 procurement process for a new contract is ongoing.

- Self-referral for some community services is expanding, with the primary care team coordinating the assurance around the provision of self-referral in line with 2023/24 operational planning guidance. All services bar Audiology, Wheelchairs and Equipment have already rolled out self-referral (MSK, Weight management, Podiatry, Falls); while the wheelchair service is open to self-referral from people already known to the service. Wheelchair and Equipment services also are accessible via self-referral into the Integrated Community Teams, with health and social care professionals onward referring as appropriate. Audiology (provided by GHFT) is working to deliver self-referral by September 2023, however there are risks to delivery including development of an appropriate web portal, and potential work force and financial risks if demand significantly increases.

- Primary care estate works continue to progress, with new schemes now approved for Minchinhampton and Hucclecote. Further work is ongoing to define and develop a primary care offer in the Forest of Dean to complement the new Forest of Dean Community Hospital and MIIU.

Improving Services & Delivering Outcomes

Diagnostics

- Performance is hovering just over the national ambition (<15% of patients waiting over 6 weeks by March 2024) for all diagnostic modalities at 15.5%. GHFT overall performance in July was 14.45%, therefore meeting the target. The main areas of challenge for diagnostics are across endoscopy modalities - more than half of patients waiting for Flexi Sigmoidoscopy, Colonoscopy or Cystoscopy were waiting over 6 weeks in July.

- 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.

- Echocardiography performance continues to be below plan - the waiting list for this modality has since the end of the independent sector contract. Additional capacity via the Community Diagnostic Centre (activity) has commenced in June 2023 which has improved performance however 27% of patients on the list are currently waiting over 6 weeks (as of July 2023). 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.

- Imaging performance remains strong – with no patients waiting more than 6 weeks for CT or MRI at GHFT in July. Diagnostic imaging performance in Gloucestershire is ranked 1st for all ICBs nationally.

- Angiogram waits at GHFT continue to be extremely long – GHFT have a recovery plan in place, and options are being explored as to whether additional independent sector capacity could be a possibility.

- Estates work for the new Community Diagnostic Centre site are continuing – contractual issues mean that the opening of the new facility will be delayed until February 2024.

Improving Services & Delivering Outcomes

Adult and Children's Mental Health

- Improving Access to Psychological Therapies (IAPT) access is at 1183 for July – remaining below 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 52.9% patients achieving reliable recovery in July – this target has been met all year, showing the consistency of the service for patients.
- After an extremely positive start to the year (0 days declared in April and May), Out of Area placements have increased slightly with June at 62 and July at 81. This remains significantly lower than the planned numbers YTD.
- Eating disorders – the proportion of patients assessed within target has improved significantly in 23/24 to date. The July position (latest validated data) shows that for adults, 95.6% received treatment within the 16 week target. The CYP service has achieved 83.3% of referrals beginning urgent treatment within a week, and 76% of routine referrals beginning treatment within 4 weeks in July. A new 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 is working well, though there can still be a long wait between initial assessment and subsequent treatment – with the service relying on bank and overtime hours to maintain performance.
- 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 shows performance has been 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 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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Our People (Workforce)

Please note: The Workforce report is updated bimonthly.

Our People Strategy: Focused Pillars

Recruitment and Retention

- International Recruitment – NHSE funding (£350k) approved for Domiciliary Care International Recruitment. Eligibility criteria for care providers is being developed and this project is being aligned with nationally funded (by DHSC) project for supporting International Care workers that is being led by GCC.
- Accommodation – a SW regional collaboration has been formed to develop a 'hub and spoke' model for a housing hub that will support NHS and Care staff with short-to-medium term accommodation challenges. A local business case is being developed to make the case for investment and outline the benefits to staff retention.
- System-wide PNA/preceptorship event was held on 11th September at GRFC – approx. 100 staff attended from across the system - there was great engagement and feedback from early evaluation responses (60% received so far) has been positive and lots of interest in similar future events and community of practice.
- ICS Legacy Mentors – Lead LM role appointed to as well as nursing LMs in Primary Care, GHC, GHFT and AHP LMs in SaLT - delivery commencing September onwards. Midwifery LMs and remaining AHP LM roles in dietetics and radiotherapy still to be appointed.

Our People (Workforce)

Please note: The Workforce report is updated bimonthly.

Our People Strategy: Focused Pillars

Innovation

- £40k funding has been received from the SW Advanced Practice Faculty for continuing System Advanced Practice (AP) lead. These funds will contribute to the costs of the AP post. Whilst the contribution is welcome, a business case for sustainable funding for the role is being written.

Valuing and looking after our people

- The Health and Wellbeing group are developing a system-wide 'early starter' programme, aimed at staff that have commenced recently in their roles (i.e. within first few months) to remind them of the health and wellbeing services that are available and listening to staff about their early experiences, the intention is that this support staff retention as a significant minority of staff leave their roles within the first year of employment.

Education Training and Development

- Facilitating the easy movement of staff between organisations has a number of elements, one of which is a "Staf Training Passport", there is a national solution that is being rolled out for this (Digital Staff Passport) and GHFT are conducing a readiness assessment for the next implementation wave

Our People (Workforce)

Please note: The Workforce report is updated bimonthly.

Our People Strategy: Foundation Themes
(Workforce Planning, Digital and Data, EDI, Leadership and Culture)

- System Leadership development programme lead post has been appointed, initial tasks are to undertake a baseline mapping and scoping of the existing organisational/regional leadership offers with a view to rationalising as system-wide offers in support of system leadership.
- A mid-point evaluation of cohort 1 of the reciprocal mentoring programme is being undertaken, this will feed into the design and launch of cohort 2. EDI initiatives.
- The inclusion Allies Programme has been launched and delegates paired to support each others learning.
- A long-term evaluation study has been carried out for the Flourish Programme (which took place in 2021/22).
- A review and alignment of national and local EDI action plans is being undertaken to avoid duplication of effort and streamline actions.
- A call out for applications for cohorts 3 and 4 of the Systems Thinking Masterclass programme was very successful with almost 100 applications (for circa 40 places). Delegates will be selected based on availability to attend the whole programme and dates have been scheduled.
- A review of One Gloucestershire leadership programme and support for Alumni has been undertaken, a proposal to widening out a leadership event across to other system leaders is being developed.
- The scope of the Digital Workforce strategy has been agreed and capacity to resource it's development is being sought.

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 Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- Gloucestershire ICB received the Collaborative Commissioning Hub (CCH) Pharmacy, Optometry and Dental Quality Report for Q1 23/24 on the 1st of August.

Pharmacy

- No serious incidents were reported, 1 incident relating to the dispensing of incorrect medication was reported and 2 complaints and 1 concern were raised during this reporting period. The Community Pharmacy Assurance Framework (CPAF) cycle for 23/24 has now begun.

Optometry

- No serious incidents were reported, no complaints or concerns were raised and no significant quality risks or concerns relating to optometry services were notified to the NHSE CCH Quality and Safeguarding Team. No quality assurance visits were undertaken by the NHSE CCH during Q1.

Dental

- No serious incidents were reported. 2 complaints and 4 concerns were received relating to a dental provider, in addition, 4 were received relating to NHSE's commissioning of services concerning dental access. Themes and trends data will be provided by the CCH once investigation has been completed. No quality assurance visits were undertaken during Q1. Quality risks and concerns continue to centre around workforce and access as reflected nationally and across the SW region. The report highlights the role of the CCH in triangulating information and intelligence to identify any adverse impacts on patient safety, experience and health inequalities.

Urgent & Emergency Care

- Work continues to systematically redesign the way care is delivered in the One Gloucestershire system, including proactive care and reviewing how this can be further incorporated in PCN's.
- The ICB are continuing to work proactively with PPG (out of hours GP service) to support the work around the concerns raised at the inspection. The ICB noted the CQC concerns about ensuring the changes are embedded in practice, hence the regular monitoring visits and meetings. Clinical staffing remains a concern, workforce, rota fill and training provision remain under review.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Community and Mental Health

- Following recent negative media interest regarding patient safety concerns at Wotton Lawn Hospital (WLH), the hospital remains in a period of enhanced surveillance and quality monitoring. The second enhanced surveillance report has now been received from the Trust and includes information and data on areas requested by the ICB in addition to providing assurance on associated matters that featured in the media reports (climbing, staff sleeping whilst on duty). Examples of current good practice at WLH have also been included. Also of note is the Trust's Homicide Action Plan which is making significant progress in 11 actions with additional focus required in the remaining 3.
- The Trust continues to see an improving position with recruitment to clinical posts within mental health inpatient services and hope to be fully established at band 5 level at WLH by the end of September.

Maternity

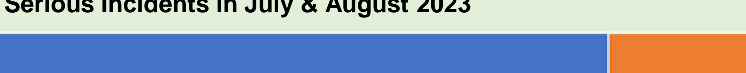
- GHNHSFT remains under a Section 29a, (2022) with an action plan in place. LMNS is receiving monthly progress updates. The ICB is liaising closely with the NHSE Maternity Safety Support Programme Advisor allocated to GHT
- LMNS summary dashboard is progressing and has been well received by all stakeholders, will include SPSS charts going forward.
- Dedicated team now appointed at GHT to work through all actions plans for Ockenden, Saving Babies Live and Maternity Incentive Scheme Y5. LMNS to approve and sign off submissions to NHSE. There are plans to develop one single action plan to include all action plans, including the 3 Yr Delivery Plan for maternity & neonatal care
- First trimester screening Serious Incident (SI) – SI & QI action plan in place, with weekly review by NHSE/LMNS/GHT – on Trust & ICB risk register
- Insight visit completed in July. The team met with staff from across the service initial feedback given to Senior Leadership team and currently working through formal feedback – due to report back Sept 2023
- Cheltenham Birth Unit & Stroud postnatal beds remain closed due to extreme staffing challenges.
- Independent Senior Advocate (ISA) has now started, 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 July & August 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)

System partners have now agreed a provisional timescale to switch from the Serious Incident Framework to the new PSIRF.

- Providers are working to a Jan 1st date of a switch from SIs to PSIRF
- Patient Safety Incident Response Plans (PSIRPs) will go to provider boards in November.
- PSIRPs will then be sent to ICB Quality Committee in December for ratification.
- This means that the last SI could be declared on Dec 31st meaning that the closedown of the last SI is expected by 25 March 2024

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.
- NHSE will shortly be launching a BI module to allow us to view incidents at ICB level.
- Eventually LFPSE will take over from the NRLS and Quality Alert system we current use.

System Safety Group

As part of the switch from SIs to PSIRF the ICB will be formally instigating a System Safety Group. This group will have two main functions:

- 1 – To oversee the implementation of PSIRF and support smaller providers to ensure full implementation.
- 2 – To bring together system learning and realise the potential of the new system.

This group will sit at a system level feeding into the System Quality Committee and will aim to bring together all those connected to it's functions. This is shown in the diagram below.

Provider assurance processes will continue including the Safety Experience Review Group at GHFT and a new assurance group at GHC.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience: Friends and Family Test (FFT) Jan – June 2023

The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS funded services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. The FFT asks a simple question: how likely, on a scale ranging from extremely unlikely to extremely likely, are you to recommend the service to friends and family if they needed similar care or treatment. The last eleven month's published results can be found opposite.

		Jan-23 Provider	Feb-23 Provider	Mar-23 Provider
GHT Inpatients	% Positive	91%	92%	92%
	% Negative	4%	5%	4%
GHT A&E	% Positive	80%	80%	79%
	% Negative	13%	13%	14%
GHC Mental Health	% Positive	84%	87%	80%
	% Negative	10%	4%	13%
GHC Community	% Positive	95%	93%	94%
	% Negative	2%	2%	3%

		Apr-23 Provider	May-23 Provider	Jun-23 Provider
GHT Inpatients	% Positive	93%	93%	93%
	% Negative	4%	3%	3%
GHT A&E	% Positive	83%	81%	78%
	% Negative	12%	11%	14%
GHC Mental Health	% Positive	87%	83%	87%
	% Negative	7%	6%	6%
GHC Community	% Positive	94%	94%	95%
	% Negative	3%	3%	3%

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Quality - Effectiveness

System Clinical Effectiveness Group

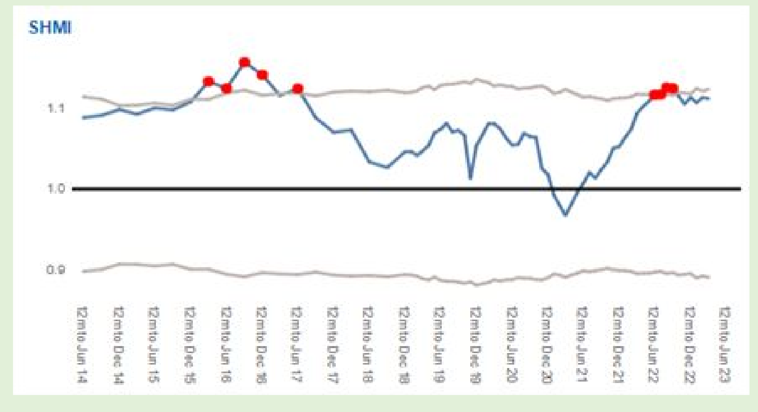
The next System Clinical Effectiveness Group (SCEG) is being held in September, that has not been a meeting since the last report.

It was agreed to set up a task and finish group including wider system partners, such as the Care Sector and Public Health for September to look a pressure ulcers as a system, this will also support the system wide CQUIN - Assessment and documentation of pressure ulcer risk.

We are currently in the process of reviewing the System Clinical Effectiveness group, with the potential to link closer with the Clinical Programme Groups and the system mortality group. From a governance perspective the SCEG will be reporting into the Quality Committee

Mortality

- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has remained within expected levels since November 2022. The chart opposite shows that while it is towards the higher end of expected levels, it is beginning to plateau.
- At the last System Mortality Group, weekend mortality rates were discussed as Gloucestershire appears to have statistically higher rates of mortality for those admitted over the weekend. A small task and finish group has been established to look at system data to understand why this might be the case. This is initially being supported by the ICB and GHFT.



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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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 organisation, this includes 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 5 2023/24 is an overspend versus plan of £2,774k. This is attributable to ICB prescribing cost increases, the net cost of industrial action incurred within GHFT, pay award cost pressures including GMS, and PFI inflationary indexation charges within GHFT. The GHFT position to date has been mitigated by non recurrent savings which are unlikely to continue into future months.
- The year end forecast out-turn is breakeven versus plan. Pressures have emerged across the system relating to workforce costs including the pay award, inflation, medicine division costs, placement costs and delivery of planned savings. Organisations 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. However, there is a high risk of non delivery of a breakeven forecast outturn for the system
- The cost of industrial action does not include any potential lost Elective Recovery Funding (ERF). The national target for elective recovery has been reduced by 2% to enable systems to cover the costs of industrial action in April. The impact of this change remains under review whilst industrial action is ongoing. The overall risk of clawback due to underperformance against ERF for the system is 16%, or £4.1m.
- System savings and efficiency plans are forecasting full delivery by year end. There are significant risks within plans and non recurrent savings are being developed to offset the risk of slippage. Risk ratings for 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 with the aim of delivering breakeven financial plan, as well as a recurrent breakeven position within the 5 year medium plan period.
- The year to date capital expenditure is £11.8m 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

Key Financial Issues

- 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 with cross system working being agreed following a workshop in August. Work within GHFT is ongoing in respect of grip and control of medical and nursing spend, with fortnightly meetings chaired respectively by the Medical Director and Nursing Director.

- 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 £1.8m. 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 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; this is likely to create a recurrent cost pressure in 2024/25. This is currently being assessed and mitigating actions identified by organisations.

- Delivery of savings plans remains a major risk for the system. Transformational savings plans include those for Urgent and Emergency Care which are high risk for the system. In addition, other areas of savings are rated as amber or red as there is currently slippage against schemes within GHFT (divisional schemes in particular), the ICB (CHC and placements savings) and GHC (non recurrent savings schemes). Forecast full year delivery remains on target through a mix of forward deliverables and milestones, and mitigating schemes.

- 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

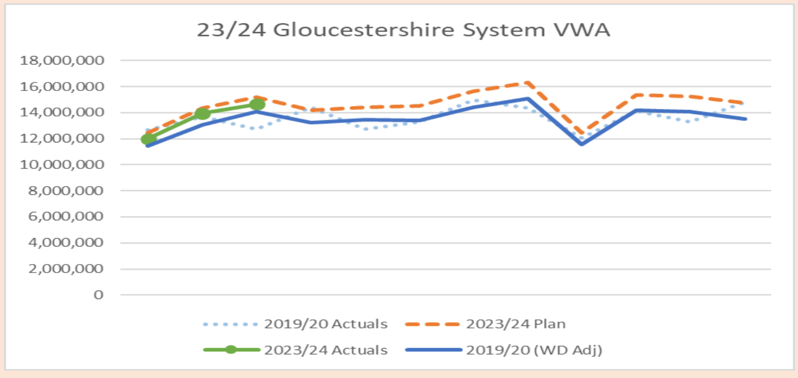
Financial Overview & Key Risks

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%, equivalent to £4.1m, and a 2% reduction in the national ERF target to enable Systems to cover the cost of industrial action and lost activity for April; this has meant a reduction of 2% to the System target to 105%. 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 ongoing. There is an ongoing National discussion as to the impact of industrial action from May onwards and any changes to system targets; until there is a national agreement the System is forecasting based on current known targets.

- Available activity for month 5 reporting is based on fixed data for April, May and June, and flex data (subject to change) for July. This shows YTD ICB commissioned activity at 99.6% of the value weighted target with under delivery by GHFT of (92.3%) and out of county NHS providers of (82.5%), offset by Independent Sector providers overperformance of (131.6%). GHFT is reporting low recovery rates in Day cases, Inpatient spells and Outpatient Procedures.

- NHSE has confirmed agreement to the first two months of freeze data.



Elective Recovery Fund – Monthly Analysis

ICB Commissioned

		April	May	June	July	August	September	October	November	December	January	February	March
Daycase	Plan	4,062,628	4,737,301	5,176,865	4,815,952	4,756,957	5,427,106	5,279,035	5,508,715	4,109,350	5,355,897	6,039,712	6,080,283
		106.9%	108.4%	106.0%	107.7%	109.5%	119.0%	116.0%	110.1%	106.6%	109.8%	126.5%	134.5%
	Actual	3,975,885	4,902,333	4,931,118	3,559,956								
		104.6%	112.2%	101.0%	79.6%								
Ordinary Admissions	Plan	3,578,597	4,149,575	3,828,031	3,790,701	4,154,771	4,330,809	4,708,559	4,105,131	3,335,113	3,847,120	3,785,844	4,115,305
		106.2%	102.7%	97.1%	96.2%	93.7%	110.5%	103.5%	88.3%	97.0%	100.9%	91.4%	99.8%
	Actual	3,321,916	3,601,738	3,951,087	3,175,668								
		98.5%	89.2%	100.3%	80.6%								
Outpatient Attendances	Plan	2,959,112	3,440,665	3,561,477	3,303,335	3,305,107	3,543,545	3,669,908	3,942,471	3,003,505	4,037,921	3,791,054	3,652,291
		107%	111%	103%	105%	109%	108%	105%	110%	109%	111%	113%	114%
	Actual	2,852,150	3,408,982	3,527,190	2,509,768								
		102.7%	110.3%	101.6%	80.1%								
Outpatient Procedures	Plan	1,557,690	1,701,259	1,776,463	1,777,548	1,719,712	1,676,874	1,862,672	1,905,477	1,468,914	1,900,320	1,758,470	1,723,522
		108%	112%	102%	110%	111%	109%	110%	108%	104%	106%	103%	107%
	Actual	1,367,970	1,497,094	1,650,062	1,200,097								
		95.1%	98.5%	95.0%	74.1%								
TOTAL GLOUCESTERSHIRE SYSTEM	Plan	12,212,889	14,044,516	14,869,800	13,925,881	14,100,222	14,209,260	15,334,844	16,002,421	12,208,589	15,048,196	14,945,784	14,471,016
		107%	107%	106%	105%	105%	106%	106%	106%	106%	106%	106%	107%
	Actual	11,517,922	13,410,147	14,059,456	10,685,736								
		100.7%	102.5%	99.8%	80.7%								
	incl.Pathways Avoided	104.8%	106.6%	103.8%	83.9%								

In M4 Gloucestershire ICB commissioned value weighted activity is 83.9% of 2019/20 against a plan of 77.3% (including pathways avoided). YTD performance is 99.6% based on the July flex position and including pathways avoided. The freeze position (April, May & June) was at 105.0%. Note Pathways avoided are contributing c.4% on top of activity recovery.

Independent Sector providers are delivering YTD higher activity volumes (132%) than GHFT (92%) and OOC NHS Providers (83%).

July flex data continues to indicate low recovery rates in GHFT for Day cases, Inpatient spells and Outpatient Procedures. This is primarily focused in Oral Surgery service day cases, T&O inpatients, and Ophthalmology outpatients.

OOC providers have underperformed across all PODs.

IS providers have exceeded recovery in Elective Inpatient Spells, Outpatient Procedures and Day cases.

Finance and Use of Resources

Dashboard

Statement of Net Income & Expenditure Position (£'000)

Month 5 2023/24 - August	Year to Date Plan Surplus/ (Deficit)	Year to Date Actual Position Surplus / (Deficit)	Year to Date Variance to Plan Favourable / (Adverse)		Full-Year Plan Surplus / (Deficit)	Forecast Outturn Actual Position Surplus / (Deficit)	Forecast Outturn Variance to Plan Favourable / (Adverse)
Gloucestershire Hospitals NHS Foundation Trust	(8,432)	(10,870)	(2,438)		0	0	0
Gloucestershire Health and Care NHS Foundation Trust	243	242	(1)		0	0	0
Gloucestershire Integrated Care Board	0	(335)	(335)		0	0	0
System Surplus/(Deficit)	**(8,189)**	**(10,963)**	**(2,774)**		**0**	**0**	**0**

Efficiency Programme (£'000)

Month 5 2023/24 - August	Month 5 Efficiency Plan	Month 5 Efficiency Achieved	Year End Variance to Plan Favourable / (Adverse)		Full-Year Efficiency Plan	Forecast Outturn Efficiency	Forecast Outturn Variance to Plan Favourable / (Adverse)	Forecast Outturn as % of Target	High-Level In-Year Risk Rating
Gloucestershire Hospitals NHS Foundation Trust	10,464	10,535	71		34,721	34,721	0	100%	AMBER - Medium Risk
Gloucestershire Health and Care NHS Foundation Trust	5,465	5,143	(322)		9,883	9,883	0	100%	AMBER - Medium Risk
Gloucestershire Integrated Care Board	5,480	5,480	0		13,128	13,128	0	100%	AMBER - Medium Risk
Total	**21,409**	**21,158**	**(251)**		**57,732**	**57,732**	**0**	**100%**	**AMBER - Medium Risk**

Other Metrics

Month 5 2023/24 - August	GHFT	GHC	GICB		ICS
Better Payment Pratice Code (total paid within 30 days or due date by value)	92%	99%	100%		99%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	2,205	0	0		2,205
Cash status	Green	Green	Green		Green

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

Finance and Use of Resources

Savings & Efficiencies

Monthly Efficiency Programme Trend Analysis (£'000)												
	M1 actual	M2 actual	M3 actual	M4 actual	M5 actual	M6 plan	M7 plan	M8 plan	M9 plan	M10 plan	M11 plan	M12 plan
Gloucestershire Hospitals NHS Foundation Trust	2,248	2,248	1,750	2,018	2,272	2,400	3,482	3,492	3,655	3,828	3,725	3,675
Gloucestershire Health and Care NHS Foundation Trust	1,786	1,786	631	631	309	631	631	631	631	631	631	632
Gloucestershire Integrated Care Board	1,096	1,096	1,096	1,096	1,096	1,096	1,093	1,093	1,094	1,091	1,090	1,091
System Total	**5,130**	**5,130**	**3,477**	**3,745**	**3,677**	**4,127**	**5,206**	**5,216**	**5,380**	**5,550**	**5,446**	**5,398**

Savings and efficiencies totalling £57.7m are planned across the system in 2023/24.

As at month 5 reporting, the year to date delivery is £251k behind plan, across the system. However, the phasing and delivery of a number of schemes within GHFT, is planned to be in H2 of 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 – good progress made on identification of further non recurrent savings in month 5, with the risk of non delivery significantly reduced. Delivery of CIP year to date remains close to planned levels.
- **GHFT**: Medium - £10.5m of savings have been delivered (£8.7m recurrent, £1.7m non-recurrent). While there continues to be significant risk in the forecast position, GHFT is still forecasting delivery of £34.7m. The highest risk in the forecast position is the Urgent and Emergency Care programme (£4m). The total value of red rated schemes within the forecast is a total of £10.8m, with amber risk at £4.2m.
- **ICB**: Medium – risk of c£2m savings. Additional non recurrent savings required to offset slippage in some planned programmes. Risk relates to Discharge to Assess beds (savings target £3.1m) and Continuing Health care and placements (savings target of £1.5m) where, as of August the combined pressure is £1.147m (£0.6m in relation to Discharge to Assess and £0.547m in relation to CHC & Placements).

Finance and Use of Resources

Financial Overview & Key Risks

Capital Expenditure (£'000)						
Month 5 2023/24 - August	Year to Date Plan	Year to Date Actual Position	Year to Date Variance to Plan (Under) / Over Delivery	Full-Year Plan	Forecast Outturn Actual Position	Forecast Outturn Variance to Plan (Under) / Over Delivery
System Capital Allocation						
Gloucestershire Hospitals NHS Foundation Trust	10,949	8,393	(2,556)	25,888	25,888	0
Gloucestershire Health and Care NHS Foundation Trust	7,380	4,071	(3,309)	11,027	11,491	464
Gloucestershire Integrated Care Board	775	0	(775)	1,860	1,396	(464)
Total System Capital Allocation	**19,104**	**12,464**	**(6,640)**	**38,775**	**38,775**	**(0)**
Other Net CDEL sources						
Gloucestershire Hospitals NHS Foundation Trust	7,492	2,568	(4,924)	21,314	23,519	2,205
Gloucestershire Health and Care NHS Foundation Trust	590	0	(590)	1,841	1,841	0
Total System CDEL (NHS)	**27,186**	**15,032**	**(12,154)**	**61,930**	**64,135**	**2,205**
IFRS16 Lease Capital						
Gloucestershire Hospitals NHS Foundation Trust	541	1,216	675	1,478	9,501	8,023
Gloucestershire Health and Care NHS Foundation Trust	322	0	(322)	1,168	1,243	75
Gloucestershire Integrated Care Board	1,872	1,872	0	4,492	4,492	0
Total System Capital including IFRS16 Leases (NHS)	**29,921**	**18,120**	**(11,801)**	**69,068**	**79,371**	**10,303**

Finance and Use of Resources

Capital: Organisational Positions, Challenges and Opportunities

Within the ICS's system capital allocation envelope, capital expenditure is showing a £6.6m year to date underspend as at month 5 of 2023/24. The forecast is for expenditure to catch up in line with plan by year end.

The GHFT YTD variance against system capital allocation is primarily driven by the following:
- revised Fit for the Future (IGIS) delivery leading slippage with certain phases of the project.
- some minor delays in GSSD expenditure profile since the plan.

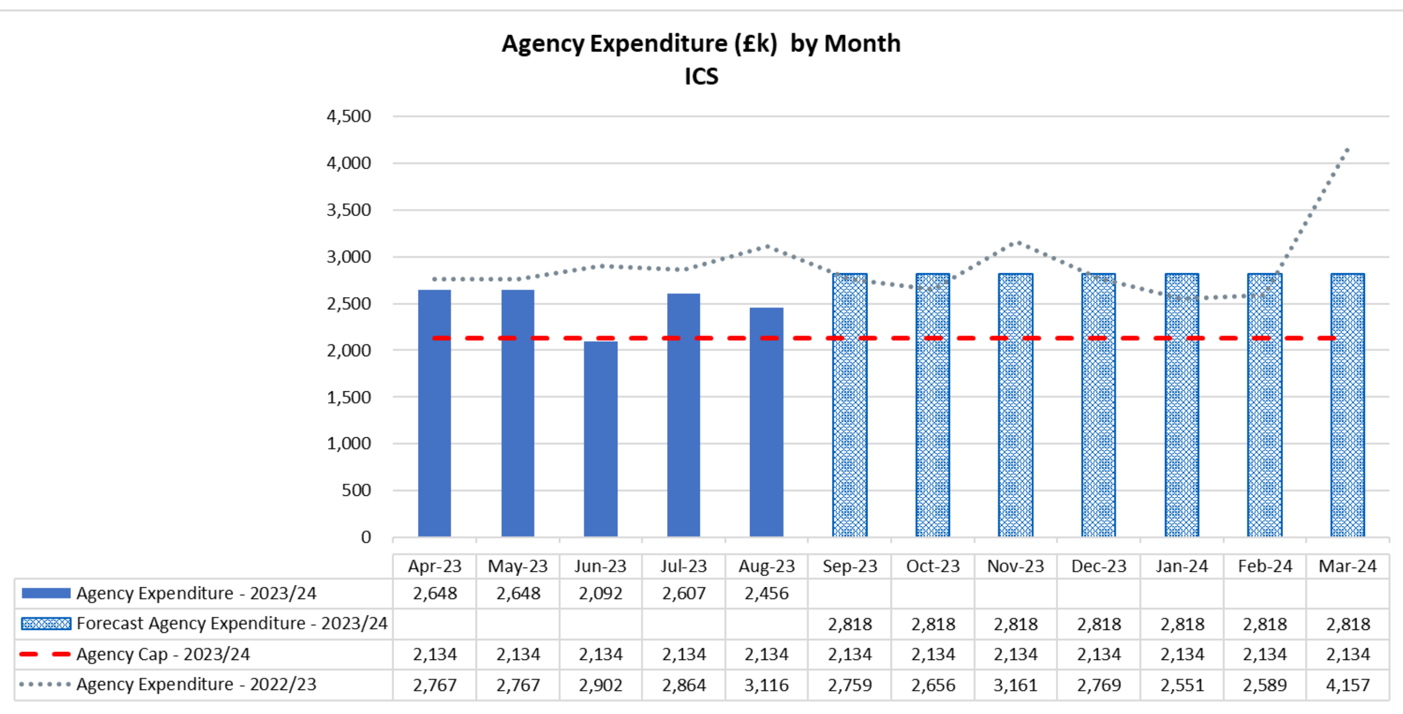
The GHFT YTD variance against CDEL also includes:
- delay in signing of contract for CDC enabling works – works progressing and still expected to catch up with planned allocation.
- reduction in the digital requirement for the Community Diagnostic Centre – although no formal declaration of underspend has been made whilst forecasts for all components of project are revisited and expected outturn agreed.
- delays in starting the works for the 5th Orthopaedic Theatre.

GHFT are awaiting funding confirmation with regards to IFRS16 capital allocation. Trust currently forecasting an £8m overspend against this compared to plan. £4m of this is expected value of Equipment within a MES contract and remaining £4m against various capital schemes (including student accommodation).

Year to date slippage on GHC net CDEL funded programmes relates to the Forest of Dean Hospital and Clinical Systems Vision project. Spend is forecast to catch up by the end of the year. Forecast has been reviewed and adjusted due to amended disposal proceeds.

Finance and Use of Resources

Agency Expenditure vs NHSE Cap



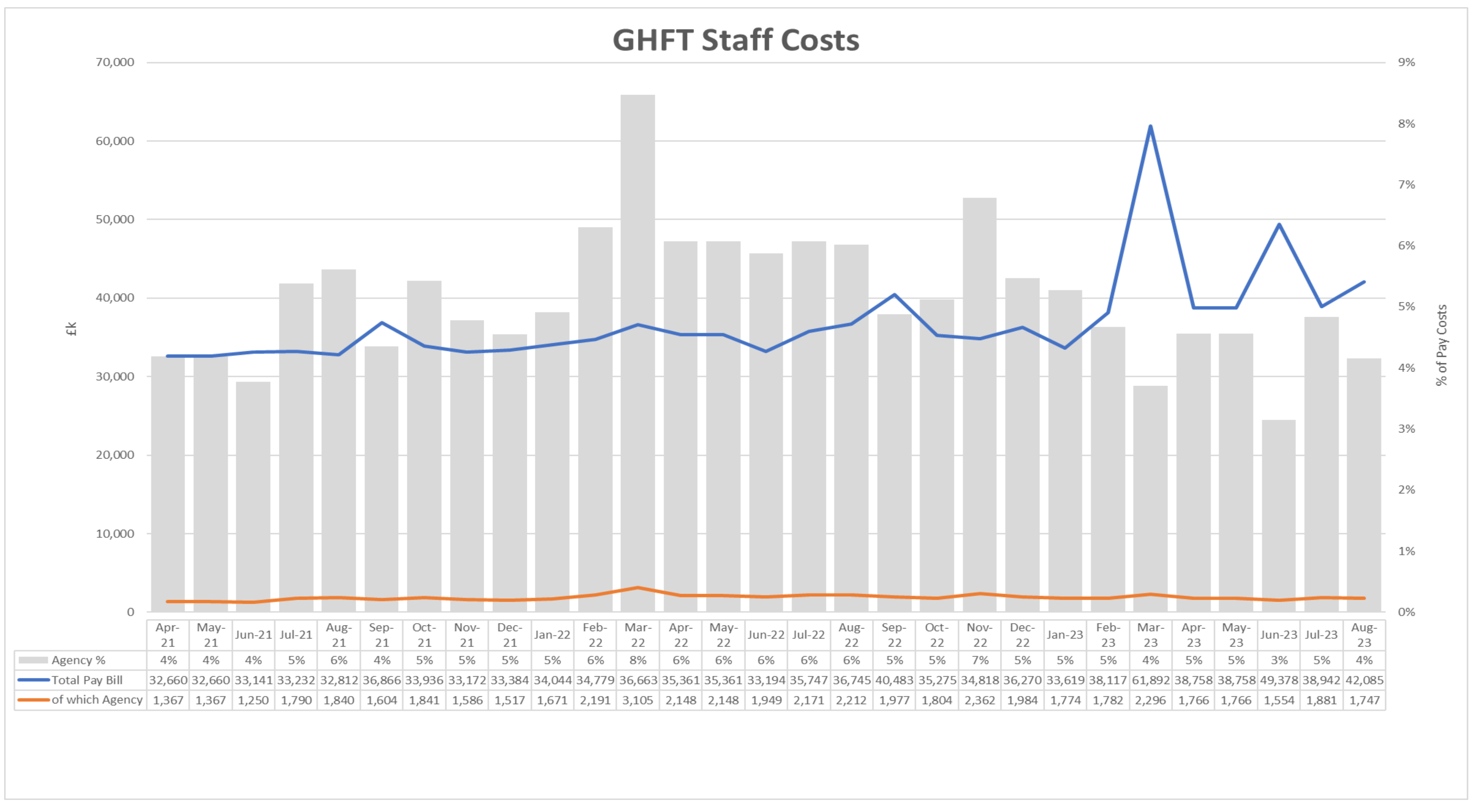
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456							
Forecast Agency Expenditure - 2023/24						2,818	2,818	2,818	2,818	2,818	2,818	2,818
Agency Cap - 2023/24	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	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	**£32.177m**
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 5, the rate of agency expenditure is above the straight line trend of the agency cap. 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 ongoing industrial action, vacancy and sickness cover, and RMN costs.

Finance and Use of Resources

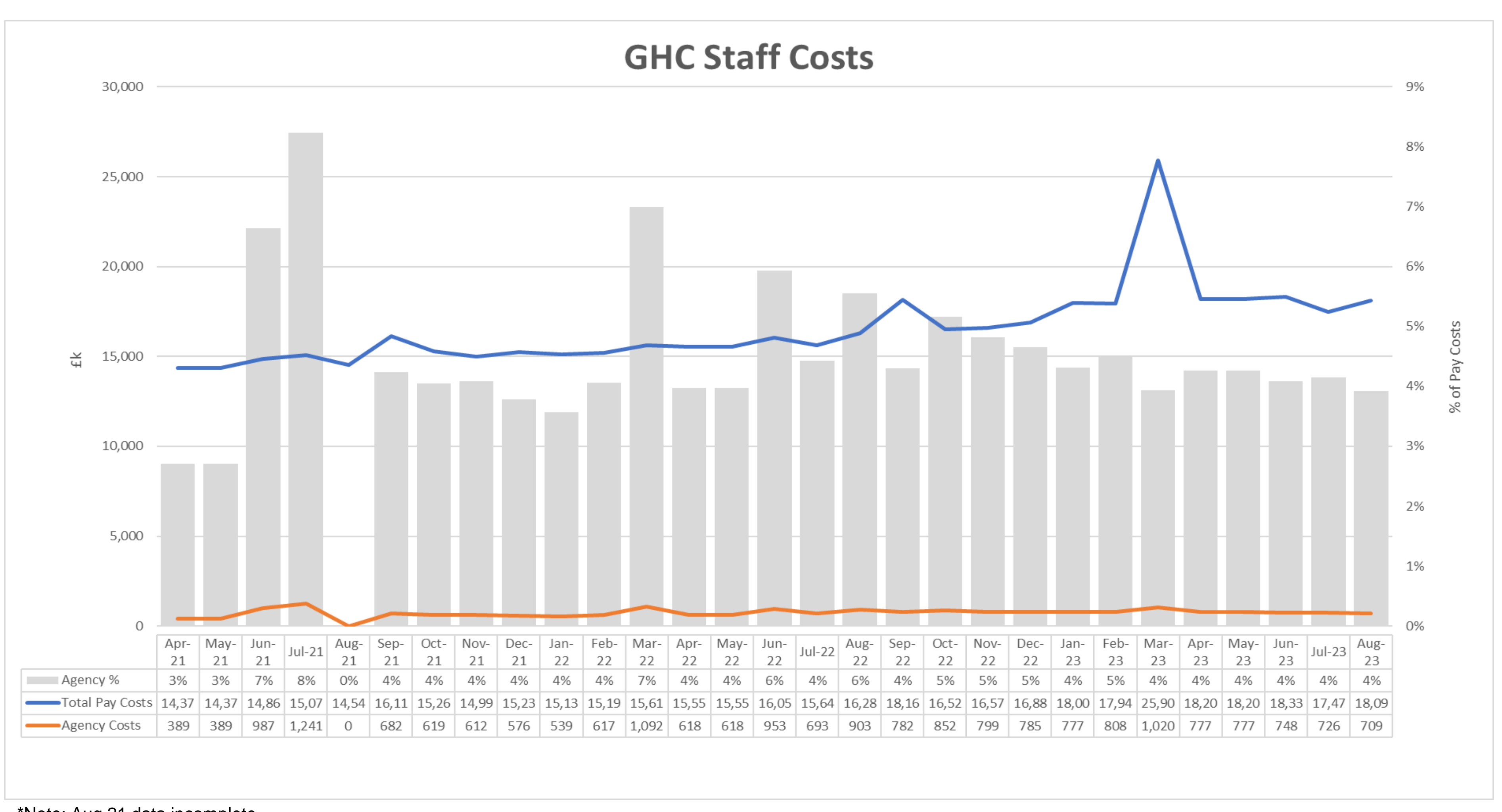
GHFT Agency Staffing Analysis



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Agency %	4%	4%	4%	5%	6%	4%	5%	5%	5%	5%	6%	8%	6%	6%	6%	6%	6%	5%	5%	7%	5%	5%	5%	4%	5%	5%	3%	5%	4%
Total Pay Bill	32,660	32,660	33,141	33,232	32,812	36,866	33,936	33,172	33,384	34,044	34,779	36,663	35,361	35,361	33,194	35,747	36,745	40,483	35,275	34,818	36,270	33,619	38,117	61,892	38,758	38,758	49,378	38,942	42,085
of which Agency	1,367	1,367	1,250	1,790	1,840	1,604	1,841	1,586	1,517	1,671	2,191	3,105	2,148	2,148	1,949	2,171	2,212	1,977	1,804	2,362	1,984	1,774	1,782	2,296	1,766	1,766	1,554	1,881	1,747

Finance and Use of Resources

GHC Agency Staffing Analysis



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Agency %	3%	3%	7%	8%	0%	4%	4%	4%	4%	4%	4%	7%	4%	4%	6%	4%	6%	4%	5%	5%	5%	4%	5%	4%	4%	4%	4%	4%	4%
Total Pay Costs	14,37	14,37	14,86	15,07	14,54	16,11	15,26	14,99	15,23	15,13	15,19	15,61	15,55	15,55	16,05	15,64	16,28	18,16	16,52	16,57	16,88	18,00	17,94	25,90	18,20	18,20	18,33	17,47	18,09
Agency Costs	389	389	987	1,241	0	682	619	612	576	539	617	1,092	618	618	953	693	903	782	852	799	785	777	808	1,020	777	777	748	726	709

*Note: Aug 21 data incomplete.

ICB Finance Report

Month 5: August 2023

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Finance and Use of Resources

Financial Overview & Key Risks

- The ICB month 5 YTD position is showing £0.3m adverse variance to plan which reflects the prescribing cost pressure taken from the latest monitoring information. The position also includes £854k for primary care dental underspend. The prescribing pressure has not been fully included in the forecast as there is only three months of data and further work is underway to understand the drivers behind the increase. In addition to prescribing there remain other pressures and risks within the financial position that are being managed, but, should they increase, will challenge the delivery of a balanced financial position. The ICB forecast outturn position remains at breakeven as per plan, however, there is now a significant risk that this position will not be manageable.

- Prescribing data for 3 months has been received and is showing a significant pressure with continuation of growth rates.(11.5% increase compared to same period last year). Note that 2022/23 had 8.5% growth in overall costs compared to 2021/22. Initial analysis is showing that c50% is due to increases in items and 50% to increases in cost. Some of the key drivers in prescribing costs are for continuous glucose monitoring devices (growth due to NICE guidance), growth in diabetes drugs and increase in Direct-acting oral anticoagulants (DOACs) due to increased diagnosis of these conditions. It is anticipated that NCSO will remain a pressure in 23/24. The Finance and Prescribing Teams are working together reviewing areas of growth and mitigations will include the ongoing ICB savings programme of active and potential savings projects to look at areas that can be accelerated.

- Discharge to assess is showing a YTD overspend of £704k due to slippage in the savings plan as well as potential additional costs. Regular discussions are in place with Local Authority colleagues to ensure cost profiles are understood.

- The Integrated Community Equipment Service is showing a £338k 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. The impact in this financial year is being assessed.

- The savings programme amounts to £13.128m (1.038% of the total revenue allocation) for the 2023/24 financial year; this is based on GICB controllable spend. The programme has been risk assessed as at Month 5 and is anticipated to deliver to plan (100%, £13.128m) of the total GICB programme for 2023/24. There is slippage in the UEC programme and CHC/placements programmes but it is anticipated that additional savings will be in place to mitigate the risk of any shortfall in order to meet the forecast.

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

Finance and Use of Resources

Financial Overview & 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.

- 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 has been reduced by 2% to enable systems to cover the cost of industrial action in that period. (105% Target) The impact of this change is currently being worked through including with out of county NHS provider API contracts. The overall risk of clawback for the system is 16% (£4.1m) if there is underperformance. Data from NHSE on M1-2 data confirms achievement of 105.3% which is very close to our internal calculations. The M3 recovery also looks likely to be confirmed at, or very near to, 105%.

- Additional high cost placements, particularly children's services and learning disabilities remain key financial risks for the ICB.

Finance and Use of Resources

ICB Allocation – Month 5

The ICB's confirmed allocation as at 31st August 2023 is £1,305m.

Description	Recurrent £'000	Non Rec £'000	Total Allocation £'000
M04 Balance Brought Forward	**1,246,462**	**50,444**	**1,296,906**
DDRB Pay Award	6,118	820	6,938
Microsoft Licence allocation adjustment		761	761
POD and Complaints Staff Transfer		284	284
Targeted Funding Heart Failure		62	62
T2 Diabetes Early Onset		64	64
PCT Primary Care Access Recovery Plan (PCARP) transition cover		142	142
PCT project management resource independent prescribing programme M4-12		31	31
Women's Health Hub Funding 23/24		298	298
TOTAL IN-YEAR ALLOCATION 23/24 @ M05	**1,252,580**	**52,906**	**1,305,486**

Finance and Use of Resources

ICB Statement of Comprehensive Income In-Year Position

Month 05 2023/24 – August Statement of Comprehensive Income	M05 Plan £'000	M05 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	257,165	256,323	842	618,263	618,368	(105)
Mental Health Services	54,645	54,209	436	131,121	131,289	(168)
Community Health Services	47,954	48,818	(864)	116,143	117,420	(1,277)
Continuing Care Services	24,992	25,154	(162)	65,473	65,473	0
Primary Care Services	75,793	75,517	276	181,402	181,242	160
Delegated Primary Care Commissioning	49,396	49,731	(335)	116,634	116,634	0
Other Commissioned Services	15,103	15,454	(351)	33,964	35,100	(1,135)
Programme Reserve and Contingency	13,434	13,514	(80)	29,297	26,836	2,461
Other Programme Services	256	433	(177)	615	743	(128)
TOTAL COMMISSIONING SERVICES	**538,738**	**539,153**	**(415)**	**1,292,913**	**1,293,105**	**(192)**
Running Costs	5,239	5,159	80	12,573	12,381	192
TOTAL NET EXPENDITURE	**543,976**	**544,311**	**(335)**	**1,305,486**	**1,305,486**	**0**
ALLOCATION	543,976	543,976	0	1,305,486	1,305,486	0
Outside of Envelope	0	0	0	0	0	0
UNDERSPEND / (DEFECIT)	**0**	**(335)**	**(335)**	**0**	**0**	**0**

Finance and Use of Resources

2022/23 Efficiencies Programme – As At Month 05

Programme	Projects	Year to Date Plan £'000	Year to Date Actuals £'000	Year to Date Variance to Plan Favourable / (Adverse) £'000	Full Year Plan £'000	Full Year Forecast Outturn* £'000	Full Year Variance to Plan Favourable / (Adverse) £'000	Forecast Outturn as % of Plan	High Level In-Year Risk Rating
PRIMARY CARE MEDICINES OPTIMISATION	Primary Care Medicines Optimisation	1,245	1,245	0	2,988	2,988	0	100.00%	AMBER – Medium Risk
	Home Oxygen	65	65	0	150	150	0	100.00%	GREEN - Low Risk
	TOTALS	**1,310**	**1,310**	**0**	**3,138**	**3,138**	**0**	**100.00%**	
CONTINUING HEALTHCARE	Continuing Healthcare / Joint Placements – All Age	645	550	(95)	1,547	1,000	(547)	64.64%	RED – High Risk
	TOTALS	**645**	**550**	**(95)**	**1,547**	**1,000**	**(547)**	**64.64%**	
URGENT & EMERGENCY CARE (UEC)	Discharge to Assess Beds (UEC Efficiencies)	1,290	283	(1,007)	3,100	2,500	(600)	80.65%	RED – High Risk
	TOTALS	**1,290**	**283**	**(1,007)**	**3,100**	**2,500**	**(600)**	**80.65%**	
OTHER	ICB Recurrent and Non-Recurrent Efficiencies (e.g. 1.1% Efficiency, Running Costs and Additional Efficiencies)	2,235	3,337	1,102	5,343	6,490	1,147	121.47%	RED – High Risk
	TOTALS	**2,235**	**3,337**	**1,102**	**5,343**	**6,480**	**1,147**	**121.47%**	
2023/24 ICB Savings Programme TOTALS		**5,480**	**5,480**	**0**	**13,128**	**13,128**	**0**	**100.00%**	AMBER – Medium Risk

**Full Year Forecast Outturn – Please not that due to the time lag in receipt of ePact data used to monitor Medicines Optimisation schemes, the 'Full Year Forecast Outturn' against these schemes consist of 'Year-to-Date Actuals' and a forecast for the remaining months of the financial year.*

Finance and Use of Resources

ICB Savings and Efficiencies

Gloucestershire Integrated Care Board (GICB) has a savings programme amounting to £13.128m (1.038% of the total revenue allocation) for the 2023/24 financial year; this is based on GICB controllable spend.

- The programme has been risk assessed as at Month 5 and is anticipated to deliver to plan (100%, £13.128m) of the total GICB programme for 2023/24; this reflects the addition of some non recurrent savings to offset slippage in some programmes.

- Whilst there is no overall movement in the reported total forecast efficiencies delivery for the ICB between months 4 and 5, there are however key risks within this forecast level of delivery and this report discusses these areas (particularly around Discharge to Asses savings, Continuing Health Care and Placements savings delivery and Medicines Optimization savings). The value of additional savings required to mitigate under delivery (£1.147m) remains a risk to the ICB in terms of overall delivery as further savings plans to deliver this mitigation are still required.

Medicines Optimisation: £3.138m

- As at Month 5 the ICB has received ePact data for three months of 2023/24. Review of activity and cost trends to date, alongside soft intelligence obtained from the Medicines Optimisation Team, has been used to report the current year-to-date and forecast delivery as being on plan. The full year effect of savings projects implemented during 2022/23 is expected to deliver c £1m of in-year savings. In addition, the Medicines saving plan includes further project implementation 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) which is also currently in line with planning expectations. However, in respect of a programme of review of significant / unexplained practice prescribing variation there continues to be potential risk due to the programme being behind original expected timescales associated with the Primary Care Offer where practices would support this work-stream and this will require close review in following months

Finance and Use of Resources

ICB Savings and Efficiencies

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 includes review of Adult continuing care (including electronic call monitoring, Fast-track assessments and CHC & LD reviews), reviews of children's complex care packages and the process development and monitoring around personal health budgets. At month 5, £1.0m forecast savings delivery continues to be reported. Year to date savings are contributed to by Electronic Call Monitoring and vacancies. The programme is continuing to aim for delivery of the originally planned £1.547m savings. Within this report further detailed update is provided.

Urgent Emergency Care (UEC) – Discharge to Assess Beds

- This programme is focusing on a £3.1m reduction in the value Discharge to Assess beds commissioned and this is being delivered through the urgent care transformation programme to ensure management of patient flow. The programme ramps up significantly over the coming months in decommissioning block commissioned and reducing spot purchase of discharge beds (commencing from 1st July). The programme is currently forecast to deliver the £2.5m in-year within 2023/24 with the recurrent £3.1m benefits delivered during 2024/25 (i.e. £0.6m under-delivery within 2023/24). There are significant inherent risks around this delivery and further detail is provided within this report.

Other ICB Recurrent and Non-Recurrent Efficiencies

- The planned £5.343m programme area is focused on transactional efficiencies, for example out of county provider contracts and budget adjustments and these have been fully delivered at the start of the financial year. However to support and mitigate pressure within the wider ICB savings programme additional savings requirement of £1.147m are reported as required. This remains a risk to overall delivery as further savings need to be identified.

Finance and Use of Resources

ICB Statement of Financial Position

	Closing Position as at 31/08/2023 £'000	Opening Position as at 01/04/2023 £'000
Property, Plant & Equipment	48	285
Intangible Assets	0	0
Total Non-Current Assets	**48**	**285**
Trade & Other Receivables	17,426	6,984
Cash & Cash Equivalents	5,486	7
Total Current Assets	**22,911**	**6,991**
TOTAL ASSETS	**22,959**	**7,276**
Trade & Other Payables	(63,113)	(83,369)
Provisions	(4,027)	(4,840)
Total Current Liabilities	**(67,141)**	**(88,209)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**(44,182)**	**(80,933)**
Non-Current Liabilities	0	0
Total Non-Current Liabilities	**0**	**0**
TOTAL ASSETS LESS TOTAL LIABILITIES	**(44,182)**	**(80,933)**
General Fund	44,182	(80,933)
Reserves	0	0
TOTAL EQUITY	**44,182**	**80,933**

Integrated Performance Report - Metrics

September 2023

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary

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Integrated Performance Report – Metrics

Metrics Overview

- The metrics we are reporting align to the commitments stated in the Joint Forward Plan. ◆ Indicates a metric from within the Joint Forward Plan.
- The following metrics have not yet been incorporated and will be included in future versions of the report:
  - *Reduce waiting time for assessments for children and young people in key services (this will include CAMHS, eating disorders, and neurodiversity)*
  - *Maintain 70% of urgent community response cases responded to in 2 hours*
  - *Increase the percentage of people dying in their preferred place of death*
  - *Increase the percentage of cancer cases diagnosed at stages 1 or 2 (to be picked up in Public Health outcomes report)*
  - *Increase the uptake rates for cervical, breast and bowel screening (to be picked up in Public Health outcomes report)*
  - *Increase the percentage of hypertension patients who are treated to target as per NICE guidance (to be picked up in Public Health outcomes report)*
  - *Increase the proportion of people aged 25-84 with a CVD risk score greater than 20% on lipid lowering therapies (to be picked up in Public Health outcomes report)*
  - *Diabetes and respiratory (additional measures to be confirmed)*
  - *Ensure that at least 75% of people on the GP learning disability register over the age of 14 have had an annual health check and health plan in 23/24*
  - *Reduce reliance on inpatient care for patients with a learning disability and/or autism per million head of the population to meet an overall target of less than 30/million (total population)*
  - *Improve waiting times for autism and ADHD diagnosis*
  - *Maintain the access rates of children and young people accessing mental health services*
  - *Increase the percentage of the estimated eligible population receiving a formal dementia diagnosis to 66.7% by March 2024*
  - *Reduce the proportion of adults in mental health inpatient settings with a length of stay over 60 days and 90 days*
  - *Eliminate waits for treatment over 65 weeks for elective care by March 2024*
  - *Maintain theatre utilisation at or above 85% for elective theatres throughout 23/24*
  - *Increase virtual ward beds to 223 and increase utilisation to 80% by December 2023*

Integrated Performance Report – Metrics

Metrics Overview (cont.)

The following metrics have not yet been incorporated and will be included in future versions of the report (continued):

- *Reduce the number of inpatients with no-criteria to reside to 160 or less by November 2023*
- *Reduce the percentage of inpatients with a stay of 21 days or longer by 15% or less by November 2023*
- *Increase the percentage of regular GP practice appointments in 14 days*
- *Increase units of dental activity delivered as a proportion of all units of dental activity contracted*
- *Maintain number of GP appointments*
- *Antimicrobial resistance – Reduce total prescribing of antibiotics in primary care*
- *Reduce proportion of broad-spectrum antibiotic prescribing in primary care*
- *Increase referrals to Community Pharmacy Consultation service in line with operational plan*
- *Increase GP referrals to the NHS digital weight management service*

Workforce Metrics

- *Reduce expenditure on third party staffing agencies as determined by partner organisations*
- *Maximise our use of the apprenticeship levy as determined by partner organisations*
- *Increase direct patient care staff in GP practices and PCNs per 10,000 weighted population*

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)

Performance Metrics

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Improving Services & Delivering Outcomes

Urgent & Emergency Care - Attendances

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Reporting Period	Dashboard Link
	A&E 4 Hour Target - % seen, treated and discharged/admitted within 4 hours of arrival to A&E (Type 1)	High	95.0%	56.69 Gloucester ICS	80, 60, 40; 2022, 2023	August 2023	56.69 Gloucester ICS	57.06 Other South West ICS	59.02 All ICS		August 2023	i
	A&E 4 Hour Target - % seen, treated and discharged/admitted within 4 hours of arrival to A&E (Type 3)	High	95.0%	99.85 GHFT	100, 99; 2022, 2023	July 2023	99.85 GHFT		96.03 All ICS		July 2023	i
S019a	Ambulance Handovers - Total resource time lost	Low		12702 GHFT	500,000, 0; Jun 2022, Aug 2023	August 2023						i
	ED Assessment - % patients assessed within 15 minutes of arrival at A&E	High		47.78 Gloucester ICS	100, 0; 2020, 2022	July 2023						i
S103a	12 Hour ED Waits - Proportion of patients spending more than 12 hours in an emergency department	Low	8.0%	30.82 GHFT	50, 0; 2020, 2022	July 2023						i
	Overnight General & Acute Beds Available and Occupied											i
	111 Call Abandonment	Low	3	16.90 Value	50, 0; 2022, 2023	July 2023						i

Type 1 and Type 3 ED activity are combined to give the system ED performance (this metric is the 80.4% target quoted in the JFP).

Improving Services & Delivering Outcomes

Urgent & Emergency Care - Ambulance

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking			Quartile Q1 = High Q4 = Low	Reporting Period	Dashboard Link
							better than / worse than					
S020a	Average Ambulance Response Times (Category 1)	Low	7 minutes	00:09:29 Gloucester ICS		August 2023	00:09:49 Gloucester ICS	00:09:18 SWASFT	00:08:21 England		July 2023	
S020b	Average Ambulance Response Times (Category 2)	Low	18 minutes	00:29:48 Gloucester ICS		August 2023	00:33:14 Gloucester ICS	00:35:42 SWASFT	00:31:50 England		July 2023	
S020c	Average Ambulance Response Times (Category 3)	Low	120 minutes	01:10:56 Gloucester ICS		August 2023	01:25:56 Gloucester ICS	01:30:09 SWASFT	01:50:09 England		July 2023	
S020d	Average Ambulance Response Times (Category 4)	Low	180 minutes	01:18:13 Gloucester ICS		August 2023	01:49:24 Gloucester ICS	01:34:14 SWASFT	02:21:19 England		July 2023	
	Ambulance Conveyance Rates (% incidents conveyed)	Low		46.70 Gloucester ICS		August 2023	47.01 Gloucester ICS	52.85 Other South West ICS	57.54 England		July 2023	

The expectation for 23/24 is to improve to 30 minutes Category 2 response time

Improving Services & Delivering Outcomes

The national target for ERF is currently 105% of 2019 cost weighted activity (taking into account baseline changes) – this has been reduced from 109% due to industrial action.

Improving Services & Delivering Outcomes

Planned Care & Elective Recovery - RTT

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	worse than	Quartile Q1 = High Q4 = Low		Reporting Period	Dashboard Link
	RTT (18 week) - % waiting list waiting under 18 weeks	High	92.0%	67.18 Gloucester ICS		July 2023	67.18 Gloucester ICS				July 2023	
S009a	RTT (52 week waits) - Number of patients on RTT list >52 weeks	Low	0	3096 GHFT		July 2023	3096 GHFT				July 2023	
S009b	RTT (78 week waits) - Number of patients on RTT list >78 weeks	Low	0.0	16 GHFT		July 2023	16 GHFT				July 2023	
S009c	RTT (104 week waits) - Number of patients on RTT list >104 weeks	Low	0.0	0 Gloucester ICS		July 2023	0 Gloucester ICS				July 2023	

Improving Services & Delivering Outcomes

Cancer

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking (better than / worse than)		Quartile Q1 = High Q4 = Low	Reporting Period	Dashboard Link
	2 Week Wait - % patients seen or STT within 2 weeks of referral	High	93.0%	96.81 Gloucester ICS		July 2023	58.17 Other South West ICS	80.52 All ICS		June 2023	i
S012a	28 day Faster Diagnosis - % patients recieving diagnosis or all clear within 28 days of referral	High	75.0%	78.77 GHFT		July 2023	71.42 Other South West ICS	73.49 All ICS		June 2023	i
S010a	31 day Treatment - activity	High		377 GHFT		July 2023	505.67 Other South West ICS	561.00 All ICS		June 2023	i
	31 day Treatment - % patients recieving treatment within 31 days of DTT	High	96.0%	93.10 Gloucester ICS		July 2023	92.47 Other South West ICS	91.35 All ICS		June 2023	i
S011a	62 day Treatment - patient waiting list number beyond 62 days	Low	180	178 GHFT		July 2023					i
	62 day Treatment - % patients recieving treatment within 62 days of referral	High	85.0%	66.27 GHFT		July 2023	62.20 Other South West ICS	59.24 All ICS		June 2023	i

Improving Services & Delivering Outcomes

Diagnostics

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	worse than	Quartile Q1 = High Q4 = Low	Reporting Period	Dashboard Link
S013	Activity - % activity vs 19/20 baseline	High		19.02 Gloucester ICS		July 2023					
	Waiting Times - % patients waiting more than 6 weeks for diagnostic test	Low	1%	15.53		July 2023					
S013a	Diagnostic Activity Levels - imaging	High		5447 GHFT		July 2023					
S013b	Diagnostic Activity Levels - physiological measurement	High		1208 Gloucester ICS		July 2023					
S013c	Diagnostic Activity Levels - endoscopy	High		1751 GHFT		July 2023					

The expectation for 23/24 is that performance against 6 week waits will improve to 15%

Improving Services & Delivering Outcomes

Mental Health - Adults

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking (better than / worse than)			Quartile (Q1 = High, Q4 = Low)	Reporting Period	Dashboard Link
S081a	IAPT Access - Number of patients accessing IAPT in year	High	14,573	14,307 Value		July 2023	14K Value				July 2023	
S082a	IAPT Recovery - % patients entering recovery following IAPT	High	50	52.90 Value		July 2023	52.90 Value				July 2023	
E.H.13	SMI Physical Health Checks - % SMI register receiving/declining full health check	High	60	58 Value		Q1 23/24	58 Value					
E.H.30	Inpatient Follow Up - % patients receiving follow up within 72 hours of discharge	High	80	85.00 Gloucester ICS		May 2023	85.00 Gloucester ICS		76.08 All ICS		May 2023	
S086a	Out of Area Placement Bed Days - inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Low	800	639 Value		August 2023	639 Value				August 2023	
	Access to Core Community Mental Health Services - rate per 1,000 of patients accessing service	High	1	9.29 GHFT		May 2023	9.29 GHFT		61.27 All ICS		June 2023	

Improving Services & Delivering Outcomes

Maternity

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking			Quartile Q1 = High Q4 = Low	Reporting Period	Dashboard Link
							better than	worse than				
E.H.15	Perinatal Access - % pregnant women accessing perinatal mental health service	High		3.08 Gloucester ICS		May 2023	3.08 Gloucester ICS	0.00 Other South West ICS	9.21 All ICS		May 2023	
S021a	Continuity of Care Pathway - % of women on CoC pathway	High	51	0.18 GHFT		July 2023						
	Smoking in Pregnancy - % SATOD	Low	8	9.07 GHFT		July 2023						
S116b	Smoking Cessation Services - proportion of acute/maternity inpatient settings offering smoking cessation services	High										
S022a	Stillbirth rate	Low		0.00 GHFT		July 2023						
S032a	Neonatal mortality rate	Low		0.00 GHFT		July 2023						
	Brain Injury Rate	Low		0.00 GHFT		July 2023						

Improving Services & Delivering Outcomes

Continuing Healthcare

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	worse than		Quartile Q1 = High Q4 = Low	Reporting Period	Dashboard Link
	Referral Completion - % referrals completed within 28 days of referral	High	80.0%	74.24% Gloucester ICS		June 2023	74.24% Gloucester ICS		73.94% England		June 2023	
	Place of Assessment - % assessments in hospital	Low		0.00% Gloucester ICS		June 2023	0.00% Gloucester ICS		0.20% England		June 2023	
	Long waits - number of cases waiting > 12 weeks	Low		3 Gloucester ICS		June 2023	3 Gloucester ICS		590 England		June 2023	
	Conversion Rate - % referrals converted to CHC	Low		4.55% Gloucester ICS		June 2023	4.55% Gloucester ICS		17.50% England		June 2023	

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)

Workforce Metrics

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Gloucestershire ICS Workforce Performance Dashboard

Leavers Rate (%)	Leavers Rate (%) [with <1ys LOS]	Sickness Rate (%)	Net Change (%) [Leaving/Joining]	Vacancy Rate (%)	Bank Usage (FTE)	Agency Usage (FTE)
13.8 !	20.8 ✓	4.1 !	3.6 ✓	13.6 !	1,019.7 ✓	498.6 ✓
Last value (diff): 13.0 (-0.76)	Last value (diff): 22.4 (+1.57)	Last value (diff): 3.9 (-0.27)	Last value (diff): 6.7 (+3.14)	Last value (diff): 13.5 (-0.15)	Last value (diff): 975.6 (+44.13)	Last value (diff): 508.7 (+10.11)
July 2023	July 2023	July 2023	July 2023	July 2023	July 2023	July 2023

ICS PROVIDERS

Filters

- ☑ Select all
- ☑ NHS Providers
  - ☑ GHC
  - ☑ GHFT
- ☑ Social Care
  - ☑ Adults
  - ☑ Children

Disclaimer

- The data included in this dashboard is not currently available for Primary Care or NHS Gloucestershire
- Social Care data is provided quarterly but distributed monthly for visual consistency
- Missing values are filled in with an aggregated average for visual consistency
- The rates are calculated using a 12-month rolling average
- The temporary staffing data is based on monthly usage

Average Leavers Rate (%)

(From Apr 2022)

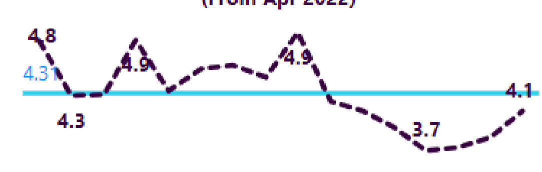
14.06
14.0
14.8
14.8
13.8
13.6
13.0
Apr 2022 Jul 2022 Oct 2022 Jan 2023 Apr 2023 Jul 2023

Average Leavers Rate (%) with <1 yr LOS

(From Apr 2022)

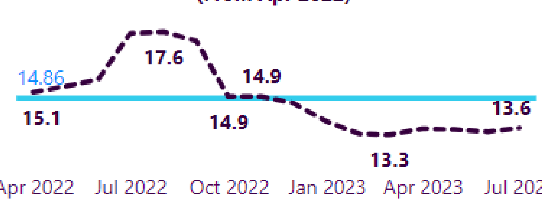
Average Sickness Rate (%)

(From Apr 2022)



Average Vacancy Rate (%)

(From Apr 2022)



Sum of Bank Usage (FTE)

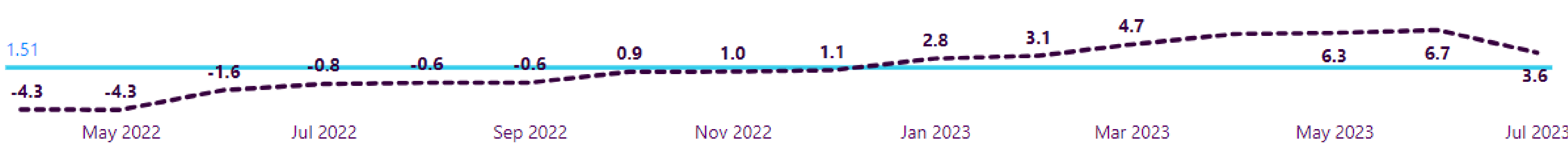
(From Apr 2022)

Sum of Agency Usage (FTE)

(From Apr 2022)

Average Net Change Rate (%)

(From Apr 2022)

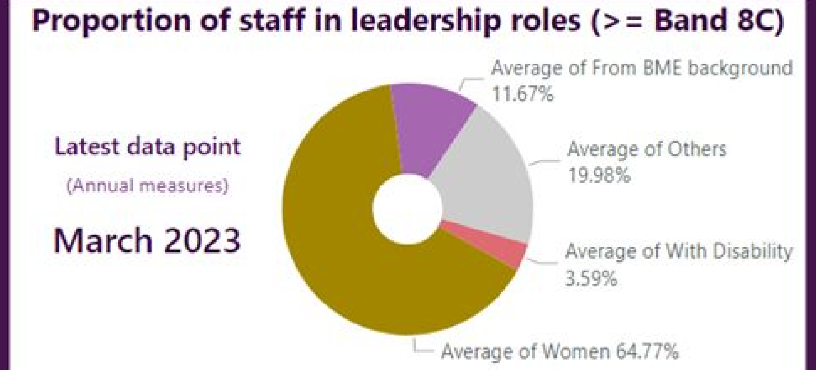


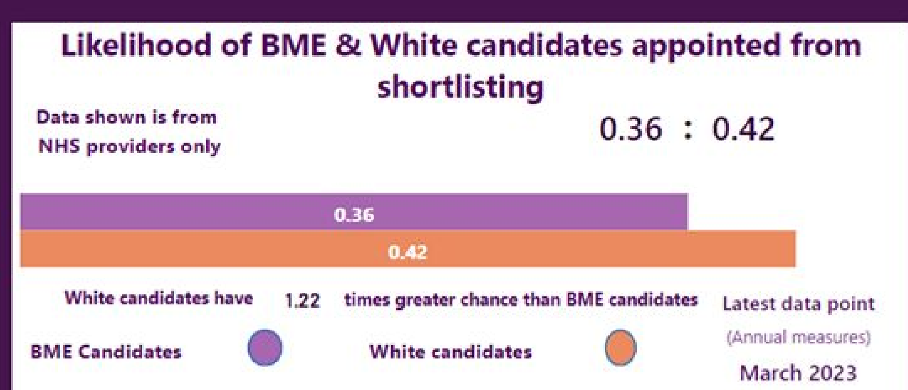
Our People (Workforce)

Gloucestershire ICS Equality, Diversity and Inclusion (EDI) measures

ICS PROVIDERS
Filters

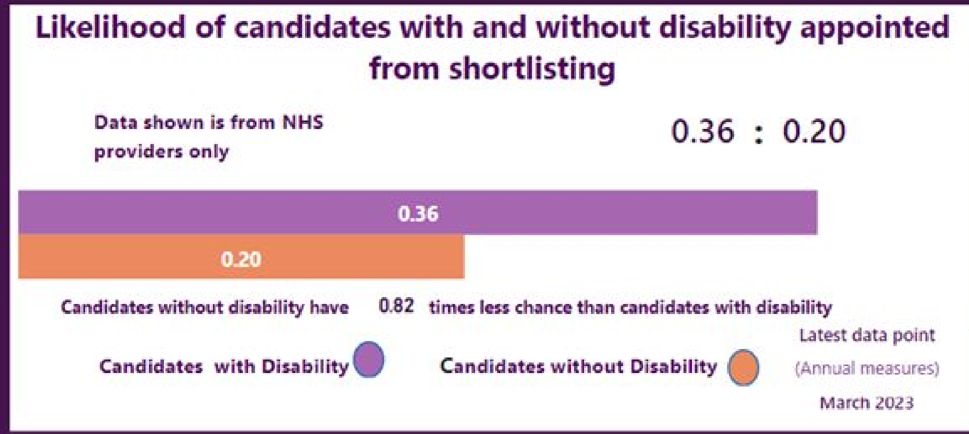
- ☑ Select all
- ☑ NHS Providers
  - ☑ GHC
  - ☑ GHFT
- ☑ Social Care
  - ☑ Adults
  - ☑ Children





Disclaimer

The percentage values for women, BME staff, and staff with disabilities in leadership roles are accurate representations of their actual presence. It is important to note that the average percentage for BME staff may include women and staff with disabilities who fall under that category. The same principle applies to women and disability categories as well. The other category is included for visual clarity purposes only.



Our People (Workforce)

NHS providers data (GHC & GHFT)

Gloucestershire ICS Workforce Performance Dashboard

One Gloucestershire

Leavers Rate (%)	Leavers Rate (%) (with <1ys LOS)	Sickness Rate (%)	Net Change (%) (Leaving/Joining)	Vacancy Rate (%)	Bank Usage (FTE)	Agency Usage (FTE)
13.8	26.7	4.5	5.5	8.2	842.5	313.3
Last value (diff): 13.6 (-0.18) July 2023	Last value (diff): 25.9 (-0.77) July 2023	Last value (diff): 4.4 (-0.11) July 2023	Last value (diff): 6.1 (+0.68) July 2023	Last value (diff): 8.3 (+0.09) July 2023	Last value (diff): 844.4 (-1.84) July 2023	Last value (diff): 331.7 (+18.44) July 2023

Average Leavers Rate (%) (From Apr 2022) · Average Leavers Rate (%) with <1 yr LOS (From Apr 2022) · Average Sickness Rate (%) (From Apr 2022) · Average Vacancy Rate (%) (From Apr 2022) · Sum of Bank Usage (FTE) (From Apr 2022) · Sum of Agency Usage (FTE) (From Apr 2022) · Average Net Change Rate (%) (From Apr 2022)

ICS PROVIDERS Filters: Select all; NHS Providers (GHC, GHFT); Social Care (Adults, Children)

Disclaimer
- The data included in this dashboard is not currently available for Primary Care or NHS Gloucestershire
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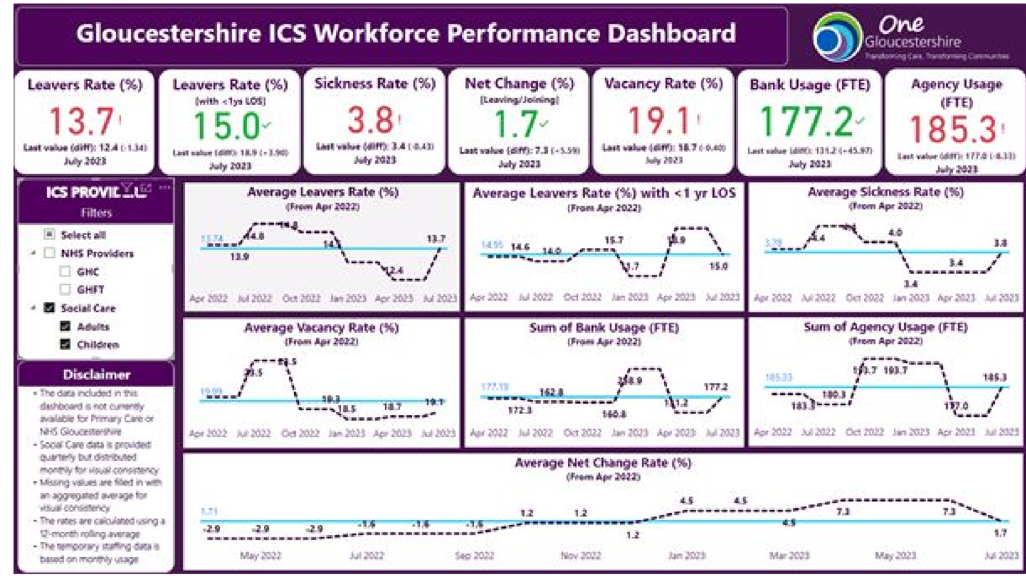
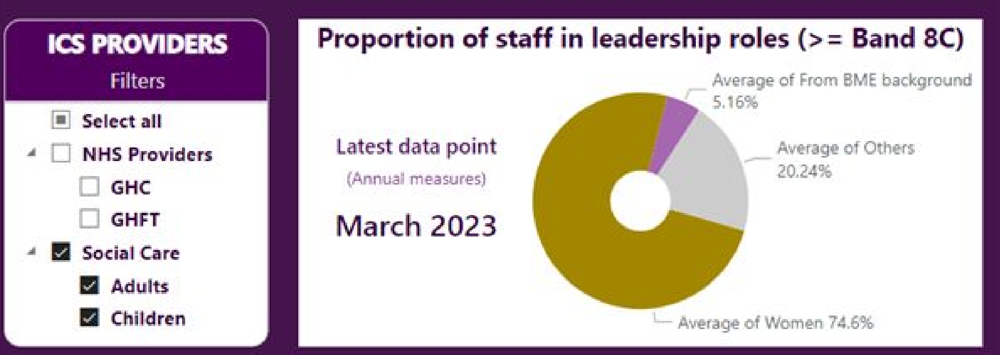
- Missing values are filled in with an aggregated average for visual consistency
- The rates are calculated using a 12-month rolling average
- The temporary staffing data is based on monthly usage

Social Work data (Adults & Children)





Our People (Workforce)

Data definitions for the Key Performance Indicators

NHS Leaver Rate (S067a)	
Definition:	The % of staff who have left the NHS during a 12-month period
Purpose:	To monitor staff leaving the NHS to support retention and recruitment programmes.
Data source:	The Electronic Staff Record (ESR)
Inclusive criteria:	Assignment status as 'Acting Up, Active Assignment, Internal Secondment'
Calculation methodology:	(FTE of all staff leaving the NHS during the 12 month period/FTE of all staff in post at the beginning of the 12 month period) *100
Leavers rate with short LOS	
Definition:	Proportion of all staff leaving the NHS that leave within one year (12 month rolling)
Purpose:	To monitor staff sustainability
Data source:	The Electronic Staff Record (ESR)
Required data:	Sum of leavers over the last 12 months data period in FTE
	Sum of leavers over the last 12 months data period in FTE but who have served for less than an year in that assignment
Sickness absence rate (S068a)	
Definition:	% of working hours lost due to sickness absence in a any one month
Purpose:	To monitor the health and wellbeing of NHS staff to support retention and well-being programmes
Data source:	The Electronic Staff Record (ESR)
Inclusive criteria:	Assignment category as 'Acting Up, Active Assignment, Internal Secondment'
Exclusive criteria:	Assignment category as bank, honorary, widow/widower
Calculation methodology:	(FTE Number of Days Sick (including non-working days)/FTE Number of Days available) *100
Joiners and Leavers profile	
Definition:	Proportion of all staff net change (leaving/joining) the NHS each year (12 month total)
Purpose:	To monitor the joiners and leavers net change to help maintain a steady workforce.
Data source:	The Electronic Staff Record (ESR)
Required data:	Sum of staff in post at beginning of the data period in FTE
	Sum of leavers over 12 months data period in FTE
	Sum of starters over 12 months data period in FTE
Vacancy rate	
Definition:	SIP vs Establishment - all staff
Purpose:	To monitor the gap between the planned establishment and the actual staff in post.
Data source:	The Electronic Staff Record (ESR)
Required data:	Sum of establishment - ALL staff in FTE
	Sum of staff in post contracted - ALL staff in FTE
Temporary staffing usage	
Definition:	Sum of temporary staff (both agency and bank) usage in FTE
Purpose:	To monitor the use of temporary staffing to provide required health service
Data source:	??
Required data:	Sum of agency staff used with in the data period in FTE
	Sum of bank staff used with in the data period in FTE

Our People (Workforce)

Data definitions for the EDI indicators

Proportion of staff in leadership role (S071a)	
Definition:	Proportion of staff in senior leadership roles (AfC bands 8c and above, including executive board members) who are from a BME background, Women and with disability groups
Purpose:	To monitor our compliance with Public Sector Equality Duty (PSED), NHS Long Term Plan, NHS People Plan- moral and ethical responsibility to our workforce.
Data source:	Output of annual WRES and WDES collection , ESR
Inclusive criteria:	All AFC staff from Band 8C and above, VSM staff i.e., Board Level Director, Chief Executive, Clinical Director, Clinical Director - Medical, Director of Nursing , Finance Director, Medical Director and Other Executive Director
Calculation methodology:	(Number of staff from BME background / Total number of staff who are 8C and above +VSM) * 100
	(Number of staff who are women / Total number of staff who are 8C and above +VSM) * 100
	(Number of staff with disability/ Total number of staff who are 8C and above +VSM) * 100
Proportion of staff recruited from different background (S---)	
Definition:	WRES – Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants
	WDES – Relative likelihood of Disabled applicants being appointed from shortlisting compared to non-disabled applicants
Purpose:	To monitor the fair recruitment across the healthcare setting
Data source:	Output of annual WRES and WDES collection , ESR
Calculation methodology:	BME (Total number of BME candidates appointed/ Total number of BME candidates shortlisted)
	White (Total number of White candidates appointed/ Total number of White candidates shortlisted)
	With disability (Total number of candidates with disability appointed/ Total number of candidates with disability shortlisted)
	Without disability (Total number of candidates without disability appointed/ Total number of candidates without disability shortlisted)

Agenda Item XX

NHS Gloucestershire ICB Board

27th September 2023

Report Title	**People Strategy – Final Draft for Approval**			
Purpose (X)	**For Information**	**For Discussion**	**For Decision**	
			X	
Route to this meeting	The People Strategy has formally been though the ICS People Committee and formal groups as below			
	ICB Internal	**Date**	**System Partner**	**Date**
	People Committee (meeting)	27/04/23	HWB Partnership	25/07/23
	People Committee (virtual)	12/09/23		
Executive Summary	We have been engaging with a wide set of committee, groups and individuals on the development of the *One Gloucestershire* People Strategy. A shared People Strategy provides the opportunity to build on recent joint working and to describe the roadmap and actions to support the supply and retention of a skilled and sustainable health and care workforce across the County. The recent publication of the NHS Long-Term Workforce Plan (June 2023) has been timely and informed the strategic context and local actions that need to be taken to implement the strategy. A number of specific engagement events have been held to inform the development of the strategy. The first of these, attended by over 70 leaders and professional across the ICS helped formulate the initial priorities, further workshops were held in relation to specific themes such as education, development and training and Health and Wellbeing. Through several iteration, we have taken the opportunity to talk about the strategy at a number of system meetings including: • Non-Executive Directors Network • Clinical and Care Professional Council. • Working with People and Communities Advisory Group • ICS People Board • Education Steering Group • Workforce Steering Group • OD Steering Group • Health and Wellbeing Sub-Group			

	Individual meetings have been held with the VSCE representatives and further engagement is planned with members of the Health and Wellbeing Partnership, e.g. District Councils (focused on implementation and collaboration) The final draft strategy is attached at Appendix 1. The strategy has four focussed themes: 1. Recruitment & retention 2. Enabling innovation in care delivery 3. Valuing & looking after our people 4. Education, Training & Talent Development These are supported by 4 foundational themes: 1. Workforce Planning 2. Digital, Data and Technology 3. Equality, Diversity & Inclusion 4. Leadership & Culture. Each of these maps to the NHS Long-term Workforce plan priority areas of “Train, Retain and Reform”, as well as to the four NHS People Promise themes of “Looking after our people, Belonging to the NHS, Growing for the future and New ways of working and delivering care”.
Key Issues to note	The strategy is being produced in the absence of the national NHS Workforce plan which when published should set the direction for systems and providers over the next 5-10 years and hopefully provide certainty on funding commitments and the national view of priorities. We need to ensure synergy and alignment with Workforce element of the Draft Interim Care Partnership Strategy and there is inevitably some overlap in terms of areas of focus. The priorities in the plan should also feed into the Workforce section of the Joint Forward Plan. Unsurprisingly, given current workforce challenges across the health, social care and voluntary sector landscape, the strategy has many ambitions. As we develop the delivery plan, we will need to consider delivery capacity. *Next Steps:* We will continue to engage further on the development of the strategy. It was originally proposed to bring the strategy for final approval to the ICB Board on 31st May 2023. Engagement has been impacted by industrial action and operational planning. To enable further engagement we are now proposing final review at the ICB People Committee on the 20th July 2023 and approval at the 31st July ICB Board meeting.

<table>
<tr><td>Key Risks:</td><td colspan="4">Workforce recruitment and retention are key risks for the health and care sector as detailed in the Board Assurance Framework, this not only has an operational impact but also an impact to delivering transformation programmes.
Historic (non-recurrent) National Workforce Funding is not assured beyond 2023/24</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></td></tr>
<tr><td>Human Resource</td><td>X</td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">It has not been possible to make an assessment of the costs the delivery of the strategy at this stage. Due to further non-recurrent funding from NHSE and HEE we have been able to grow the ICS delivery team in 2023/24. We anticipate that we will need to make an investment request to sustain the delivery team at this level into 2024/25. This request will be submitted as part of the 2024/25 prioritisation process. We will continue to explore other non-recurrent funding opportunities to support delivery of the strategy throughout the coming year.

We await further detail on the £2.4bn national allocation announced for the implementation of the NHS Long-Term Workforce Plan and what local allocations this may result in.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The Health and Care Act 2022, give the CQC powers to assess Integrated Care Systems. Interim Guidance (pending government approval). Assessing whether organisations are well led is currently a key domain in CQC assessments, this has a direct link to one of the foundational themes in the strategy: Leadership and Culture.

The NHS Long-term Workforce plan has informed and influenced the development of the strategy and implementation will be aligned between the two.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">There are several aspects of the strategy that can support our efforts at reducing health inequalities including our approaches to valuing and looking after our staff, accessibility to good training and education opportunities and how the system supports the employability of our wider communities. This is a key focus of the workforce element of the strategy.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">Equality, Diversity and Inclusion is a foundational theme of the strategy and core to its success. The strategy sets out an ambition that the principles of Equality, Diversity and Inclusion are embedded as the personal responsibility of all members of staff.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">Not applicable.</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">We engaged with ICB’s Working with People and Communities Advisory Group in the development of the strategy and their contribution has informed it’s drafting.</td></tr>
</table>

Recommendation	The ICB is requested to formally review the final draft and subject to any requests for final edits, approve the One Gloucestershire People Strategy.		
Author	Tracey Cox Zack Pandor	**Role Title**	Director, People Culture & Engagement Workforce Transformation Programme Manager
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
VCSE	Voluntary, Community and Social Enterprise
WRES	Workforce Race Equality Standard
WDES	Workforce Equality Disability Standard
BAF	Board Assurance Framework

One Gloucestershire

People Strategy

2023

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Introduction

Across the Gloucestershire health and social care system we recognise our people are our greatest asset. This has been the case since the NHS was founded 75 years ago and most recently was unequivocally demonstrated by health and social care colleagues in our response to the pandemic.

However, if we are to meet the demands and expectations of the population we serve, we recognise the workforce is also one of our greatest challenges. Many parts of our system are experiencing shortages of staff impacting on the delivery and recovery of services. Clinical Programme Groups are struggling to deliver planned transformational service change to improve health and social care for the residents of Gloucestershire. The Independent care sector face particular difficulties competing for staff against the health service and the private sector (e.g. retail).

We also know that both nationally and locally the morale of health and social care staff is much lower than it has been in the past. The impact of the pandemic, the on-going recovery of services and rising patient demand and workloads has meant many staff feel over-worked and burnout. There are high attrition rates and more staff want to retire early.

The development of a shared People Strategy for One Gloucestershire provides the opportunity to build on recent joint working and to set the roadmap and actions to support the supply and retention of a skilled and sustainable workforce as well as meeting the vision of our local Integrated Care Partnership Strategy and the needs of our population over the next 10 years.

There is much to be done. We need to collectively create the best possible working environments for our shared workforce, with a continued focus on the health and well-being of our staff and work places where staff feel safe, supported and able to thrive. We need to focus on those priority areas that we can sustainably deliver as a system, aligning collaborative effort with organisation-led plans.

We want to be able to attract and retain more staff to Gloucestershire building its reputation as a great place to live, work and learn, where staff can build and develop their careers and work flexibly.

We also want to build our reputation for developing new ways of working, for research and innovation in workforce transformation, with a workforce that is able to make the best use of new technologies.

We are committed to developing and building stronger relationships with partners across the ICS and with schools, higher education institutions and Universities to help us realise this strategy.

We hope you will enjoy reading this strategy and we welcome your feedback.

Tracey Cox
Director of People,
Culture & Engagement

Professor Jane Cummings CBE RN
Chair of People Committee

Overview of Gloucestershire

The Gloucestershire Integrated Care System is one of the smallest and less complex ICSs in the country. We are coterminous with our Local Authority: Gloucestershire County Council, have one Acute Hospital, Gloucestershire Hospitals' Foundation Trust (operating across two sites in Gloucester City and Cheltenham) and one Community and Mental Health services provider, Gloucestershire Health & Care Foundation Trust (GHC). This lays a foundation for close collaborative working and joining up our efforts to provide an opportunity to present an attractive proposition to potential staff.

We also have 69 GP practices working across 15 Primary Care Networks. We have circa 200 care home providers and circa 150 community-based care providers.

We work closely with our six District Councils through Integrated Locality Partnerships. We also have a thriving voluntary community and social enterprise sector as well as an established VCS Alliance. Over the last 2 years we have worked with the VCS Alliance to establish a strong working relationship with our VCSE and have developed the systems and structures for this to continue.

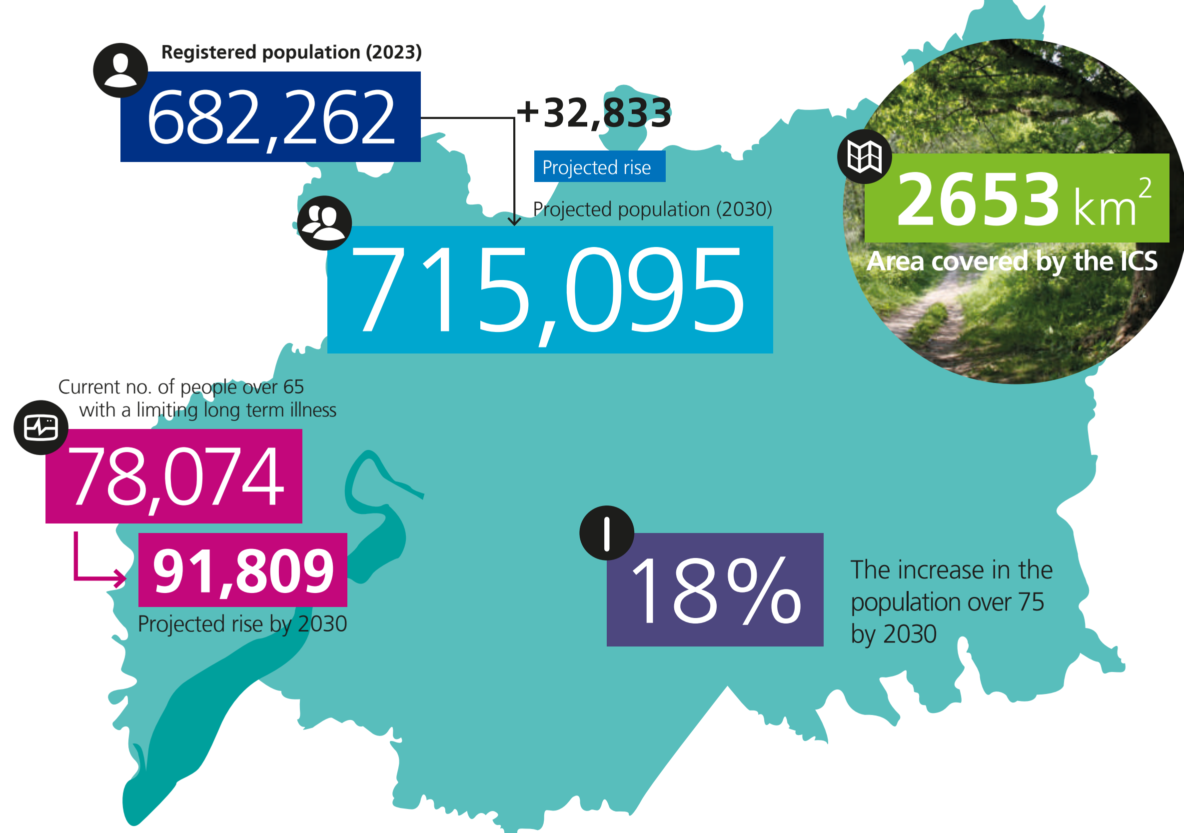
We have strong relationships with a wide range of local and regional organisations including the University of Gloucestershire (UoG) and other Higher Education Institutes (HEIs); we work closely with NHSE, the South West Leadership Academy, the Academic Health Science Network and the remaining six ICSs across the South West.

Gloucestershire has a population of approximately 682,200 – expected to rise to 715,095 by 2030.

Like many systems we have a number of demographic challenges.

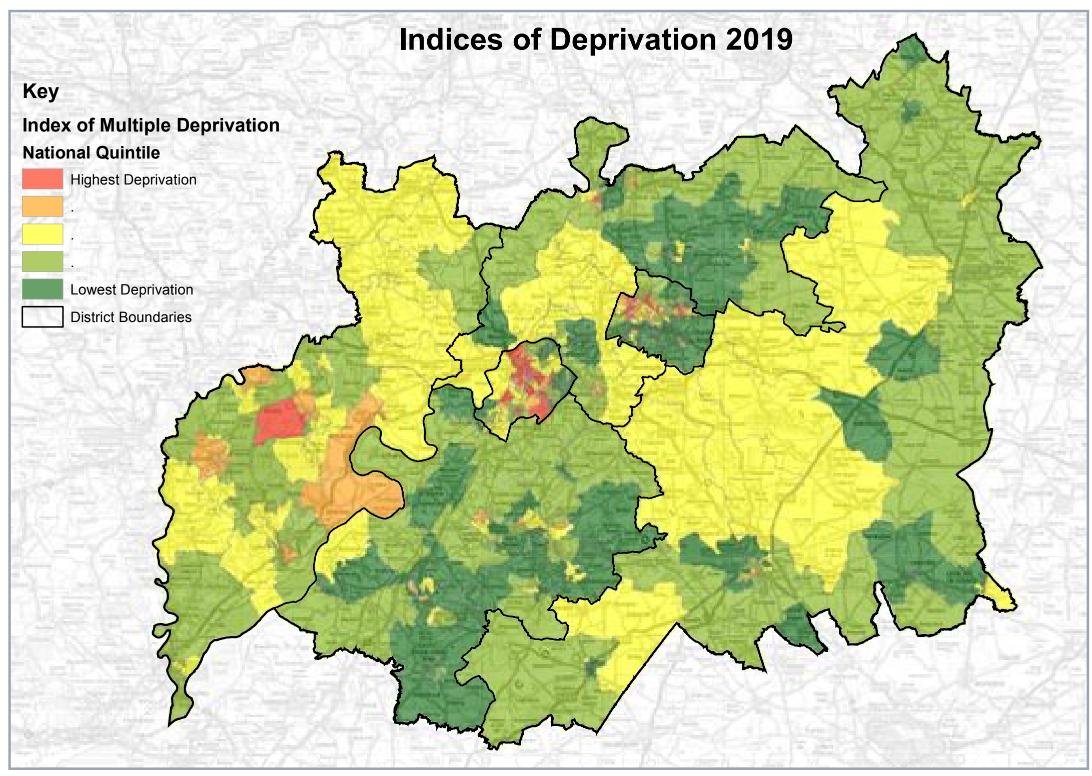
The proportion of the population 75-84 are expected to increase by 41.7% from 2018 to 2028, whilst from 2028 to 2043, the increase will be greatest in the age group 85 or over (an increase of 60%). These changes mean that by 2043, the proportion of people in the county who are aged 85 or over will have risen from 2.8% to 5.0%.

Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds and a higher proportion of people aged 65+. The county experiences a net movement of over 400 people aged between 18-30 leaving the county each year.



We also have pockets of both urban and rural deprivation. Life expectancy is 7.4 years lower for men and 5.4 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

We have a smaller proportion of people of working age (56.3% compared to 58.4%) and 4.5% of population is unemployed (17,450).



Overview of our workforce

Across Gloucestershire we have over 28,000 staff working in health and social care. Our combined workforce includes nearly 5000 nurses, 1800 medical staff, over 2000 Allied Health Professionals and healthcare scientists over 6800 support and administrative and clerical staff and nearly 10,000 staff who provide direct care.

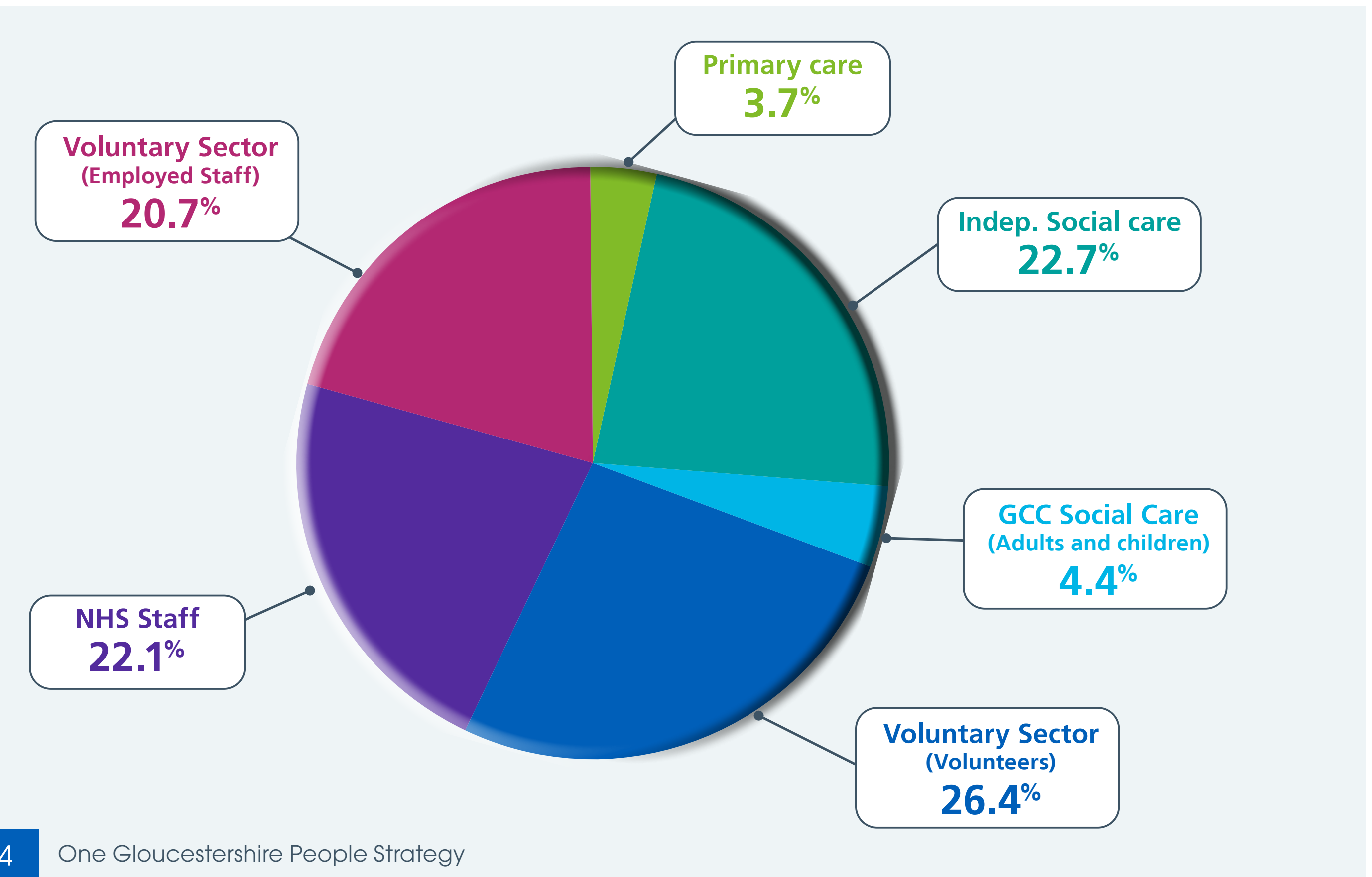
We have over 17,500 staff working in the independent care sector (care homes and domiciliary care) and over 1000 in the local authority.

We also have over 2850 primary care staff working in our 69 practices. From the 1st April 2023 we also became responsible for the commissioning of 112 community pharmacies, 66 Opticians and 77 dental practices.

In addition there are an estimated 7000 employed staff and 14,000 volunteers working in the voluntary, community and social enterprise sector (VSCE).

Gloucestershire has a total health and social care of over 28,700 wte, with over half of that workforce based within social care. There are a further estimated 21,000 VSCE staff.

The average age of our workforce is 45 years, 82% are female and 18% are male. 12% of staff are from an ethnic minority backgrounds. 4% of staff declare having a disability and 2.8% identified as LGBTQI+.



Our Challenges

We face significant issues with recruiting, developing and retaining staff – as is the case across the country.

Post pandemic we still have a workforce that is tired and further impacted by the rising cost of living. Staff satisfaction with pay is at its lowest level for many years and we are competing for staff with other sectors such as retail and hospitality. This is especially pertinent for the independent social care sector.

We have an aging staff profile and an aging population particularly within key services such as primary care and social care.

The recent (2022) NHS staff survey results shows a mix of some very good and some very challenging performance for our organisations.

All our ICS organisations have much more to do to improve equality, diversity and inclusion, to reduce staff experience in relation to bullying and harassment and improve the representation of ethnic minority staff at higher grades.

With an independent care sector that has a large a diverse provider base, implementing change with ICS-wide solutions is also a particular challenge.

Volunteer numbers withing the VCSE dropped off after COVID and have not recovered to pre COVID levels. This is putting a strain on VCSE services and volunteer recruitment remains a significant issue for the sector.

As with all challenges, these also present opportunities, how we can build on our strong collaborative partnerships, promote the unique aspects of our system and our County and use local community people and assets to address the workforce needs now and into the future.

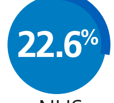
We have significant vacancy rates across the system

Approx **1200 vacancies** across GHFT and GHC

Nurse vacancy rates are **12.2%**

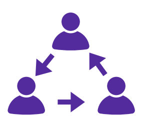
Social Care has over **1700 vacancies** across Gloucestershire

% Staff over 55 years



22.6%	26.5%	35.0%	22.0%
NHS Staff	Social Care Staff	Nurses	GP's
		Primary Care	

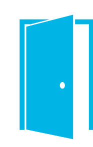
Turnover of staff is a significant challenge for our system



NHS Staff turnover rates are **12.6%**

Social Care turnover rates are **13.2%**

Staff leaving within 12 months of starting



NHS = **14.3%**

Adult Social Care = **13.3%**

Children's Social Care = **10.1%**

**Figures correct April 2023*

Related Strategies & Plans

National Context

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.

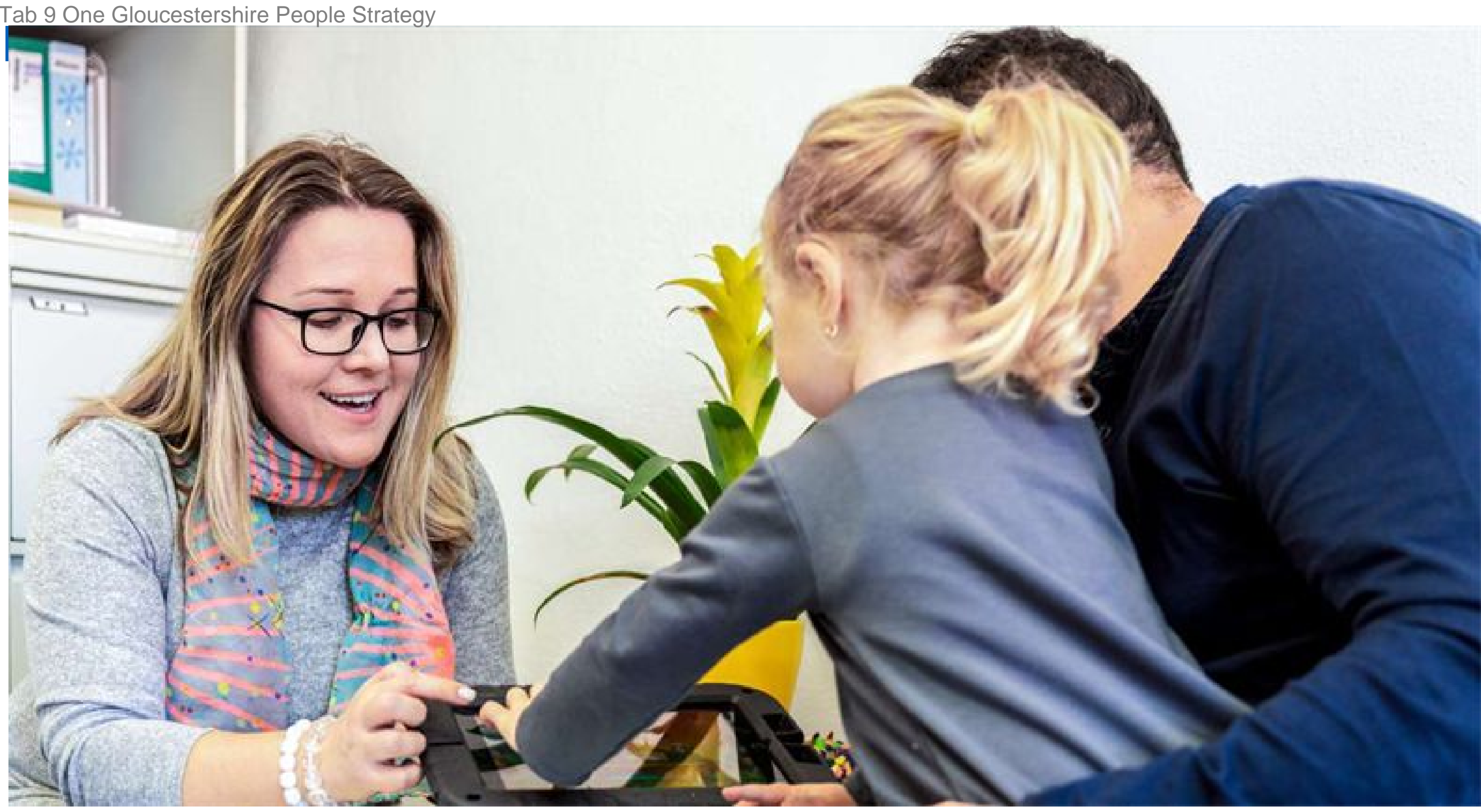
The plan has three priority areas:

- **Train:** Substantially growing the number of doctors, nurses, allied health professionals and support staff. There is £2.8bn of investment over the next five years to fund additional training
- **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. Our short-term focus, in line with the national plan, will be on recruitment and retention.

There is a commitment to refresh the plan at least every two years.

We have also considered the national guidance on the People Functions for Integrated Care systems – 10 identified functions that systems should consider as part of the development of Integrated Care Boards but with a specific focus on local needs and priorities.



Local Context

The recently published Integrated Care Strategy identified ***Creating One Workforce for One Gloucestershire*** as one of its priority themes - recognising that without a sustainable workforce we will not be able to continue to deliver safe and effective services or transform care for our local population.

This strategy reflects and builds on the ambitions described in the Integrated Care Strategy but also identifies other priority areas for action.

It is also recognises that many of our local partners will have developed their own organisational workforce and people plans which set out individual organisational based priorities. This strategy does not seek to negate those strategies but to identify the areas where joint working at system level can add value, deliver potential efficiencies and ultimately improve the sustainability of our workforce for all partners.

Supporting these organisational strategies, focused workforce strategies are also being developed, for example an Allied Health Professionals strategy is in final stages of production.

Strategy on a page

"Developing One Workforce for One Gloucestershire"

Focussed Themes

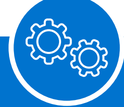
Recruitment & Retention

Recruitment

- Recruit for skills & pathways
- Widen access routes to attract people to work in health & social care
- Collaborate on system-wide approaches to recruiting & attracting staff & temporary staffing solutions

Retention

- Providing staff with a strong voice & getting basics right
- Supporting career progression, understand generational and cultural differences & promote flexible working.



Enabling Innovation in care delivery & people services

- Right workforce for right care in the right place, boosting the transformation work of the Clinical Programme Groups
- Support rotation of staff across clinical pathways
- Support Enhanced, Advanced & Associate practice developments to gain traction
- Driving innovation in People Services to provide high-quality people services across the ICS.

Valuing and Looking after our people

- Proactive approach to looking after our people
- Deliver a System-wide health and well being focus and service provision with a core basic offer
- Provide training for all line managers on health & wellbeing
- Developing an agreed Health & Wellbeing Strategy for Gloucestershire

Education, Training and Talent Development

- Maximising awareness and accessibility of learning opportunities, including apprenticeships, across all staff groups
- Develop system-wide learning recognition, portability and talent management processes
- Strengthen relationship with University of Gloucestershire & other Higher Education Partners, Further Education Institutions and training providers.

The strategy has eight themes, depicted as four cross-cutting themes ("the foundations") and four focused themes ("the pillars"). Although shown as distinct themes they are inter-related.

Example 1

When we are innovating and developing new care pathways, we undertake workforce planning to ensure the new models are sustainable, we may need to recruit new staff and existing staff will need development through education and training, including new digital skills.

Example 2

Retention is heavily influenced by valuing and looking after our people which also has a strong link to ensuring staff feel we act fairly with respect to equality, diversity and inclusion, and this in turn is underpinned by a kind and compassionate leadership culture.

Mapping our ICS People Strategy to the NHS Long-Term Workforce Plan
(June 2023)

NHS Long-Term Workforce	Train	Retain	Reform
ICS People Strategy Theme			
Recruitment & Retention	✓	✓	
Innovation	✓		✓
Looking after our people		✓	
Education, Training and Talent	✓		✓
Future workforce planning	✓	✓	✓
Digital, Data and Technology literacy	✓		✓
Equality, Diversity and Inclusion		✓	
Leadership and Culture		✓	

Mapping our ICS People Strategy to the NHS People Promise (July 2023)

NHS People Promise	Looking after our people	Belonging to the NHS	Growing for the future	New ways of working and delivering care
ICS People Strategy Theme				
Recruitment & Retention	✓		✓	
Innovation				✓
Looking after our people	✓	✓		
Education, Training and Talent			✓	✓
Future workforce planning			✓	
Digital, Data and Technology literacy			✓	✓
Equality, Diversity and Inclusion	✓	✓		
Leadership and Culture	✓	✓	✓	

Theme 1 (Foundational): Leadership and Culture

"Does our culture allow for genuine autonomy for leaders?"

"What does 'non-linear' development' look like?"

"Focus on the middle management layers of our organisations is really important"

"How do we encourage professionals who want to develop and progress but not manage a team?"

"Do we need a common set of value, behaviours and competency framework across the system?"

"How do we build on the success of the collaborative leadership programme with respect to talent management"

Leadership and culture has a significant impact at all levels of the workforce; our health and social care workforce has been through enormous pressure in recent years and continues to face unprecedented demands and so it is vital to ensure that great leadership (both clinical and non-clinical) and a kind and compassionate culture of civility and respect is nurtured and developed as a core component of our people strategy

Where are we now

- Some shared leadership development programmes, underpinned by non-recurrent funding and short term commitments
- Inadequate understanding of leadership development needs across the system
- One Gloucestershire Leadership Programme Alumni identified with further development opportunities planned potential to grow and develop this cohort further
- Predominately organisational focused cultural development with limited sharing of approaches
- Lack of detailed shared understanding of system capability and/or a long term development plan for the system

Our Ambition

- Consistent high quality multi-professional leadership is defined and demonstrated across all levels and across the system
- All Partners proactively think about leadership and culture as a key component to the delivery of the People strategy and workplans
- Sustainable long term agreed leadership development strategy and delivery plan that supports all system partners
- We have embedded a culture of kindness, civility and respect across our system
- Systems Leadership is the default leadership mindset – what's in the best interest of all of us across the system
- Embedding a Restorative, Just and Learning Culture
- To make speaking up a Business as Usual through Freedom to speak-up services

Theme 2 (Foundational): Equality, Diversity and Inclusion

"What make's staff feel like they belong? Have we asked them?"

"Getting the basics right"

"Need to involve the staff this impacts into the discussions"

"Link to culture and leadership – creating a safe culture to challenge and confidence/competence to do so"

"Should the system focus be in health inequalities, leaving the organisations to focus on the staff inequalities?"

"Need representation at all levels"

The NHS has one of the most diverse workforces in the public sector, however, we know from research data, staff surveys measures and anecdotes that the workplace experience of all staff, their work-related outcomes and opportunity to progress is inconsistent. Whilst there has been a welcome and overdue emphasis on EDI, we know we have more to do in addressing inequality in staff outcomes (notwithstanding a continued focus on wider health inequalities in our population).

Where are we now

- We have delivered several ICS-wide and organisational specific ED&I initiatives.
- Several cohorts of the Flourish talent management programme were taken-up by staff with protected characteristics (race, disability, sexual orientation) and their line managers.
- Allyship & Reciprocal mentoring programmes are being established to help leaders across the system develop greater understanding and empathy.
- Each of the ICS partners continue to offer cultural awareness and EDI programmes to managers and staff.
- Organisational actions plan are developed and tracked based on WRES, WDES, Gender Pay Gap and staff survey data.
- Some shared working on the Equality Delivery System (EDS)
- Support Programme for EDI Network chairs

Our Ambition

- We genuinely embrace diversity in all of it's dimensions and aim to ensure that our work places are free from discrimination and that our workforce at all levels is representative of the populations we serve. This extends beyond legally protected characteristics into social deprivation.
- We will ensure the principles of Equality, Diversity and Inclusion are embedded as the personal responsibility of all members of staff
- We will ensure all our policies, procedures, systems and practices are reviewed and de-biased.
- Our staff report that they feel they work in teams and organisations that operate fairly, and that are open and free from any form of discrimination.
- Collaborative delivery of the **NHS EDI Improvement plan**

Theme 3 (Foundational): Digital, Data and Technology

"Within 20 years, **90%** of all jobs in the NHS will require some element of digital skills. Staff will need to be able to navigate a data-rich healthcare environment. All staff will need digital and genomics literacy."

The Topol Review: Preparing the healthcare workforce to deliver the digital futureEric Topol, 2019

We believe having Digital, Data and Technology (DDaT)" as foundational theme of a People Strategy as an indication of it's importance. We have witnessed an extraordinary pace of digital innovation in the past couple of years. Virtual clinics and wards, virtual working are now the norm and these have placed additional demands in terms of skills and forced many of us to change the way we work, which has been an additional source of stress.

Looking into the future, we are faced with the prospect of technology either performing selected tasks as well as or better than humans (e.g. picking out abnormal scans), so a focus on our people's confidence and skills to ensure we can embrace and benefit from the opportunities technology affords us and mitigate against any risk is essential.

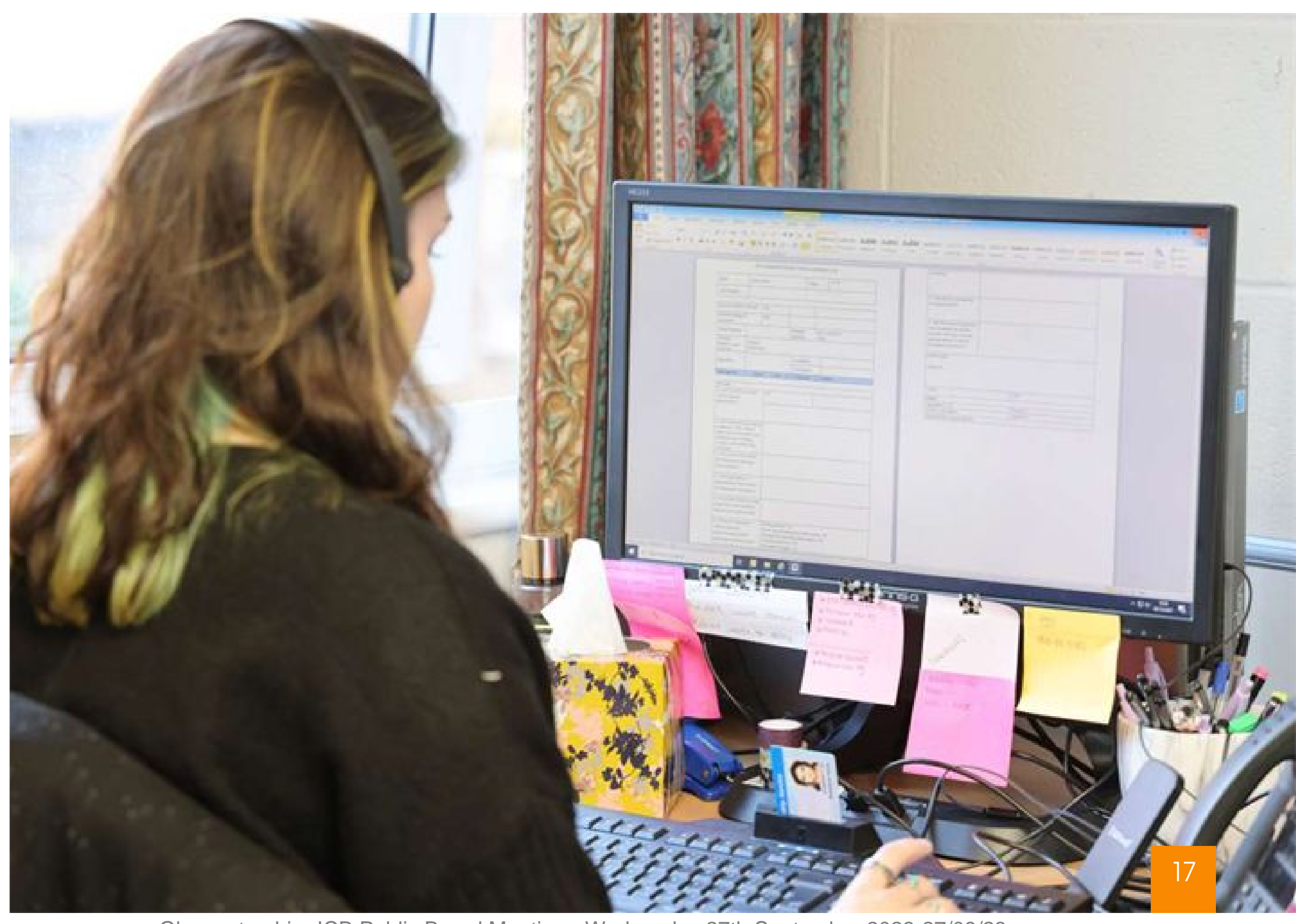
Greater use of Digital, Data and Technology is also an important element of providing great people services (link to innovation in people services)

Where are we now

- Digital literacy variable across the workforce
- Technology-related change not always focused on the people change elements
- Technology-related change being a cause of additional staff stress and a factor in retention
- Specialist technology skills are in high demand and we are often unable to compete in the jobs marketplace for these.

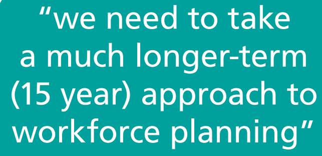
Our Ambition

- Development of a digital workforce strategy
- Development of Digital Skills and Education offer for all staff to develop and enhance digital literacy
- Support and develop digital specialists (including clinical informaticians) across the ICS
- Delivery of simulation-based and Technology Enhanced Learning (TEL) as a key enabler for training both digital skills required and innovative methods of education and to increase the number of people we can train
- Development and optimisation of current workforce systems for the ICS
- Using DDaT to provide innovative and excellent people services.



Theme 4 (Foundational): Workforce Planning

"we need to take a much longer-term (15 year) approach to workforce planning"



Workforce Planning is the process of analysing, forecasting, and planning workforce supply and demand, assessing gaps, and determining interventions to ensure that we have the right people - with the right skills in the right places at the right time - to fulfil our strategic and operational service delivery objectives.

It's an iterative process starting with understanding our strategic objectives (as per Integrated Care Strategy and 5-Year ICB Plan 'Joint Forward Plan'). It is a foundational element of the strategy as it provides a structured, evidence-based method and set of tools upon which to identify priorities and take action to address them.

Where are we now

- System partners individually report a range of different workforce data with potential inconsistency in data sets. We are developing our understanding of primary care and social care data sets, however, HR systems are different within each of the organisations, the scope of what HR data is recorded varies across each of them and there is no central system-wide repository. National data repositories have delays in data availability and need local processing before using.
- We have limited workforce planning capacity and capability (primarily concentrated in a few specialist areas) and workforce planning is predominately focused on a short term (1-3 year) time period.
- Workforce planning is inconsistently integrated with service planning and no standard methods or tools are in place or widely used.

Our Ambition

- We have the opportunity to create a common methodology in workforce reporting and upskill more staff (within the operational service areas, transformation teams and people services) to be confident in workforce planning, developing a 5-year and longer-term view of our workforce needs across all levels of practice and integrated across health and social care.
- Improve the integrity and availability of in the data and have a system-wide view of it.
- Future service investment plans are underpinned by evidence-based workforce approaches that support long-term sustainable services.
- Alignment and planning timelines mirroring the 15 year timescale of the national workforce plan and we can respond positively to the significant expansion of training.
- Opportunities to embed integrated approaches to workforce planning across pathways and traditional boundaries.

Theme 5 (Pillar): Recruitment and Retention

"What's the 'Gloucestershire pitch'?"

"Getting the basics right"

"Develop the business case for a living-wage across the whole system"?

"Can we avoid employing fixed-terms posts, we always have vacancies"?

"Shared pathway-based recruitment"

"How do we be less tribal and territorial?"

Recruitment: Having sufficient staff with the right skills in the right place is the cornerstone of our people strategy. Whilst worker shortages are not unique to the health and social care sector, the impact of not having sufficient staff has a huge impact on timeliness of access to care and safety of care; not to mention the strain it places on those that are working in the sector.

Where are we now

- Organisation-based recruitment activity with limited sharing or co-ordination
- Competing for staff and talent between organisations and across county/country borders
- Variation in reward packages
- Improving co-ordination for apprenticeships and cross-partner levy utilisation
- Improving co-ordination for widening participation initiatives
- Risk-averse recruitment meaning some posts are offered as fixed-term making attraction challenging
- Provider organisation International Recruitment in place
- Some values based recruitment practices
- Variability in time to hire and recruitment practices.

Our Ambition

- Reduce system vacancy rates through increase system wide coordinated promotion and recruitment campaigns, and collaborative international recruitment
- Improved workforce ‘mobility’ across One Gloucestershire, with streamlined Education and Learning programmes including blended, accessible and safe educational approaches
- Increased domestic growth of supply for clinical roles through local HEI provision
- Increased roles recruited via apprenticeships and new and extended roles (e.g. nursing and physician, associates, advanced practitioners)
- Consistent, agile and efficient “time to hire” practices using technology
- Embedded inclusive recruitment policy and practice
- Maximising our roles as anchor institutions and proactively reaching out to VCSE and local communities, with a focus on underrepresented communities.
- Career paths that facilitate us to “grow our own” workforce

Retention: Once we have the staff, holding on to their dedication and commitment is equally essential. Not having sufficient staff places additional burden on those that are in post and coupled with increased demand and not feeling valued (strong link to health and wellbeing and leadership) we can struggle to retain them.

Where are we now

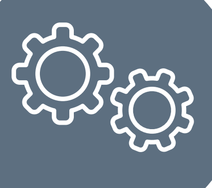
- Highest leaver rates (nationally) for some staff groups (e.g. midwives); top (i.e. worst) quartile for AHPs, Nursing support. Nurses showing a decline and special cause variation
- High percentage of staff approaching retirement (>age 55) across the system, with 43% of admin and clerical staff in Primary care aged 55 or over; 23% are over age 60
- GP Partners declining; all GPs 59/10,000 against regional average of 62/10,000, though above national average at 57/10,000, 2nd lowest increase in GP Registrars across the SW
- Social Care all staff turnover rate of circa 40%, direct patient care staff 35% (4,200 leavers in 21/22)
- Gaps in the data to understand (qualitatively and quantitatively) why staff are leaving.

Our Ambition

- Improve data collection and analysis on the characteristics of leavers across the system including reasons for leaving. Have a suite of KPI’s that will demonstrate where improvements in retention have been achieved
- Improve work life balance for staff through flexible working offers for all staff across both clinical and non-clinical settings throughout their working lives (as individual circumstances change)
- Improved experience for Health and Social Care colleagues, to feel engaged, supported, invested in and valued.
- Improve clarification and offers for career development with a focus on early careers and talent management.
- Provide opportunities for staff to work across the system to gain experience and provide a flexible workforce
- Implement the 5-high impact retention actions for nursing and midwifery and monitor performance against
- Welcome internationally recruited staff with provide them with pastoral support and assistance to enable them to remain, flourish and develop their careers within Gloucestershire Health and Social Care.

Theme 6 (Pillar): Enabling Innovation in care delivery & people services

"Develop new and different roles"



"Greater use of the Voluntary sector"

"We need to be more inventive. We need to take different approaches, doing things differently, and doing different things differently"

There is a long history of collaborative working through the clinical programme groups, some of which are focused on disease pathways (e.g. diabetes, respiratory, Eye-Health) and others focused on service user populations (e.g. Children and Young People, Mental Health, Older and Frailty). These groups have been working on transforming services to meet future needs. Integral to building and sustaining new models of care and service delivery are the existing staff that will need to be developed and new staff recruited. There are other change and transformation initiatives being undertaken which have a significant people impact, such as greater use of digital tools to support care delivery.

The Human Resources and Organisational Development functions that support our people services themselves are innovating and transforming to be even more efficient, effective and customer-focused.

All of these make for a complex picture of changes that will impact staff, making this an essential theme of our people strategy.

Where are we now

- There is significant amounts of transformation activity taking place across the ICS, from the work of the clinical programme groups to digital improvements. The workforce element of these are integral to the success of these programmes, however, their impact is not always comprehensively understood or proactively planned for in a coordinated and consistent way.
- Gaps in key roles have slowed down delivery of some transformation programmes.
- Increasing ICS-wide collaboration in People Services planning with mature governance structures. Variable collaborative delivery structures focused on projects.

Our Ambition

- Transformation programmes are able to deliver the step change improvements in the health and social care delivery to our populations fully enabled by a skilled and adequately resourced workforce.
- Local review and implementation of the "**Future of HR and OD plan**" and "**Vision 2030**" with people services appropriately resourced and structured to provide strategic and operational support across the ICS.

Theme 7 (Pillar): Valuing and looking after our people

"Happy workforce = happy patients"

"Ensure we hear the minority voices, is their equitable access?"

"Need to involve the staff this impacts into the discussions"

"Move from reactive to proactive Health and Wellbeing"?

"Have a minimum and consistent system-wide offer"

"Promote and publicise access to existing service better"?

"HWB strongly linked to workforce cultures"

"Do we know root causes"?

We have a skilled and dedicated workforce who provide essential services to the population of Gloucestershire under increasingly demanding circumstances. Whilst our staff are committed to looking after our patients, service users and their families and carers, it is imperative we look after our staff. We know from evidence there is a strong correlation between the experience of staff and those they care for (positively and negatively), and that retention is linked to staff experience, so this makes sense from a business and service delivery perspective, however, as leaders we believe there is overwhelming moral imperative to value and look after our people.

Where are we now

- Renewed focus on Health and Wellbeing of staff in response to Covid-19 pandemic, with many initiatives launched, some of which were system-wide
- Some health and wellbeing initiatives are based on non-recurrent funding e.g "The Wellbeing Line" across One Gloucestershire
- Baseline mapping of Health and Wellbeing services across ICS (and wider), indicating innovative services available within some organisations and much commonality in services available, though variable take-up (especially when overlayed with EDI factors)
- Variable insight as to impact of services (limited evaluation).

Our Ambition

"One Gloucestershire commits to proactively engaging and enabling all our people across the whole county to stay healthy, well and safe throughout their working lives; acknowledging the whole person, providing holistic support when needed and ensuring that the appropriate support is available and easily accessible to all staff based on an understanding of their need."

- Focused action in four Health and Wellbeing (HWB) areas:
  - Supportive HWB culture – more than provision of HWB services
  - Access and inclusion – Equitable access across the ICS and parity of available services
  - Collaboration across the ICS
  - Engagement with staff that use/need the services
- Addressing health inequalities in our workforce
- Embedding a Restorative, Just and Learning Culture
- To make speaking up a Business as Usual through Freedom to speak-up services

Theme 8 (Pillar): Education, Training & Talent Development

"Equality of opportunity and access for all"

"Protected l earning time is essential"

"Needs are different dependant upon point in career"

"Knowing what is available to access across the system and wider"

"focusing required (StatMan) learning on essentials and being able to port learning across our organisations"

"Support for educators (esp. those who are also practicing clinicians"

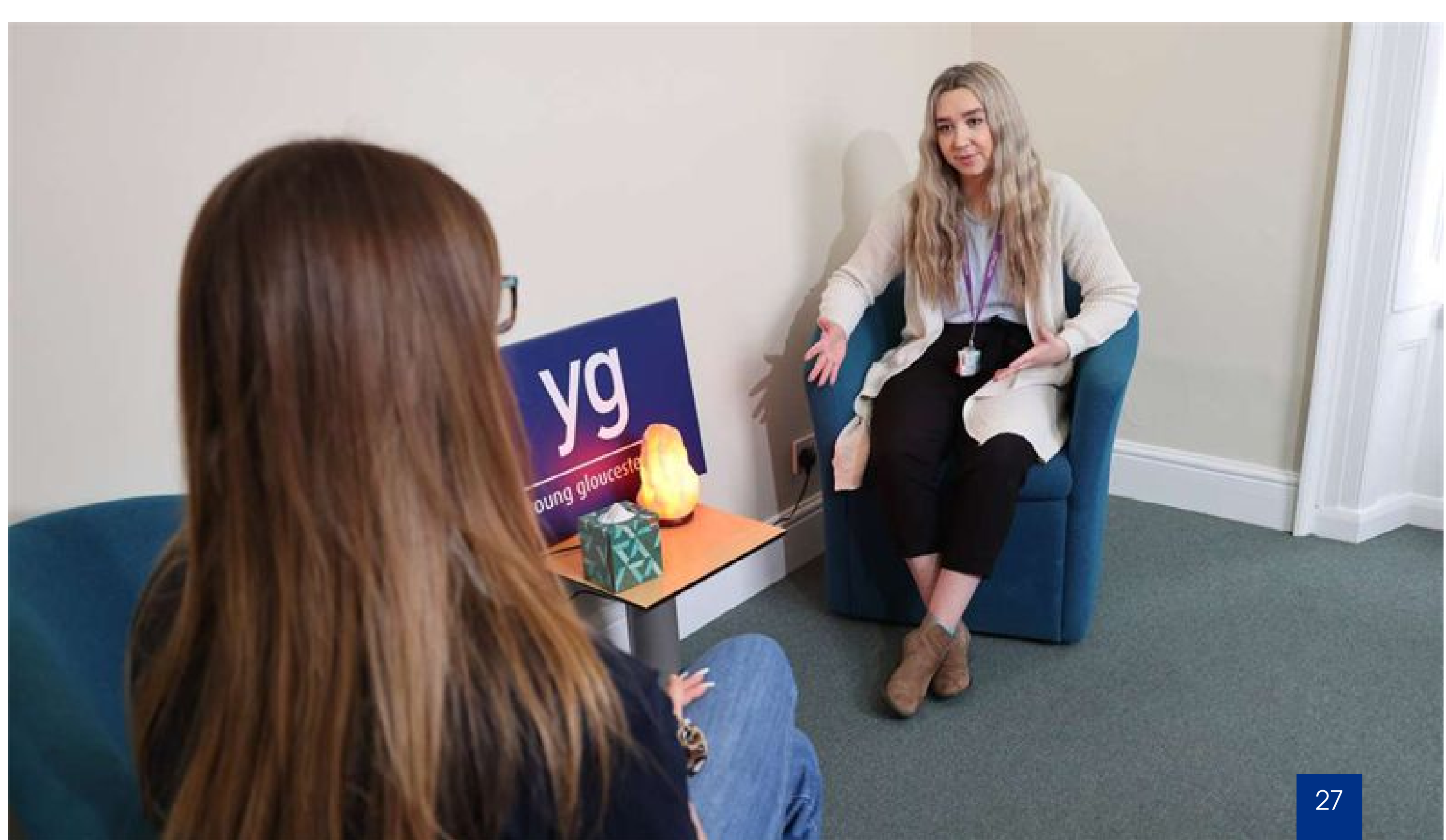
Education, Training and Development is essential to ensure we continually invest in our staff so they have the necessary skills to deliver a safe service, meet their personal and career ambitions and enhance service productivity. It takes many forms from traditional classroom-based education to using new technology (such as Virtual Reality), encompasses a broad range of clinical and non-clinical disciplines and is delivered by internal teams as well as specialist external partners.

Where are we now

- A wide range of learning opportunities (clinical and non-clinical) available within each organisation, though variable in terms of awareness, accessibility and take-up. Most opportunities only available within organisations to their staff.
- Early involvement in University of Gloucestershire City Campus, Health and Care facility
- Development offers not consistently mapped back to population health objectives or known training gaps and needs.
- ICS Widening Access and Apprenticeship Hub
- Absence of co-production of training and development offers informed by those with lived experience
- Clinical placement provider of under/ post graduate health professions education, apprenticeship and trainee programmes in partnership with Regional and National HEIs, Further Education Colleges and Training Providers.

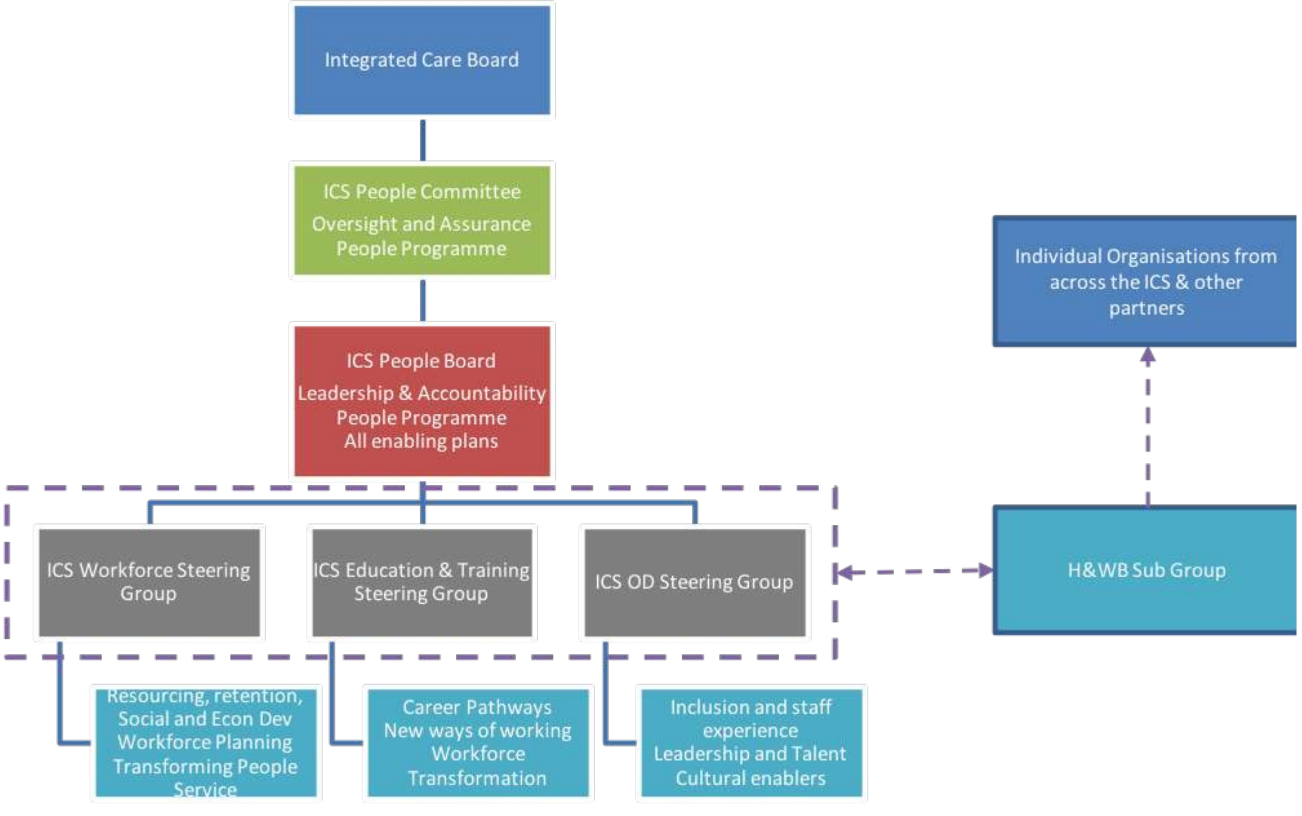
Our Ambition

- High-quality opportunities related to strategic needs with population health focus
- Access and take-up comprehensive and equal across all staff groups
- Agreed training is consistent, easily portable and recognised across organisations
- Excellent collaborative working between training providers, further and higher education institutions (local, regional and national). Benefitting from their state of the art facilities meeting current and future education and development need.
- Innovative use of technology for learning enhancing learning access, experience and effectiveness
- A culture of continuous professional development across all staff groups, with protected time to dedicate for this
- Maximising the use of traineeships, apprenticeships and having clear career pathways
- Co-produce content informed by those with lived experience
- To maximise capacity and further the range of professional placements; delivering placement models for learners which enhance learning, prioritise the development of competence, connect and integrate theory, evidence and experiences.
- Implementing the **NHSE Educator Workforce Strategy**.



Delivery and Governance

We will use our existing People Function governance structure and sub-groups to manage and oversee delivery of agreed priorities.



Key Projects –
Lead: Workforce Steering Group

Project Category	Project Name
Recruitment	International recruitment
	Be In Gloucestershire recruitment campaign
	Recruitment events collaboration
	Staff accommodation
	Inclusive recruitment
	Veterans recruitment
Retention	Legacy Mentors
	Retention Diagnostic
	Nursing retention toolkit
	System workforce agility
Workforce Planning	National returns
	Targeted Workforce planning support
	Identify WF planning training requirements
Reduce agency and Temporary Staffing Costs	Temporary staffing group
	Bank process alignment
	E-rostering
	ICS shared bank

Key Projects –
Lead: OD Steering Group

Project Category	Project Name
Culture	Health Wellbeing vision and action plan
	HWB retention conversations
Transformational System Leadership	Map current provision
	System capability requirements
	Existing development programmes
	One Gloucestershire leadership programme alumni
EDI	Reciprocal mentoring
	EDI literacy
	Inclusion Allies
Coaching, talent and succession planning	Flourish evaluation & Alumni Support
	My e-coach

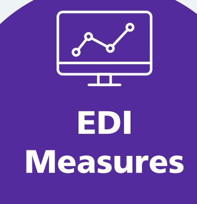
Key Projects –
Lead: Education Steering Group

Project Category	Project Name
Enabling key skills	Social Care, Community Nursing and AHP Upskilling Funding ICS
	Shop window of offers across the system
	HEE educator Workforce strategy
	Systemwide induction Programme
Innovation	Innovation (TEL)
Workforce Transformation	Apprenticeships & widening participation strategy development
	Levy maximisation and transfer
	University of Gloucestershire city campus facility
	System-wide advanced practice
Supply	Placement capacity
	System-wide Career Promotion collaboration

How will we know if we are making a difference?

Measures to track progress:

Staff Engagement


EDI Measures

Apprenticeship levy utilisation

Vacancy Rate

Sickness Absence

Staff Turnover

Agency Spend

Targets are set by each organisation based on their respective baseline positions.

SAMSUNG

The work on the people strategy commenced in early 2023, at that time the chair of the People Committee was Clive Lewis. Clive sadly and unexpectedly passed away in May 2023. We would like to pay our tributes to Clive for his leadership and inspiration to our work on this strategy and his wider contributions to the work of the ICB in "*Making Gloucestershire the healthiest place to live and work – championing equity in life chances and the best health and care outcomes for all.*"

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September 2023

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Part 1

Thursday 1st June 2023, 14.00-15.30pm

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, GICB
Dr Andy Seymour	AS	Chief Medical Officer, GICB
Cath Leech	CL	Chief Finance Officer, GICB
Prof Jane Cummings	JC	Non-Executive Director, GICB
Dr Marion Andrews-Evans	MAE	Executive Chief Nursing Officer, GICB
Ayesha Janjua	AJ	Associate Non-Executive Director, GICB
Participants Present:		
Becky Parish	BP	Associate Director of Engagement and Experience, GICB
Carole Allaway-Martin	CAM	Councillor, Gloucestershire County Council and Member of Parliament
Helen Edwards	HE	Deputy Director of Primary Care and Place, GICB
Helen Goodey	HG	Director of Primary Care & Place, GICB
Jeanette Giles	JG	Programme Manager, Primary Care and Place, GICB
Julie Zatman-Symonds	JZS	Deputy Chief Nurse, GICB
In attendance:		
Andrew Hughes	AH	Associate Director Commissioning & Primary Care Premises Lead, GICB
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Declan McLaughlin	DM	Head of Contracting, Primary Care and Place, GICB
Emma Jones	EJ	Practice Manager, Hucclecote Surgery
Fabian Toner	FT	Developer Representative, Gloucestershire County Council
Dr James Lambert	JL	Lead GP, Hucclecote Surgery
Kate Usher	KU	Head of Primary Care Workforce Development, GICB
Kirsty Young	KY	Primary Care Programme Manager, GICB
Dr Laura Halden	LH	Head of Gloucestershire Primary Care Training Hub, GICB
Sarah Rogers	SR	GP Nurse Lead of Primary Care Training Hub, GICB
Tim Scruton	TS	Practice Professional Advisor Lead, Osmond Tricks

1. Introduction & Welcome

1.1 CG welcomed those present and also a member of the public, Mr Nigel Mummery.

2. Apologies for Absence

2.2 Apologies were noted from Mary Hutton and Ellen Rule.

2.3 It was confirmed that the meeting was quorate.

3. Declarations of Interest

3.1 CG declared an Interest in Item 7 on the agenda as his daughter was a patient at Hucclecote Surgery. He stated that he would stay and lead the conversation, but would be abstaining on voting to ensure that there was no perception of a Conflict of Interest. This was duly recorded for this meeting as requested.

LH declared an Interest as being a GP at Gloucester Health Access Centre and for the Inner City PCN; and also temporary clinical lead for Blakeney, Forest of Dean PCN. LH also stated that she sits on the LMC and was previously a partner at Hucclecote Surgery, albeit not involved in any decision pertaining to their premises today.

4. Minutes of the Previous Meeting

4.1 The minutes of the previous meeting held on 17th April 2023 were approved as an accurate record of the meeting.

5. Action Log & Matters Arising

5.1 **17.04.23, Item 9.2 - Risk Report.** *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 stated that this risk would be assessed and brought back to the August meeting of the PC&DC with a briefing paper around the process that is followed to determine such level of risk. **Action: Item to remain open.** **HG**

17.04.23, Item 10.2 – Delegation Documents. *CG noted that access to embedded documents during the signing off delegation were not accessible. Moving forward, more information on risk management and mitigations was requested for the next PC&DC Committee*. HG informed that this had now been resolved. **Action: Item closed.**

17.04.23, Item 12.4 – Research for Gloucestershire. *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 had subsequently circulated information to the members following the meeting. **Action: Item closed.**

17.04.23, Item 14.1 – TWNS PCN Evaluation. *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. HG agreed to arrange this for the Committee.* HG said this would be brought back to the next (August) meeting or subsequent one (October). She would confirm this at a later stage. **Action: Item to remain open.** **HG**

6. Questions from the Public

6.1 There were no written questions from the public. CG said that this meeting was the first where a member of the public had attended since April 2015. A decision was made by the ICB on 31 May 2023 that Part 1 of the PC&DC meetings would continue to be held in public for the foreseeable future and CG stated that he looked forward to welcoming members of the public to attend as was their right.

7. Business Case for the development of a new surgery in Hucclecote

APPROVED

7.1 CG welcomed AH to the meeting who also introduced Dr James Lambert, Emma Jones, Rob Barnes, Fabian Toner and Tim Scruton who were all involved in this process. The Report of a Business Case set out the case for change and preferred option for the development of Primary Care (PC) services in Hucclecote. The Business Case had been circulated to voting members prior to the meeting.

7.2 AH informed the Committee that the development in Hucclecote had been a priority for over seven years. Moreover, he acknowledged that the Practice had worked hard at preparing the Business Case through what had been a challenging financial and commercial period. The Practice had subsequently moved from a GP led scheme, to a third party led scheme with Gloucestershire County Council.

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

- Facilitation of the transformation of service provision to meet the needs of national and local strategies, particularly an expansion in the range of services.
- The support of workforce and training challenges.
- To address the inadequacy of the current condition of the building.

7.4 Further benefits were set out in Section 6.5 of the Report. AH identified that there had been an extensive options appraisal, with the preferred option being identified as explained in the Business Case and in the Summary of the Report, which had been supported by the Primary Care Operational Group (PCOG).

7.5 This development would be led by Gloucestershire County Council on a site owned by the Council and a new surgery development would also incorporate some housing. The site was approximately 0.4 miles away from the existing surgery and there might be an opportunity to expand what is currently, a very tight boundary for Hucclecote surgery.

7.6 The total capital costs of the new surgery were £4.93m. This would be funded by the County Council who would receive rental from the Practice, who would sign a 30-year lease. The lease costs would be reimbursed by the ICB along with rates. The ICB currently reimbursed Hucclecote Surgery £77,129 per annum for rent and rates to provide GMS services from the existing building. Total rent for 822m2 net internal area (inclusive of a supplementary payment, car parking and VAT) and rates for new the Surgery would be £308,314. GPIT and HSCN capital costs confirmed by the IT team would amount to £75,151.

7.7 The ICB would provide £398,331 fee support to cover appropriate legal costs, monitoring surveyor fees and Standard Duty Land Tax (SDLT) due after completion and capped financial assistance with exit costs associated with the existing surgery. Provided approval for the scheme was given, it was anticipated that construction would commence during the summer of 2024 with the new facilities opening in late summer/early autumn of 2025.

7.8 Dr James Lambert on behalf of the partners of Hucclecote Surgery, spoke about the current surgery at Hucclecote being unfit for purpose due to the small size and being so outdated. A new surgery would negate the struggle to accommodate new staff and additional roles, whilst enabling the Practice to take on more students in their teaching capacity, and to allow expansion to be able to deliver much higher quality services for the community.

7.9 JCu said that there was no reason, as long as CL was content with the additional funding, as to why this scheme should not be supported so long as it was fit for the future and having a potential link for more integration of teams across health and social care. She

APPROVED

was keen to support this scheme.

7.10 TS said that two areas of expansion had been designed into the plans for around the next 15 years. HG extended thanks to the GP partners who had invested a great deal of their time into this project which had finally come to fruition.

7.11 CL said that it was imperative that the articulated benefits needed to be drawn out, clearly delivered and that the investment in Primary Care could be evidenced, given that the ICB were currently in a constrained financial position. Recruitment remained a huge risk, particularly around the training and the skill mix.

7.12 CG said that the District Valuer's Report, which he had seen, was supportive of this scheme and contained confidential information which was why it had not been made available at this part of the meeting. CG said that the ancillaries were growing and he had no problem with the GPIT; the area he wanted to question was around the £398,000 and asked whether there was any way this could be reduced, especially around the exit costs. AH said that there was some commercial sensitivity here but was allowed to say that the exit costs needed to be picked up by the developer in order for the scheme to proceed.

7.13 CG would like to have a meeting with interested parties to look at prospective future plans to examine affordability and the priorities that lie therein which would have to be taken into account along with all the other priorities that the ICB were supporting. CL said there was also a slightly broader issue to raise with NHSE in terms of capital developments and any messages that would need to be flagged. AH said that with the market being as it was, construction costs could not be borne by GPs.

7.14 CG said he would abstain from voting, (as per Declarations of Interest) and said it was a very balanced report and the need was definitely there. CG asked for Committee members to vote and the scheme was unanimously supported and approved by all members present.

Meeting Outcome: The Committee agreed the following recommendations :

- ***To a recurrent annual investment of £308,314 to fund the delivery of a Gloucestershire County Council capital funded new Hucclecote Surgery to cover rent (including actual rent, a supplementary payment, car parking and VAT) and rate costs. Based on existing levels of reimbursement this would be a net annual recurrent increase of £231,185;***
- ***To provide a one off financial fee support amounting to a maximum of £394,961 available from 2024/2025;***
- ***To support the allocation of £75,151 including VAT from the GPIT capital budget to fund GPIT and HSCN requirements.***

JCu left the meeting at this point.

8. Primary Care Workforce Update

8.1 KU gave a general update on the current situation at the start of the presentation saying that appointment levels remained consistently higher than pre-pandemic levels. There were also new roles within Primary Care (with further additions to Additional Role Reimbursement Scheme i.e. ARRs) and placement expansions to support the future workforce.

8.2 LH spoke about the challenges being faced by GPs:

- Overall GP numbers had decreased 2% since the March 2019 baseline.
- GP partner numbers decreased by 19.6% since baseline, whilst salaried GPs have increased by 37.7% (SW has the 2nd highest WTE of GPs per 10k patients) – Partner numbers are reflective of national trends.

LH described the many challenges being faced by GP partners and how joint work with the Local Medical Committee (LMC) would address these issues, including:

- A workforce survey to identify vacancies, leavers and retirements.
- GP Continued Professional Development (CPD)/mini fellowship funding.
- GP support lead and GP retainer peer support group.
- Dedicated GP career/support resources.
- Fellowship opportunities - Health Education England (HEE), Integrated Care System (ICS)/Training Hub - Health inequalities and specialism fellowships.
- An annual locum event.
- GP flexible pool.

8.3 Similarly, nurses are facing challenges, some of which were :

- An ageing nursing workforce and retirements with 9 out of 15 PCNs reporting planned leavers/retirements in the next two years).
- There is a myth that student nurses couldn't enter Primary Care upon qualifying as a nurse.
- There had only been a 3.6% increase in the nursing workforce in Gloucestershire since 2019, compared to a regional increase of 9.7%.

8.4 Work continues to support the county's nurses – some of the ongoing schemes are:

- Nurse on Tour programme and wider expansion of student nurse placements.
- Planned Careers Fair and mock interviews in order to gain experience.
- Spark Nurse and Preceptorship Nurse Scheme.
- Nurses added to Additional Roles Reimbursement Scheme (ARRS) as Advanced Practitioners (APs) - Advanced Practice lead starting soon and planned Advanced Practice engagement event.
- Exploring joint General Practice Nursing (GPN)/community nursing roles (planned Rosebank pilot for catheter clinics).
- Trainee Nursing Associate (TNA) role increasing (TNA Practice Education Facilitators in post).

8.5 Reception, administrative and practice manager staff continue to face difficulties around pay, and 7 out of 15 Primary Care Networks (PCNs) reported planned Practice Manager retirements. Abuse of staff affects retention and training sessions for staff, including health and wellbeing are being offered. Other areas being examined include:

- Promotion of apprenticeship options (and other roles such as GP assistants).
- Development of flexible pool to support staff recruitment and retention.
- Development of communities of practice.
- Collaboration with LMC to support Practice Manager training, with a recognition more needs to be done.
- Recruitment open days.
- Employment and Skills Hub collaboration.

APPROVED

8.6 AS referred to the statistic around lack of GP partners and he explained that salaried GPs were constrained by their contracts, so would do a morning surgery but not see extra patients. If GP partners over a period of time continued to see large numbers of extra patients, then this would have a huge effect upon them and thus sustainability would become an issue, both locally and nationally.

8.7 OA said housing the future ARRs workforce in primary care premises will present challenges. OA said that there were 355 new ARRs roles across the PCNs but no increase in premises capacity for them, which affected recruitment. After March 2024, there would be issues around staff pay increases unless a solution was found before then. OA also said that what was being heard at ICB level was very different from LH and KU's workforce report. There was for example, an increase in GP numbers reported from the ICB but OA thought that this had included GP trainees. It would take two locum GPs to equate to an output of a partner GP, which again, had only been captured in the report from LH and KU.

8.8 HG said there was still an appetite for a partner model as opposed to that of an entirely salaried one. Value for money, productivity, owning it; all these things worked well for partnerships so the ICB should be doing its utmost to support GP practices and partnerships to continue and to address the concerns being raised around the ARRs and funding. HG said that her team were working at full capacity on all the projects and looking to improve the situation at every opportunity.

8.9 LH said that the Training Hub were working closely with the ICB, who receive resignation notifications from GP Partners. An email will automatically be sent to the leaving GP, (which LH and KU are copied into) which then gives them an opportunity for a confidential one to one conversation with an independent GP and if this is declined, there is a survey that can be anonymously completed. This will give an understanding of the reasons for leaving the partnership and what would have helped them to perhaps have stayed.

8.10 Now that the Partnership Scheme had ended, the system needed to see what could be done locally about the offer to GPs. There was a possibility of stakeholders being brought together just for one or two meetings, to draw on some themes and suggestions, so that the ICB could be approached for funding, enabling an agreed offer to support GP partners within Gloucestershire.

8.11 CG recognised all the work that Primary Care had done and reflected that a change in future Government may have implications for how dentistry could be commissioned. The statistics being reported through to the ICB were the ones that were nationally required with national definitions attached to them.

8.12 CG said that in the short term it could be pointed out that local reporting did not reflect national reporting and thus enable Board members to understand this. CL said that there needed to be clarity as to why the ICB were reporting in the way that they did, and why there were differences, with short, medium and longer term plans for the future. **Action: HG will send a formal email to ensure that what is being presented at ICB level is accurate around workforce.** **HG**

Meeting Outcome: The Committee noted the information presented in the Primary Care workforce update.

9. Highlight Report

9.1 JG spoke about the PCN Capacity and Access Improvement Plans which were due for submission to NHSE by 30th June 2023. Seven Plans had been submitted by close of

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play on 31st May for initial review by the ICB. . Further Guidance was still awaited around the Community Pharmacist Consultation Service which would be launched by the end of 2023.

9.2 DM gave a brief update on Pharmacy, Optometry and Dentistry (POD). A lot of work was being done on this by Primary Care and by other teams and any issues being experienced are also being felt across the whole of the SW, where collaborative work was being undertaken to address and solve those issues. Work is still in transition with contractors still engaging with NHSE and continuing to embed processes within the ICB. Further information would be available at the next PC&DC.

9.3 HG said DM continues to work with colleagues on this in various meetings. Expectations had been made clear to NHSE and a meeting yesterday confirmed that the ICB would be receiving what it required. Finances were still in the process of being clarified as well as the Risk Register and quality input. The focus was on dental strategy, in particular access, and the Pharmacy Strategy Group was set to meet on 5th June 2023. CG was concerned about Pharmacy with service delivery being at odds with pharmacists leaving and looked forward to seeing further work in this area.

9.4 AS queried the GP appointment data (which JG confirmed was national data). He thought Gloucestershire offered a higher number of GP appointments pro rata compared to other ICBs, and had also recovered much quicker following the pandemic. It would have been helpful if this information were to have been communicated by NHSE.

9.5 BP spoke about management of complaints around POD and informed the Committee that the team, who were previously worried about this, were close to having something signed off in terms of how this would operate from 1st July 2023. The new arrangements would be much improved around any complaints. CG, asked whether the PALS team were recruiting, and was informed that this was not currently the case as a process around administration and commissioning was underway. A further update would be forthcoming.

Meeting Outcome: The Committee noted the Primary Care Highlight Report.

10. Performance Report

10.1 **Investment and Impact Funding** - Nationally IIF has been updated for 2023/2024 and had been reduced to 5 indicators. An updated PCN dashboard was in development and would be shared with PCNs monthly to help them monitor their progress against each of the indicators. Individual PCN progress against the 2022/2023 IIF Indicators would be included in a future Performance report when data becomes available.

10.2 **Severe Mental Illness Physical Health Checks** - The national aim for SMI physical health checks for 2023/2024 remains at 60%, and the local PCN DES & IIF dashboard captures performance updates at practice and PCN level monthly.

10.3 **General Practice Appointment Data** – The national data available at the time of this report related to March 2023. Data from NHS Digital showed the number of appointments in Gloucestershire increased to 395,686.

10.4 HG said that Gloucestershire are offering approximately 10% more appointments than the national average, but the charts in the report did not reflect this to the public. HG said it was important: to maintain good access for patients, and practices not to send patients routinely to NHS 111. It was important that good access was maintained and a revolving door into other services was not created, which would be unhelpful.

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10.5 HG suggested a further conversation with herself, CL and MAE as to how the Performance report data could be addressed to demonstrate the reality and to overcome the discrepancies. CG said this would need to be in the private domain and if done at PCN level, this would be slightly removed from individual practices.

10.6 BP informed the Committee that the national results of the GP Patient Survey would be available in July 2023 and this would be reported on at the next PC&DC meeting. It was likely that the results for Patient Satisfaction would dip not only in Gloucestershire but nationally. Some detailed analysis would be carried out to see what was behind this and work also will be carried out with Patient Participation Groups. **Action: GP Patient Survey results to be brought to the meeting in August 2023.** **BP**

10.7 DM spoke about the data for Pharmacy, Optometry and Dentistry (POD) for which a monthly pack was produced by NHSE which was Gloucestershire specific. A workstream for this was being actioned and more information would be available at the next Committee meeting. **Action: DM to bring more specific data on POD to the next Committee meeting.** **DM**

Meeting Outcome: The Committee noted the Primary Care Performance Reports.

11. <u>Primary Care Quality Report</u>

11.1 MAE introduced the Primary Care Quality Report which had been circulated prior to the meeting.

11.2 MAE reported on the Joint Targeted Area Inspection (JTI) on Safeguarding. The inspection would be undertaken by Ofsted, CQC, GPs, the Inspectorate of Constabularies, Children’s Services and the GICB. Work continued with the CQC around the provision of data and information.

11.3 MAE explained that the intention was to limit the involvement of the GPs and information from five cases would be examined. Primary Care had been alerted that an inspection was forthcoming and the specialist nurse in the Safeguarding team would contact those practices concerned with the cases. Help and support would be offered throughout the process to all staff involved.

11.4 MAE confirmed that it was unlike a CQC inspection as there would be neither a rating nor a report. A recommendation letter instead, would be sent to those concerned. This would be a public document with accountability around the content of the letter. This inspection did involve a great deal of work from many staff and the inspection team would be in the area for three weeks.

11.5 Julie Zatman-Symonds (JZS) was pleased to report that boarding at Gloucestershire Health and Care (GHC) had now completely ceased and there is ongoing work around the Newton mobilisation and flow which it anticipated would yield significant results.

11.6 JZS informed that she had been meeting regularly with the CQC and PPG colleagues regarding the recent action plan from the re-inspection. The CQC were still concerned about staffing at weekends, as well as Out of Hours in the week and how workforce reports were coming through. JZS intended to conduct a weekend visit to the team.

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11.7 JZS said the NHS 111 call abandonment rate had increased significantly but that no harm had been reported. She was unsure as to how this assumption had been concluded and the process around this, so would work alongside colleagues to look at issues that do present, as a result of abandoned calls and how that triage was being set up.

11.8 JZS informed the Committee that there had been a recent SW Practice Nurse Conference and Award ceremony in Exeter and two GICB nurses had been nominated for an award, one of whom was Sarah Rogers, whose input had been very impressive.

11.9 JZS thought it important to mention that new nurse partners in county, from1st August 2023, would hopefully enhance career progression and aid retention going forward.

11.10 JZS noted that it was hoped to give better access to dental services to residents in care homes and a senior nurse was currently working with DM to examine this area.

11.11 JZS informed that a fifth hotel for asylum seekers had opened in Cheltenham. All health checks had now been completed for the 68 people, who were predominantly single males. Most were previously registered with a GP practice in Devon and re-screening took place to identify any areas where the ICB might need to work alongside Public Health. There were some presentations of mental health issues which might need further support.

11.12 JZS said that GHFT were reporting a rise in C-Difficile numbers but this was not due to an outbreak. This may affect community discharges and Primary Care colleagues had been made aware.

11.13 BP spoke about recruitment for the People's Panel. This had involved recruiting members of the public across the county in order to ask for their experiences and to help test things out. Currently numbers are at around 684. The demographic and age spread was also very good with care givers amongst the numbers which would give perspectives from both patients and those who care for them. It was hoped to get a message out to these people regarding the NHS's 75th birthday on 5th July and then surveying would commence. The Health and Care Partnership will find this group very useful.

11.14 CG informed Mr Mummery that two new nurse partners would be practising from Drybrook Surgery and thought he would be interested. Mr Mummery thanked CG for this information.

11.15 CG expressed concern around one of the asylum seekers having been on a hunger strike but was informed by JZS that the person concerned had received treatment, was back to full health and had been moved, as requested, away from Gloucestershire.

Meeting Outcome: The committee noted the Primary Care Quality Report.

12. Financial Report

12.1 CL gave a verbal update of the financial position as at the end of March 2023. The ICB's delegated primary care co-commissioning budgets showed an end of year position of £148k overspent, this was made up of several overspends (Global Sum budgets, prescribing and Other GP services) which have been offset by a number of underspends. The recurrent implications within the financial position had been built into the 2023/24 budgets.

12.2 Some of the underspends were likely to be non-recurrent so there was an overarching pressure to move forward from the 2022/23 financial position.

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12.3 There was a £431k overspend on the global sum. This expenditure was driven by changes in the population which then increased contractual payments, as contracts were based on a weighted capitation formula. Work was ongoing to refresh 2023/24 budgets in line with published guidance on population demographics.

Meeting Outcome: The Committee noted the verbal financial update.

13. ICS Transformation Programme & ILPs Highlight Report

13.1 HE highlighted some key areas from the report. There had been successful delivery of the Community Investment Fund schemes across six localities; this was the non-recurrent £300k allocated by the SW region in the autumn – this funding had been fully allocated and spent. The GICB had been highlighted across the SW as a system that had suitable structures and mechanisms in place to flow funding such as this, quickly and appropriately.

13.2 HE informed that a report had been written which summarised the use of the funding along with the challenges and learning from this. Please find the link to the video attached below. It had been very pleasing to hear from local people and organisations about the positive impact that the funding had delivered across the county.

https://youtu.be/9K8FwU-wtV8

13.3 HE said that sharing work at PCN and locality level and more broadly across the county and other systems, involved a visit from Matt Nelligan, Director of System Transformation at NHSE. Presentations showcasing ILPs and ILP priorities were also planned for the Countywide Patient Participation Group, South West Region Place Leads, and Active Gloucestershire in the coming weeks.

13.4 HE informed that collaboration with colleagues from Milton Keynes had taken place that week which presented an opportunity to learn from another system. OA was planning the PCN Away Day where there would be an opportunity to share some of the work at PCN level and explain the use of the Quality Improvement funding.

13.5 HE highlighted the Community Health & Wellbeing Hubs for which plans continue. There would be two in Gloucester, one in Cheltenham and one in the Forest of Dean. It was a requirement to have the capability to undertake vaccination. If funding allowed, additional hub sites would be considered.

13.6 HE spoke about the work being done in Stroud which coincided with Carers Week on 5th June 2023. All the practices across Stroud and Berkeley Vale would send text messages to their patients asking them if they were carers (the wording would be very sensitive) and should people respond positively, there will be a way to automatically code the patient record in SystmOne with all 17 practices using one consistent code to log the respondents. Those identifying as carers would be offered additional support and information and there will be local media coverage in the Stroud area.

13.7 CAM said that the presentation that had been taken to the Partnership this week had been enthusiastically received, certainly from the voluntary sector, who were excited about the broad range of things demonstrated. The Discovery Group discussed ideas and innovations which CAM had been part of afterwards. Not only had the presentations been of high quality, but the resonance in the room was significant and CAM extended thanks to HE and her team for organising such a superb event.

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13.8 CG congratulated HE and colleagues on their work, saying that the film showing the benefits of the money received by individuals and organisations had been very heart-warming and said he looked forward to more to come in the future.

13.9 CL noted that the quantitative benefits needed to be clearly demonstrated in order for the GICB to make a case for future investments. Some would be longer term investments and some, although having been trialled, would not be so successful. Prioritisation work was under way and CL just wanted to point this out so PC&DC were sighted on this.

13.10 CL spoke about qualitative outcomes and how data needed to be better aligned for projects along with the process. Clarity about the metrics would also be important. CL said that the Finance team were speaking to the BI team around qualitative metrics and it would be ideal to bring all the information together in this way.

13.11 HG said it was about the quality of life that individuals had and that it was, for example, difficult to measure the outcome of people not being lonely and not being restricted in terms of opportunities. HG said a review of the Tewkesbury model would be useful to see what it would look like for Cheltenham where there was a higher number of people with frailty. It would also be a bigger area to evaluate.

13.12 CG said that the methodology was more interesting and that clinicians in secondary care would be able to capture their data more easily. CG said that all that was needed was a consistent methodology which demonstrated differences having been made, which if achievable, would result in a very worthwhile investment.

13.13 HE extended reassurance to the Committee in saying that a number of Primary Care colleagues were meeting with Project Management Office (PMO) colleagues next week, particularly around the evaluation of strengthening the local communities grant and something similar would also be done with the Quality Improvement funding.

Meeting Outcome: The Committee noted the ICS Transformation Programme & ILPs Highlight Report.

14. AOB

14.1 AJ wanted to commend the ongoing work to maintain the Primary Care performance activity. AJ explained that other parts of the country were really struggling with appointments, and she commended the team for being able to hold the line in troubling times. AJ also said that regarding complaints moving from NHSE to the ICB, the careful communication of this to patients needed to be borne in mind. AJ was excited to be part of this and to hear all the valuable comments today.

14.2 CG invited Mr. Mummery, member of the public to add any comments. Mr. Mummery extended thanks to the Committee for allowing him to attend, saying that he had enjoyed the meeting, and had been impressed by the presentations and use of data, finding this both pleasing and interesting. Mr Mummery said that he thought the quality of the meeting had been first class.

14.3 CG said that as part of the Standing Orders, the Committee may resolve to exclude the public from a meeting, or part of a meeting, where it might be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the Resolution, and arising from the nature of that business of the proceedings, or for any other reason permitted by the Public Bodies Admission to Meetings Act 1960 as amended or exceeded from time to time.

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14.4 CG said the Committee would be looking very closely at what could be put into Part 1 of the PC&DC meeting and by the very nature, Part 2 was designed because of the confidential nature of the providers being dealt with. CG hoped that provided assurance going forward.

14.5 Mr. Mummery said he thought that an Agenda to Part 2 of the meeting should be made available so that the public were able to see the title of what was discussed and it was very clear to him in the Constitution, the Terms of Reference, Standards of Business Conduct, and the Nolan Principles embedded in the Constitution, that a resolution was needed to explain this, and that the Resolution needed to satisfy certain criteria.

14.6 CG said that he would look at the possibility of allowing the Agenda of Part 2 of the PC&DC meeting to be allowed to go into the public domain. CG said that he would be taking further advice on this aspect.

The meeting closed at 15.30.

Minutes Approved by: PC&DC Committee Signed (Chair): Colin Greaves Date: Thursday 3rd August 2023

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NHS Gloucestershire System Quality Committee

Wednesday 12th April 2023, 14.00 – 17.15

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

Members Present:		
Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Dr Marion Andrews-Evans	MAE	Chief Nursing Officer, GICB
Suzie Cro	SC	Programme Director - Nursing and Midwifery Excellence, GHFT
Sarah Morton	SM	Chief AHP Professional Lead for Gloucestershire ICS
John Trevains	JT	Director of Nursing, Therapies and Quality, GHC
In attendance:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning Team
Alison Moon	AM	Non-Executive Director and Chair of Quality Committee, GHFT
Anneka Taylor	AT	Commissioning Manager, Elective Care, GICB
Christina Gradowski	CGi	Associate Director of Corporate Affairs, GICB
Cheryl Hampson	CH	Head of Quality & Performance, Adult Social Care, GCC
Dawn Collinson	DC	Governance Administrator, GICB
Emily White	EW	Director of Quality, Performance & Strategy, Adult Social Care, GCC
Helen Ballinger	HB	Clinical Commissioning Manager, Integrated Care Team, GICB
Jane Haros	JH	Senior Clinical Commissioner, Integrated Care Team, GICB
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Melanie Munday	MM	Associate Director of Integrated Safeguarding, GICB
Ryan Brunsdon	RB	Board Secretary, GICB
Robert Mauler	RM	Assistant Director, Quality Development and Patient Safety, GICB
Sam O'Malley	SOM	Safeguarding Adults Lead Nurse, GICB
Trudi Pigott	TP	Deputy Clinical Quality Director, GICB

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1 Apologies for Absence

1.1 JCu welcomed members to this System Quality Committee meeting.

2 Apologies

2.1 Apologies were noted from Andy Seymour, Matt Holdaway, Julie Zatman-Symonds, and Sarah Scott.

2.2 It was confirmed that the meeting was quorate.

3 Declarations of Interest

3.1 JCu declared an interest in her Department of Health and Social Care role.

4 Minutes Of the Last Meeting held on 16th February 2023

4.1 The minutes of the previous meeting, subject to small typing errors, were deemed to accurately reflect the meeting held and were approved by the Committee members.

5 Matters Arising and Action Log

JCu said that verbal updates could be obtained regarding the open actions from previous meetings and decisions made as to whether they should be closed throughout this meeting. JCu requested that the Action Log be circulated a fortnight before each meeting to that actions can be completed.

Post Meeting note – The Action Log was reviewed following the meeting due to not being fully discussed during the System Quality Committee.

5.1 **18/08/2022, 7.16 – Recruitment figures for Children in Care Team.** MAE updated that 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. **Action: MAE to update at the June meeting around the mitigating actions being taken in order to try to address recruitment issues around Children in Care.** **MAE**

5.2 **20/10/2022, 8.1** – Self Harm in schools. **Action: JT to bring an update on self-harm in schools to a future meeting.** **JT**

5.3 **20/10/2022, 9.2 – Updating ToR for System Quality Committee. Action: CGi to consult with JCu and Colin Greaves on updating the ToR before taking them back to the ICB Board for approval.** **CGi**

5.4 **14/12/2022, 8.4 –** Not discussed.

5.5 **14/12/2022, 6.3 –** Not discussed.

5.6 **14/12/2022, 8.8 –** Not discussed.

5.7 **Confidential 14/12/23,1.4** – Not discussed

5.8 **16/02/2023, 6.2.3 – Safeguarding Adults Policy**

This was discussed in Agenda Item 10. **Action Closed.**

5.9 **16/02/2023, 6.2.3 – Safeguarding Adults Policy**

This was discussed in Agenda Item 10. **Action Closed.**

5.10 **16/02/2023, 10.6 - Out of Hours Update** – Not discussed.

5.11 **16/02/2023,11.9 - Social Care Quality Update** – Not discussed.

5.12 **16/02/2023,14.8 - Delays in Community** – Not discussed.

5.13 **12/04/2023, 5.13 -** New Action: Primary Care quality and metrics was raised with an action to bring this back to the next meeting and discuss a forward plan. **TBC**

5.14 Dame Gill Moran, JCu, MH, and Mark Golledge had recently met with Dr. Ananthakrishnan Raghuram, Consultant Respiratory Physician and Associate Medical Director at Gloucestershire Hospitals Foundation Trust (GHFT), who had expressed taking a different system approach to risk. Dr. Raghuram wanted to actively identify pre-emptive actions which could be taken in the event of pressure escalation around clinical pathways and clinical care.

5.15 Dame Gill Morgan had requested that this topic be brought to this meeting for a discussion with any subsequent decisions to come to this Committee for sign off. JCu suggested increasing the number of medical colleagues for any future meetings, especially if they were around clinical pathways.

5.16 Dr. Raghuram introduced himself and explained that he was enthusiastic about trying to bring about clinically based mitigations for managing patient pathways. He said that there were so many crises for which every system was desperately trying to find solutions, and there were already a series of actions that every organisation took to mitigate against escalations, particularly at Operational Pressures Escalation Levels (OPEL).

5.17 Dr Raghuram said that it was necessary to ensure that patient pathways were running as efficiently as they could be, to keep patients safe, with the minimum resources. Dr. Raghuram said that it would be good to agree the management mitigations in an OPEL 4 situation in order to keep patients safe at home. Ideally a plan could be agreed prior to any crisis occurring. The agreed plan could then be given to the clinicians involved, to enact. What was considered good practice could be further improved as a result of future learning.

5.18 JT thought that having a 'break the glass' plan was always a good idea but these plans were often reliant upon one or two very experienced people knowing when to initiate them and were also dependent upon having sufficient workforce in place in order to facilitate implementation.

5.19 Dr. Raghuram's challenge to the GICB was not only to have those plans as documents but to implement a living way of working which meant having the expertise behind the plans and to encourage the patients and staff to believe in and embrace the system. Dr. Raghuram wanted the pockets of very good practice in Gloucestershire to become the norm and have a few pathways evaluated before next winter. Some enablers may be to examine how the system worked across pathways in terms of workforce. Advance testing could be conducted to enable and support this clinical programme approach but there were definite opportunities here.

5.20 AM said there was a need to target support out in the community and this could be directed around population health planning and what the population health data was informing us, to make best use of the workforce. AM had recently seen some cancer work which was taking account of the postcodes and what the data from the population of those areas had revealed. Working along those lines could be potentially very useful. JCu agreed and said that population health data would feature in the next Board Development session.

5.21 MAE said that it would be helpful to examine current data and there was potentially some mapping work which could be conducted. Some mitigation work was already in hand and MAE was keen to implement plans to prevent the system going through various crises. Having

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something in place that covered system-wide risks and issues was needed but would need to be quantified and managed. Looking at where the risks were greatest and where the biggest impact could be made, would be a good starting point.

5.22 JSo asked whether the Transformation programme was doing any work here and MAE responded that their remit was around longer term planning and not crisis management. MAE thought the Urgent Care Clinical Programme Group would know more about mitigation building and may also be able to support some of the work going forward.

5.23 ***<u>Meeting Outcome</u>: The Committee members agreed to support Dr. Raghuram with his work on system approach to risk around clinical pathways and clinical care, via various Clinical Programme Groups, Executives and colleagues across the system.***

6 <u>Primary Care Quality Report</u>

6.1 JCu said that this report contained items other than those around primary care and she felt it would be better for all system partners to have an equal contribution into this report around quality and risk management. MAE said that an ICB Quality Report would come to the next meeting and would cover areas of ICB responsibility. The Primary Care Quality Report would, however, remain the same, and thus could result in some areas of duplication.

6.2 AM mentioned the opportunities for Pharmacy, Optometry and Dentistry (POD) where through transformation of some of those services, appointments would be released, enabling colleagues to assist in other areas.

6.3 JSo spoke about the Key Issues and Assurance Report from the Quality and Performance Committee at GHFT which went to their Board, revealed any key concerns and examined the risk ratings in terms of the actions and outcomes. JSo felt this was at the right level but was unsure whether GHC did anything similar to that of GHFT in terms of reporting. JT explained the robust reporting system that GHC used, which also incorporated information from a monthly dashboard. It was felt overall that this Committee should be focusing on priority areas of risk.

6.4 JM suggested that a workshop be organised, in order to bring focus on system quality strategy and priorities, potentially using one of the SQC meetings. It was felt it would be good to focus on:- **TCB**

- Exploring the reporting of other ICBs at their Committees enabling production of a truly integrated report.
- Demonstrating how the ICS was developing against four or five of its quality priorities.

6.5 AH highlighted some of the main areas in the Primary Care Quality Report:-

- Covid vaccine update – intention to vaccinate the over 75's by the end of May, this could however lapse depending upon the availability of the vaccine.
- PPG Update – JZ-S had attended all the necessary meetings with the CQC who are planning to do a warning notice follow up on 19th April. The ICB had also given PPG notice that they would be going out to tender with a contract change in the summer.
- Delay Related Harm – a small group of GPs with an interest were working on this, but data was proving hard to gather. JZ-S will provide regular updates.
- FoD Surgery – all issues were going through PC&DC who were fully briefed and both patients and staff continued to be fully supported.
- Migrant Update – the Home Office had yet to decide whether the Regency Halls (student accommodation) in central Cheltenham would be used as contingency accommodation

or widening dispersal accommodation. Another proposed hotel was deemed unsuitable and had been withdrawn.

- Many of the South West ICBs had attended a recent event in Taunton regarding Podiatry, Optometry and Dentistry (POD) for which feedback is awaited. 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.

6.6 AM raised Newton Europe's work and asked whether this would give any Key Performance Indicators (KPIs) and improvements or trajectories. JCu explained that this Committee tended to examine performance issues and much of Newton's outcome information was based on potential financial savings relating to saved bed days. MAE said that JZ-S had met with Newton and was collaborating with them on patient outcome measures, so that information would be brought to this Committee. Gloucestershire was the first area who had requested this kind of information. JCu said that delay related harm and a reduction in boarding were two immediate areas which came to mind. **Action: MAE to speak to ER around which parts of Newton Europe's work on quality outcomes could be reported to this Committee in future.** **MAE**

6.7 JSo spoke about CQCs undertaking reviews of ICBs going forward but was unsure as to the format these would take. MAE said this would be quite broad and a Board Development session would be a useful place to talk about the new inspection regimes, part of which will encompass quality and JCu would expect that to come to this Committee. CQCs will also be inspecting local government departments and social care, which may or may not be part of a system-wide inspection. **Action: MAE to send any documentation on CQC ICB inspections to CGi to aid future agenda setting for ICB Board Development sessions.** **MAE /CGi**

6.8 ***<u>Meeting Outcome</u>: The Committee members noted the contents of the Primary Care Quality Report.***

7 System Assurance Report

7.1 **<u>GHFT</u>**

SC said that GHFT were in day 2 of industrial action and were in a Planned Business Continuity Incident (PBCI) with the Control Room to support the management of the services, which had worked well last time to address issues contemporaneously. Flow remained challenging and a Quality Summit had to be postponed at the request from clinical teams.

The number of boarded patients had been slowly reducing from December and were down to 15 in February. Staff were keen and had made it very clear, that they wanted boarding to stop as this affected the privacy and dignity of the patients and the movement between hospital wards for the staff.

CQC – No new inspections had taken place but CQC had been to B. Braun Avitum UK Ltd. with their Section 29A and feedback is awaited. A number of estates issues had been raised which had since been put in place and GHFT continue to work to ensure that B. Braun are placed within suitable environments.

CQC are expected back in about a year's time and GHFT were monitoring surgery and action plans and conducting mock CQC inspections to test out that what had been communicated on paper, was actually being addressed.

Staff Survey results – the Quality Delivery Group had been checking the scores, looking at which of those had impacted quality and how GHFT could make improvements.

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7.2 Some moderate harm events and complaints had occurred around boarding. The Board needed to know what the plan for the system was, in order to bring to fruition a realistic exit from this practice. Deborah Lee and Deborah Evans had committed to raising this again as a system request. There needed to be a combined approach to managing the system differently on this issue.

7.3 JM spoke about the Staff Survey results and said that quality of care was about Gloucestershire's staff and colleagues. GHC had started to use heat maps which revealed where the hot-spots were. JM asked if there was anything similar that would help to triangulate the quality with the staff survey. SC said GHFT did not have heat maps but discussions had taken place around how the connection between wards having a high poor staff experience, had other problems such as pressure ulcers and falls. CGi explained that the way the system was set up for Staff Survey reporting was dependent upon how staffing lists had been configured and if set up properly, enabled the data to be examined at a much deeper level.

7.4 JCu spoke about delayed discharges in the system and said she would be happy to share the approach being taken around some of the worst performing organisations and systems across the country to help our system decrease the numbers. The system could choose then whether it would like to carry out its own self-assessment and checking to understand where the delays were. JCu had already offered help to Deborah Lee and Deborah Evans. MAE spoke about the difficulties around housing for patents and putting together packages of care for them before they left hospital. MAE invited JCu to attend a meeting that she chairs every Thursday morning which would give an overview of these types of issues discussed.

7.5 JT referred to AM's comments about boarding which were tied up in the Newton Plan and the timescales around that. It would be a good idea to have some insight around what the priorities and drivers were for this. JCu thought the Newton work was fairly medium to long term and it would not realise many benefits very quickly. Newton was about sustainable transformation and change and would be embedded and be continued. **Action: JCu will speak to ER as to how delays could be mitigated in the shorter term around discharges whilst the Newton work continues.** **JCu**

7.6 **<u>GHC Quality Dashboard</u>**
JT said that Willow Ward and Mulberry wards had done well at Charlton Lane over the past few months so was a good measure of the CQC plans. Rapid tranquilisation from a patient safety perspective was a difficult area in which to get 100% consistency of zero variation, but this was being managed internally. Inconsistency remains around the availability of agency clinical staff.

JT said that moderate harms were on a slowly increasing trajectory. The analysis so far was showing this was being driven by pressure ulcer issues and GHC were examining some inconsistencies here. The four Patient Safety areas were falls, self-harm, pressure ulcers and medication errors. Further development work is under way to examine this. Work at a patient care level around self-harm was looking at the reduction of head-banging, which involved small numbers, but was an area of high risk.

JT spoke about the Edenfield Unit scandal which triggered national work from the Centre about quality in mental health and safety about institutionalised abuse. A regular slide is produced for the Board on what was being done in that space to reduce the risk of closed culture abuse. The breakaway and de-escalation compliance in some of the riskier areas needed to be improved.

7.7 MAE said that she and JT had been looking at the quality and improvement work using the Quality, Service Improvement and Redesign (QSIR) toolkit. Some areas seemed to be disengaged from the system quality agenda and it would be good to ensure that these were tied together. JT said that GHC were lobbying for support in Patient Safety technology for community and mental healthcare settings where there was a lack of a national programme. Technological

solutions could often help in areas of staff shortages but were expensive. Any lobbying power from this Committee would be welcomed. **Action: System Quality Committee to identify some key priority areas which need either Regional or National support in order to resolve them.** **TBC**

7.8 JCu spoke about doing deep dives on delay related harm in community hospitals on Eating Disorders in mental health especially in children and the impact this had as a system around access to treatment whilst taking up beds that were not really right for them. It would be good to address these areas as a system rather than as individual organisations. **Action: JCu and JT to identify priority areas where deep dives could be conducted from a system quality assurance aspect.** **JCu/JT**

7.9 ***Meeting Outcome:* The Committee members noted the System Assurance Report.**

8 Social Care Quality Update

8.1 Actions

EW said that following the last Committee meeting the safeguarding team had been asked to take the following actions:

To ensure that Adult Safeguarding could fit into other quality areas – this was being examined but due to the way Adult Safeguarding system was set up, this could take more time.

To provide data around Delay Related Harm in Discharge to Assess (D2A) beds. There was no data but EW gave an assurance update. There were issues around the D2A communication therapy provision service delivery issues leading to potential risk to harm. The project will undertake further analysis into the wider work around flow into the D2A Action Plan. The Director of Operations is to pick this work up and this will result in a much more clearly defined project. **Action: EW to give an update on Delay Related Harm in Discharge to Assess (D2A) beds at the next meeting.** **EW**

8.2 EW said there were three care homes (two for older people and one for younger adults) which examined from safeguarding concerns, some of which were triggered through CQC action and some through awareness of social care safeguarding issues. Two of the three care homes were under embargo meaning that new care packages were not being placed there. Four domiciliary care agencies were also under a similar embargo and this was due to a mixture of quality concerns. Clearly these issues affected capacity.

EW will bring future reports to the System Quality Committee which will mirror a lot of the detail received from other system partners.

8.3 EW spoke about the Social Care Quality Strategy and welcomed the discussion around priorities and conducting a workshop of which Social Care would be a big part. There were many ways in which quality was understood in Adult Social Care in the Council but there needed to be a robust way of collating this in a suitable and meaningful way for this Committee and to demonstrate and implement other quality assurance processes.

EW introduced Cheryl Hampson who was the new Head of Quality and Performance who is conducting an 'as is' Review of Quality in Adult Social Care in Gloucestershire to bring in more consistency in description around this. The Review will give information on what is known now and will reveal gaps and unknowns leading to the development of the Adult Social Care Quality Assurance and Management approach which will enable a much more comprehensive line of reporting which will feed into the various system committees. EW said this Review was not being done in isolation but involved other ICB colleagues in its development. **Action: EW to bring a**

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comprehensive update on the Review being conducted for Adult Social Care in Gloucestershire to the next meeting. **EW**

8.4 CQC Assurance - EW said that Adult Social Care were preparing the first draft of their self-assessment which wanted to highlight the impact that they had made and bring out the voices of staff and those with lived experiences more strongly as well as addressing the data issues. An Engagement Plan has been brought together with various engagement events being undertaken and EW is working with key colleagues to ensure that the Adult Social Care presented in the self-assessment is the one recognised by system partners.

The CQC had now published the framework which mirrored that of the local authority. The assurance programme that the CQC will run will be in tandem with the local authority and will influence what happens in the ICB and vice versa, so the planning will be collaborative. **Action: Rob England (Children's Social Care) to be invited to the next Committee meeting in relation to GCC running their assurance programme in tandem with the CQC.** **TBC**

<u>Meeting Outcome</u>: The Committee members noted the Social Care Quality update.

9 Maternity Assurance - Gloucestershire Hospitals NHS Foundation Trust (GHFT)

9.1 SC stated that the Perinatal Quality Surveillance reporting needed to reflect the work of the Safety Champions who will be involved in the report in the next quarter, as having attended a recent meeting, feedback was that this had worked very well.

9.2 Staffing remains on the Risk Register with vacancies fluctuating between 15 and 24. Work continues around attraction, recruitment and retention to ensure that midwives can be retained by conducting 'stay interviews.' Other vacancies in maternity had however been filled.

9.3 There were three areas that still required attention around the induction of labour delays. The data is easier to understand now and one of the consultant obstetricians will present this at a future meeting. The Ockendon Action Plan had closed but a new National Maternity Delivery Plan had arrived. It was hoped that a soon CQC inspection would result in Maternity being able to come out of their Inadequate rating. A new Maternity Improvement advisor was working in maternity on the improvements that could be made.

10 Policies for Approval, including Effective Clinical Commissioning Policies

10.1 <u>Joint Working within Pharma Industry Policy</u>

10.1.1 CGi said this policy had been updated. Key changes were:

- Any rebates and the joint working arrangements to be reported to the Quality Committee and to the Audit Committee at least twice a year.
- The key principles in the policy must be adhered to when engaging with the pharmaceutical industry as well as the Standards of Business Conduct.
- Any Conflicts of Interest must be discussed with CGi and Adele Jones, Chief Pharmacist.
- Any hospitality gifts should be uploaded onto The Association of British Industry (ABPI) website. This is reportable to both the auditors and the Audit Committee and ensures that monitoring and reporting are tightened.

JCu said that the policy was only recommended for GPs and CGi explained that the Conflicts of Interest Guidance 2017 which did include GPs had been abolished. It was recommended that if there was a training event and the GICB presented some of the training materials, then disclosure statements should be written to state that the ICB were not there to promote or endorse the products of any pharmaceutical company; however they could provide a lunch.

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JCu referred to Section 6 and asked whether the policy had been reviewed and ratified by the ICB Chief Medical Officer and the ICB Operational Executive Committee. CGi said it still has to go to a few more Committees and groups within pharmacy, but it was here at this Committee that the approval process was conducted. Andy Seymour and Adele Jones had already seen this policy and agreed it and CGi had discussed it with the GICB auditors.

JM asked why it had come to this particular Committee and CGi said it was because concerned quality as opposed to investment and financial issues. MAE said that the Committee were working with the pharmaceutical industry to improve patient care and outcomes, and this was why it was thought prudent to present the policy at this meeting for approval.

***Meeting Outcome**: The Committee members approved the Joint Working within Pharma Industry Policy.*

10.2 Serious Incident Policy

10.2.1 RM said that these two policies were being brought so that the Committee could approve them having, been transferred from the CCG into the ICB. They were still representative of everything previously done under the Serious Incident Framework of 2015. Going forward there were a number of things that could be addressed differently but today the request was to implement a six-month rollover for these policies from a governance point of view in the interim period between these policies and the new Serious Incident Framework coming into being.

JSo raised 6.6 where this referred to an Integrated Governance and Quality Committee – to be amended. JSo queried the wording around the activities commissioned by the GICB. On page 5 of the policy. After much discussion it was agreed to change the wording to reflect more accurately the points the policy wished to put across. In six months' time there would in any event be a whole new Serious Incident Framework. RM said that NHSE guidance was still awaited around Primary Care for POD and it would be an iterative process around policies during the coming months.

Meeting Outcome: The Committee members approved the policies subject to the wording being accurately reflective of the policies and for the policies to be reviewed in six months' time.

10.3 Adult Safeguarding Policy

10.3.1 MAE said that there had been comments about this Policy at the last meeting which MM and SOM had amended and added to:-

- MM said that a section written by SOM, had also been added on Transitional Safeguarding where support could be offered around complex cases, covering children moving into adult services.
- A Quality Impact Assessment (QIA) had also been completed and included.
- Referring to the Domestic Homicide Review (DHR) section where the text referred to 'he.' MM said that a discussion had arisen about using 'he/she' so MM had checked on this and had been advised to adhere to Home Office guidance, leaving the text as it was, but to acknowledge that this needed to be updated. MM had taken a small line from the Domestic Homicide guidance, explaining that when the term 'he' was used it also referred to 'she.'

Alison Moon extended thanks to those involved in the work on this policy, saying that she was happy with it and it had been well written.

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MM said that it was hoped that a future integrated, overarching Safeguarding policy could be written collaboratively with the system to encompass input from all organisations. JCu asked that the voluntary sector also be remembered when constructing this policy.
***Meeting Outcome**: The Committee members approved the Adult Safeguarding Policy.*

10.4 Benign Skin Lesions Policy

10.4.1 This policy had not been taken to the Local Medical Committee and JM thought that if a policy had an impact on general practice it was a good idea to consult with general practice in the broader sense. It was unsure as to how many GPs would be involved in the removal of benign skin lesions. **Action: AT to take Benign Skin Lesions policy back to Richard Thorn for further clarification.** **AT**

***Meeting Outcome**: The policy will be taken back to Richard Thorn by AT for an update to be given to the Committee members via email who can then give their approval.*

10.5 Open and Upright MRI Scans Policy

10.5.1 This policy had been brought to make life easier and quicker for both GPs and their patients. The approach had been changed to allow open referral for these.

***Meeting Outcome**: The Committee members approved the Open and Upright MRI Scans Policy.*

10.6 Continuous Glucose Monitoring Policy

JSo led on this policy as JCu declared an interest here.

***Meeting Outcome**: The Committee members approved the Continuous Glucose Monitoring Policy.*

10.7 Varicose Veins ECCP Policy

10.7.1 AT said that the policy was presented to the Committee last year with revisions to the policy but further clarifications had been requested around the rationale for those changes. These had been provided in the paper by Mr David Cooper with support from Dr. Emma Le Roux, Clinical Lead in Elective Care.

JSo asked when NICE Guidance would be reviewed to reflect national practice. AT said that other areas had ben looked at and very few places met NICE Guidance word for word.

After discussion, and due to the many queries it was decided that AK should take this back to Richard Thorn. **Acton: AT to take the Varicose Vein policy back to Richard Thorn to gain further background information on NICE Guidance, education and training for Primary Care settings and GP and Patient engagement.** **AT**

***Meeting Outcome**: Subject to having sufficient background information, the Committee Members decided that they would be able to approve the Varicose Vein policy via email at a future date. The Committee would have the policy approved at the Clinical Effectiveness Group with a stipulation that it was to be evaluated a year after implementation.*

11 System Quality Risk Register Update

11.1 A list had been made of all the risks assigned to the Quality Committee. 4risk had introduced some software which had been easy to use but had since upgraded their system. RB had spent a great deal of time in attempting to run a report which showed risks of 12 or above which related to the quality risks. This had proven difficult due to being unable to manipulate the system. Realtime Services Manager (RSM) who run the 4risk management system had been asked to provide some training in order that staff could be appraised of the new system.

11.2 RM said he would check as to whether some of the risks around Medicines Optimisation had been done as he was sure they had been. There were also some people named who had left or retired. CGi will check to see whether the current system is still sending reminder emails to risk owners. RM did try to sort out an Excel spreadsheet that hid the risks below 12, but the system is not satisfactory and the main account manager had been contacted around these system concerns.

11.3 JM would like to understand how risks come to be on the Risk Register and also queried as to how system-wide risks would be raised. This could be another aspect to bring to the workshop. CGi said that the same fundamental process was followed as that used by GHC but the reporting was not working due to the system changeover. System-wide risks were put on the Board Assurance Framework (BAF) and then reported to the Board. There were 9 key strategic risks aligned to the ICS system priorities for 2022/23 and now that we are into 2023/24, there was a request to see whether they would be refreshed or whether they would stay the same.

11.4 JSo said that there should be a flow of risks coming in from different places rather than coming in straight to the Board and it should be recognised at any one time that a strategic system risk could begin to come in from the work of other Committees.

11.5 EW thought that risk owners should be checked and where the same risk cropped up within the Integrated Commissioning Team, then the risk owner should be one and the same. A cross check on those would be a good idea. JSo stated that the Board Assurance Framework risks as they are strategic and high level, should stay on the Framework . CGi said that there is still a discussion to be had around whether there should be a Board Assurance Framework for the system and one for the ICB which some systems were proposing. Under this could be a lower set of risks which were seen by the Board which were not 15 and above. This was still in debate.

11.6 JCu suggested:

Action: Risks and reviews of risks are to be placed at the beginning of Agendas for future meetings with any new risks added to the Risk Register at the end of the meetings. Any red risks relating to this Committee should be discussed and those more serious should be escalated to the Board for a public or a private session. **RB/ CGi**

11.7 ***Meeting Outcome*: The Committee noted the System Quality Risk update.**

12 Update on 2023/24 Commissioning for Quality and Innovation (CQUIN) framework

12.1 Not discussed due to time constraints. **Action: Update by TP on 2023/24 CQUINs to be added to the next meeting agenda for discussion.** **RB/ TP**

13. Palliative and End of Life Care Update

13.1 JH and HB presented slides on this topic.

- By 2040 there will be 100,000 more people dying each year in the UK.
- The number of people dying with a palliative care need is projected to increase by up to 42% over this period.

- The number of children with life-limiting and life-threatening conditions will rise from 87,572 in 2017 to 96,275 in 2030.
- This increase in demand is set in the context of workforce challenges. The CQC of highlighted that "workforce shortages are having a direct impact on the quality of people's care. These shortages must be addressed."
- A workforce needs to be in place that supports more people being able to die at home.

13.2 Slide 2 demonstrated the statistics that go out with the End of Life Report which is produced monthly. The data from the PCCAG team and the BI team was different and work continues around consistency of reporting. The figures are quite low currently as data collection only commenced in October 2019. When systems are joined up this will show clearer figures. Work continues with Primary Care on their coding and rolling out of a whiteboard will really help with this.

13.3 There is a Palliative Care Register of 3387 and most of those people had a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Plan in place. This Plan came into being in Gloucestershire in October 2019 and was the main Plan for recording a person's resuscitation status and is also a personalised plan about a person's care, wishes, and where they would like to be cared for during the last stages of their life. The same Plan can be used for those with Long Term Conditions and indeed, anyone can make a ReSPECT Plan.

13.4 Gloucestershire is 6% below the national average of people dying in hospital. There have been increases of deaths in Discharge to Assess (D2A) beds and it is important to understand this. The Palliative End of Life Strategy is an all age Strategy and the Children's and Young People's Services have also adopted the Advance Care Plan and the ReSPECT Plan for Gloucestershire's young people who have multiple learning disabilities and long term illnesses. There are more young people who now have Plans in place.

13.5 JH said that funding from Health Education England is being used to work on a framework to bring in consistency to End of Life, and this framework can be used across all sectors. Eventually a web page (similar to that of Somerset) will be built which anyone can access to help with resources and information and training programmes. The team are looking to improve bereavement services across the county and longer term there will be a wider procurement. Your Circle did a big piece of work with access to all the services which will also eventually go onto the ICB website. Your Circle is a directory to help people find their way around care and support and connect with people, places and activities in Gloucestershire.

13.6 A film is also being developed with two GPs in the county and this will bring forward the subject about having early conversations and this will be brought back to this Committee when it is ready. This piece of work was the result of a pilot which was run around Future Care Clinics which had been very successful. Two films were made with collaboration from Learning Disabilities partners, the National Resuscitation Council, Inclusion Gloucestershire which are now on the National Resuscitation Council's website. The whiteboard has been nominated for a South West Personalised Care award to highlight some of the work that had been done as a team.

13.7 Some people who have cared for those at the end of their lives have fed back into various groups and this had proved invaluable in how the work had evolved to support and care for people. Leaflets had also been printed for carers to support them in how they could care for people at the end of their lives. JH said that all ICBs now have a legal requirement to ensure that there is 24/7 access to palliative care and a lot of work is being done here at the moment. This is being done as an integrated approach with partners which involves listening and learning to enable things to move forward, and to ensure that anything being produced is of good quality. A self-assessment is required and this will be undertaken within the next few weeks.

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13.8 JH said that there needed to be a Rapid Home to Die pathway and one piece of work was started with system partners was to develop a Multi-Disciplinary Team. JH said that this work had resulted in seeing deaths in the Acute Trust drop dramatically. This had been a key part of the work and it had brought people together to understand all their individual roles and responsibilities. This work had however been put on hold as there was some evaluation needed around it. A co-ordinator is also needed for the Multi-Disciplinary Team. The learning so far was that if one part of the system did not participate, the whole pathway collapsed. Stakeholder comments had been very positive and showed that this had been a good piece of work (See slide 8).

13.9 JH spoke about the End of Life Personalised, Proactive Whiteboard (Slide 9) which was evaluated. Work had been conducted with Dr Robin Hollands to ensure that people reaching the end of life had a co-ordinated approach and had plans in place. The feedback from GPs was brilliant and had saved them time and stopped many crises just before the weekends. Some funding has come from NHSE and expressions of interest had gone out around the Co-Ordinator in Primary Care post with eight PCNs coming forward to say that they wanted to collaborate on this work to develop a whiteboard. The project had just been reinstated and Dr Hollands had taken it to the next level, to include not only those people who were dying within the next 6-12 months, but anybody with a long term condition who was likely to deteriorate. This would also work for people on virtual wards.

13.10 JSo asked about the Somerset website and HB said that it was really easy to follow with easy search tick boxes to allow access to information. JH said that our system did not have single point of access for information and this showed a need for a 24/7 hub. Feedback from others had been that ours was a difficult system to navigate.

13.11 There was a question around whether there was any data from ethnic minority groups and whether the ReSPECT form came in different languages. JH said she had taken this back to the National Resuscitation Council because this had been raised. This is due to it being an emergency plan and if it were to be written in a different language, there could be delays about making an emergency decision. There is an understanding of the Plan in different languages for people to understand so that this can be communicated across. There is also an easy read document or those with learning disabilities and information in Arabic and what it means to the individual.

13.12 There was a concern around patients that people who died in Discharge to Assess (D2A) beds were not being identified in hospital before they were discharged. These patients were on the wrong pathway and did not have access to the correct care that was available to them and this was why a gatekeeper was needed for the D2A beds. Several audits had been done and once someone had been placed on a pathway, they stayed on that pathway and the frail and elderly often deteriorated very quickly so this is an area that JH and colleagues will be examined and addressed.

13.13 JH and HB were thanked for all the work done so far on this project, which was much appreciated and the value was recognised.

14 Any Other Business

14.1 There was no other business raised at the meeting.

<u>Date and Time of next meeting:</u> TBC

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NHS Gloucestershire ICB People Committee

Thursday 27th April 2023, 14.00hrs

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

Members Present:		
Clive Lewis	CL	Non-Executive Director (Chair)
Dr Andrew Seymour	AS	Chief Medical Officer, ICB
Deborah Evans	DE	GHFT Chair
Prof. Jane Cummings	JC	Non-Executive Director
Dr Marion Andrews-Evans	MAE	Chief Nursing Officer, ICB
Mary Hutton	MH	Chief Executive Officer, ICB
Neil Savage	NS	Director of HR and OD, GHC
Tracey Cox	TC	Director of People, Culture & Engagement, ICB
Claire Radley	CR	Director for People and OD, GHFT
Participants Present:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, ICB
Josebha Santhini	JS	Senior Workforce Analyst, GHC
Ruth Thomas	RT	Associate Director: OD, Learning and Development, GHC
Sophie Elizabeth-Atkins	SEA	ICS People Programme Manager, GHC
Zack Pandor	ZP	Senior OD and Leadership Consultant, CSU
In Attendance:		
David Cryer	DC	Good Governance Institute
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB
Ryan Brunsdon	RB	Board Secretary, ICB

1. Introduction & Welcome

1.1 CL welcomed members to the People Committee.

2 Apologies for Absence

2.1 Apologies were received from Prof. Sarah Scott.

3 Declarations of Interest

3.1 There were no declarations of interest received.

4 Minutes of the Previous Meeting

4.1 The minutes of the meeting held on Thursday 12th January 2023 were agreed to be an accurate record of the meeting.

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5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **06.10.22, Item 8.17,** Recruitment and Retention Update. To explore the potential for a Gloucestershire-wide recruitment campaign highlighting how the county is a great place to live and work. **Action: Closed.**

5.1.2 **12.01.23, Item 5.10,** Social Care Vacancies. SS, CGi and CH to include social care vacancies on the workforce report. **Action: Closed.**

5.1.3 **12.01.23, Item 6.11,** Exit Data. NS and CH to liaise around including additional exit data in the Integrated Workforce report. **Action: Open.**

5.1.4 **12.01.23, Item 6.11,** GP and Registration Data. CH to split the data between GPs and Registrars. **Action: Open.**

5.1.5 **12.01.23, Item 6.11,** GP Leavers. CH to investigate GP leavers and areas of deprivation. **Action: Open. This action is now being picked up by JS.**

5.2 Matters Arising

5.2.1 NS updated members on developments regarding the industrial action by health workers and he stated that the government was engaged in negotiation with staff. NS explained that Royal College of Nursing (RCN) had accepted the pay rise offered but radiographers had rejected the offer. NS further stated that another major trade union, Unite, was still to respond to the offer.

5.2.2 NS explained that the government was unlikely to revise the pay rise offer proposed. MAE cautioned that major disruptions to health services were expected including significant reductions in other services to enable redeployment of available staff to essential services. NS added mitigations included changes to MIU provision and urging local communities to only access Gloucester A&E or 999 if their condition was life threatening; for any other serious threats to health, people should use 111 and alternative services. NS emphasised that it was important that people follow this essential advice.

6 ICS People Function Summary Report

6.1 TC presented the report and stated that the system at large was experiencing a significant deficiency in critical workforce skills. TC also highlighted that the ICB's Operational Plan aimed at improving workforce recruitment and staff retention. The workforce component of the Operational Plan had been completed and submitted to the regional Health Education England (HEE) team who agreed that the plan was realistic, deliverable and affordable. TC cautioned that there was a risk that the workforce deficit was likely to increase over time based on current and future predicated trends.

6.2 TC presented comparative regional and national data which captured statistics on vacancies for the period covering April 2022 – December 2022. TC highlighted that the

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region was performing slightly better than the national position. TC expressed a need to invest in programmes which promote the equality, diversity and inclusion agenda and workforce programmes should be re-modelled to promote Gloucestershire as a destination of choice for health and care professionals.

6.3 TC stated that the ICB was encouraging its staff to take trustee roles and also emphasised that trusteeship was a powerful way for staff to contribute to the local community and a great way of developing skills and experiences. TC cited promotion of voluntary work in the local system as a platform for further developing routes into employment in heath and care. She added that volunteers could potentially become a valuable pool for local recruitment.

6.4 RESOLUTION: The People Committee noted contents of the ICS People Function summary report.

7. Workforce Intelligence & Programme Highlight Report

7.1 SEA presented the report and stated that the Human Resource teams across the system were collectively invested in efforts to drive forward a workforce strategy. Plans on a Page representing the proposed work plan for 23/24 for each of the 3 Steering Groups: Education and Training, Workforce Development and Organisational Development Steering Group were being taken to the People Board. TC suggested that plans should also be circulated to members for feedback. **Action: SEA to circulate.** **SEA**

7.2 SEA explained that her team was setting up two Working Groups to look at agency costs; one Group would cover temporary staffing issues and look best practice approaches being deployed and the other Group would work on electronic staff rostering. It was expected that such efforts would support a reduction in agency work and its associated costs. SEA also stated that the final Annual Operational Planning was due for submission on 4th May 2023.

7.3 SEA presented statistics on local staff sickness absenteeism rates as follows:

- NHS Staff – 5.7%.
- Adult Social Care – 4.6%.
- Children Services – 2.9%.

SEA also stated that the Nurse vacancy rate was 13.7%, but children social care staff increased by 4.3 wte. SEA re-emphasised a need to focus on joined-up workforce planning.

7.4 SEA cautioned against the risk of ICS partners acting individually and failing to secure, retain and develop the workforce necessary to deliver ICS's strategic objectives. She emphasised that individual organisational challenges impacted the local system's capacity and compromised outcomes of workforce plans. TC stated that a joined-up collaborative approach to workforce planning premised upon comparative performance measured against outside systems aided benchmarking and enhanced the quality of workforce outcomes.

7.5 RESOLUTION: The People Committee noted contents of the Workforce Intelligence & Programme Highlight report.

8. Overview of ICS Staff Survey Results and Action Planning

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8.1 Integrated Care Board (ICB)

8.1.1 TC and CGi presented the outcome of the ICB Staff Survey. TC presented the report and explained that the report covered the outcomes of the 2022 NHS Staff Survey which was based on the following themes:

- compassion and inclusivity;
- recognition and rewarding of staff;
- listening to the voices of staff;
- health and safety issues;
- continuous learning;
- work flexibility;
- sense of belonging.

8.1.2 CGi stated that the transition from a CCG to an ICB was relatively smooth and the ICB performed well in comparison with other ICBs. TC reiterated that Staff Surveys presented an opportunity for organisations to benchmark their performance. TC explained that the ICB identified staff morale, workforce shortages and dissatisfaction with pay levels as areas where the ICB had performed less well. CGi added that other areas that needed further attention included staff burnout and elements of bullying of staff from various cohorts.

8.1.3 CGi clarified that the ICB scored well on most of the elements cited in paragraph 8.1.1. CGi added that the ICB was developing action plans within Directorates to address low performance, or slippage. CGi added that training in managing sickness and combating bullying or harassment formed an important element in the development of essential line management skills. CGi explained that the ICB would also utilise supplementary channels such as Lunch and Learn sessions and other awareness programmes.

8.2 Gloucestershire Heath Care (GHC)

8.2.1 NS presented the GHC Staff Survey outcome and stated that 55% of the staff participated in the Survey. NS added that the target audience for the Survey included bank employees. NS stated that the overall score was good. NS highlighted that 70% of the participants stated that they would recommend GHC as a good employer to work for. NS described the Survey as an instrument for identifying and reversing slippage in directorates.

8.2.2 NS explained that in the case of GHC, the Surveys helped identify:

- a need to address problems such as violence against frontline staff perpetrated by rogue members of the public;
- a need to improve listening skills of the part of line managers;
- a need to address bank staff morale.

8.2.3 NS held the view that the inherent weakness in the Surveys lay in their short life cycles. He stated that when an organisation was in the process of introducing changes in response to a Survey outcome, it would find itself already in the season of another Survey. NS also

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proceeded to emphasise that Survey outcomes added value through feeding into the workforce strategy.

8.3. Gloucestershire Hospitals Foundation Trust (GHFT)

8.3.1 CR presented the outcome of the Survey and explained that bank staff participated in the Survey, and the overall participation rate stood at 50%. CR acknowledged that the outcome of the Survey identified several areas of weakness. CR highlighted that the Board and executive management were candid in accepting the outcome of the staff survey and they were committed to addressing areas of poor performance.

8.3.2 CR emphasised GHFT's appetite for a cultural shift and the need for creating a sense of ownership in the minds of staff through the upgrading of line management skills. Members discussed the problems identified. MAE cautioned and expressed the need to be cognisant of the impact of staff morale on quality outcomes and patient safety. TC reassured members that partners were keen to collectively support GHFT wherever possible in addressing the challenges and problems identified through the Survey. It was noted that a meeting with Regional colleagues was being arranged to identify potential areas of support.

8.4 RESOLUTION: The People Committee noted contents of the Overview of ICS Staff Survey Results and Action Planning report.

9. Draft People Strategy

9.1 TC and ZP presented the report and TC stated that the awaited national NHS Workforce Plan was expected to deliver guidance on long term workforce needs across the health and care sector and this would impact on local planning, future commitments, and funding assumptions. CT explained that the ICB and its partners considered it prudent and beneficial to proceed with local workforce planning rather than suspending planning until publication of pending guidance.

9.2 TC explained that the local people strategy was structured around five key areas namely:

- valuing and looking after local communities;
- recruitment and retention;
- enabling innovation in care delivery;
- education, training and talent nurturing;
- future workforce planning.

9.3 The highlighted strategic planning needs included:

- the need to focus on developing models that promoted rotation of staff within the system.
- a significant focus on retention initiatives
- improving efficacy in workforce integration and placement;
- investing in leadership, development and talent management programmes;

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- paying attention to widening participation, apprentices and other trainee roles;
- embedding inclusion policy at every level of the local system.

9.4 ZP re-emphasised the necessity to embed and create a culture of civility and respect across the system. ZP highlighted the value of collaborative leadership through shared leadership development programmes. ZP stated that utilisation of data to illustrate lived staff experience provided valued information for workforce strategies.

9.5 ZP reiterated a need for a common set of values, standardisation of behaviours and a competency framework across the system. JC concurred and stated that working collectively promoted integration and created an environment conducive to enabling and encouraging innovation and delivery of better outcomes.

It was noted further engagement on the strategy was due to take place including a dedicated session to look at Education and Training needs as well a session with the Working with People & Communities Advisory Group.

9.6 MH stated that workforce strategies should not be suspended because of lack of funding. MH emphasised that human resources partners should bring to attention of the Board and Executives, what needs to be happen even if there was no identified source of funding for such strategies. MH added that Boards and senior executives had to accept the challenge of sourcing funds widely and go ahead with implementing plans. TC explained that a further update on the People Strategy would be brought before members at the next meeting.
Action: TC and ZP to submit an updated People Strategy to the July meeting. **TC & ZP**

9.7 RESOLUTION: The People Committee noted contents of the draft People Strategy report.

10. People Committee Board Assurance Framework & Risk Register

10.1 TC presented the Risk Register adding the three steering groups, namely Workforce, Organisational Development and Education & Training had recently reviewed their Risk Registers and referred material risks impacting on workforce strategy to the People Board and People Committee. 7 risks had been identified as rated 15 and above:

These relate to: -
1. Inadequate Workforce Supply (risk score 20)
2. On-going industrial action (risk score 16)
3. Band 2/3 HCA pay issue (risk score 16)
4. Cost of living impact of staff (risk score 16)
5. Placement capacity expansion (risk score 16)
6. Future Clinical Professional Development (CPD) funding (risk score 20, this is an increased risk score)

This included an additional new risk relating to Workforce and risk to transformation of services. This new risk has been scored as 16 (originally 12) and relates to 2 concerns:

i) Risk to service transformation when innovation projects cannot commit to permanent roles when funding is non-recurrent. This can result in a reduced quality of applicants and recruitment difficulties.

ii) Clinical Programme Groups may not be giving full consideration to education and training requirements when developing future service models and ensuring these are translating into long term training commitments and support.

TC added that it was necessary that Clinical Programme Groups (CPGs) fully considered education and training requirements when developing future service models so that service plans were realistic and deliverable.

10.2 NS explained how workforce funding mechanisms and non-recurrent funding approaches created an environment which caused a risk to enabling strategies. This was an area that required a different approach.

10.3 TC presented the workforce element of the BAF and invited the group to consider the current risk score of 16, noting a request at the last Board for the People Committee to re-look at this. It was noted that GHFT currently have a risk score of 20 for workforce on their BAF. The group discussed this point and agreed a higher score was warranted. A discussion took place on the risk appetite and approach adopted by GHFT. The Trust had shifted its approach and agreed to look at issues through the lens of its workforce, this had significantly impacted on the decisions and approach the Trust was taking.

10.5 RESOLUTION: The People Committee noted contents of the Board Assurance Framework & Risk Register.

11. Policy Updates

11.1 CGi presented and requested the following:

1. approval of extension of Domestic Abuse policy;
2. approval of extension of Social Media policy;
3. approval of Policy Format & Approval Process policy;
4. approval of Learning & Development policy;
5. approval of Menopause policy.

11.2 CGi explained that if approved, the policies would be published on the ICB's intranet. Members discussed the draft policies. JC stated that the System Quality Committee favoured standardisation of policies across the local system. AS registered reservations regarding approval of the Menopause policy in its current form. AS stated that the policy did not address menopause in its totality because it excluded effects of menopause on men health. Members concurred and agreed this issue should be considered. **Action CGi.** **CGi**

11.3 RESOLUTION: The People Committee:

- **Approved policy extension to the Domestic Abuse policy to July 2023.**
- **Approved policy extension for the Social Media policy to July 2023.**
- **Approved the Policy Format & Approval Process policy.**
- **Approved the Learning & Development policy.**
- **Approved the Menopause policy subject to its amendment to include men menopause.**

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12. Any Other Business

12.1 There was no other business.

The meeting ended at 16:30

Date and Time of next meeting:

The next meeting will be held hybrid on 20th July 2023 at 14:00hrs.

Minutes Approved by:
Signed (Chair):Jane Cummings Date: Thursday 20th July 2023

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