Gloucestershire Integrated Care Board Meeting

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

Main Hall, Churchdown Community Centre, Parton Rd, Churchdown, Gloucestershire, GL3 2JH

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** *Apologies: Ann James, Dr Jo Bayley, Martin Holloway*	Information	**Chair**
2.	2.02 – 2.02pm	**Declarations of Interests** The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	**Chair**
3.	2.02 – 2.04pm	**Minutes of the meeting held 27th September 2023**	Approval	**Chair**
4.	2.04 – 2.05pm	**Action Log & Matters Arising**	Discussion	**Chair**
		Business Items		
5.	2.05 – 2.10pm	**Questions from members of the public**	Discussion	**Chair**
6.	2.10 – 2.30pm	**Patient Story (Healthwatch Topic – (Fibromyalgia)**	Discussion	**Healthwatch /Becky Parish**
7.	2.30 – 2.40pm	**Clinical Programme Group (CPG) Pain Management**	Discussion	**Ellen Rule / Gemma Artz**
8.	2.40 – 2.50pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
9.	2.50 – 3.05pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
10.	3.05 – 3.25pm	**Integrated Finance, Performance, Quality and Workforce Report (including Health Outcomes Report)**	Discussion	**Mark Walkingshaw Tracey Cox Marion Andrews- Evans Cath Leech Siobhan Farmer**
		Decision items		
11.	3.25-3.30pm	**Emergency Preparedness, Resilience & Response Assurance**	Approval	**Marion Andrews Evans**
12.	3.30 – 3.40pm	**Smoking and Vaping Consultation Response**	Approval	**Dr Siobhan Farmer**
13.	3.40 – 3.45pm	**System Quality Committee Terms of Reference**	Approval	**Prof Jane Cummings**
		Discussion items		
14.	3.45pm – 4.00pm	**Delivery Plan for Recovering Access to Primary Care**	Discussion	**Helen Goodey**
15.	4.00 – 4.20pm	**UEC Programme Update (Winter & Transformation)**	Assurance	**Ellen Rule**
		Information items		
16.1	4:20 – 4:25pm	**Chair's verbal report on the Audit Committee** meeting held on 4th October 2023 and minutes of meeting held 27th June 2023	Information	**Julie Soutter**
16.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 5th October 2023 and minutes of meeting held 3rd August 2023	Information	**TBC**

16.3		**Chair's verbal report on the System Quality Committee** meeting held on 19th October 2023 and minutes of meeting held 17th August 2023	**Prof Jane Cummings**
16.4		**Verbal report on the People Committee** meeting held on 26th October 2023 and minutes of meeting held 20th July 2023	**Tracey Cox**
16.5		**Chair's verbal report on the Resources Committee** meeting held 17th November 2023 and minutes of 7th September 2023	**Prof Jo Coast**
17.	4.25 – 4.30pm	**Any Other Business**	**Chair**

Time and date of the next meeting

The next Board meeting will be held 31st January 2024

Boardroom, Shire Hall

Withdrawal of the press and public

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

(for reasons of commercial in confidence discussions)

Gloucestershire Integrated Care Public Board Meeting

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

Meeting Room, Churchdown Community Centre Parton Road, Churchdown, Gloucestershire GL3 2JH

Members Present:		
Prof Jane Cummings	**JC**	Non-Executive Director, NHS Gloucestershire ICB *(Vice -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
Dame Gill Morgan	**GM**	ICB Board Chair
Dr Jo Bayley	**JB**	Chief Executive, GDOC
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
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
Carole Alloway-Martin	**CAM**	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council
Christina Gradowski	**CGr**	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Deborah Evans	**DE**	Chair, Gloucestershire Hospitals NHS Foundation Trust
Graham Russell	**GR**	Vice-Chair, Non-Executive Director (GHC)
Helen Goodey	**HG**	Director of Primary Care & Place, NHS Gloucestershire ICB
Ingrid Barker	**IB**	Chair, Gloucestershire Health & Care NHS Foundation Trust
Dr Olesya Atkinson	**OA**	GP, Primary Care Network Representative
Dr Paul Atkinson	**PA**	Chief Clinical Information Officer, NHS Gloucestershire
Ryan Brunsdon	**RB**	Board Secretary, NHS Gloucestershire ICB
In attendance:		
Ayesha Janjua	**AJ**	Associate Non-Executive Director, NHS Gloucestershire ICB
Becky Parish	**BP**	Associate Director, Engagement and Experience, NHS Gloucestershire ICB
Dawn Collinson	**DC**	Corporate Governance Administrator, NHS Gloucestershire ICB
Dr Hein Le Roux *(Item 6)*	**HLR**	Clinical and Professional Lead, Improvement Community
Neil Penny *(Item 6)*	**NP**	Senior Integrated Commissioning Manager
Kathryn Hall *(Item 6)*	**KH**	Associate Director Improvement Community
Zack Pandor *(Item 9)*	**ZP**	ICS Strategic Workforce Transformation Programme Manager, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 The Vice Chair welcomed those present to the meeting. The Chair of the Integrated Care Board (ICB) joined the meeting online. Apologies were received from Mark Cooke, Martin Holloway, Pete Bungard and Stephen Otter.

1.2 There was one member of the public in attendance.

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.

3. Minutes of the meeting held on 26th July 2023

3.1 The minutes from the meeting held on 26th July 2023 were agreed as an accurate record of the meeting.

4. Action Log and Matters Arising

4.1 An amended Action Log had been completed and circulated to Board members prior to this meeting. This Action Log was shorter and there had been a recommendation to close the majority of the actions other than the one listed below:

25/01/2023 – Min 6.13,6.15 and 6.16 - The use of electronic cigarettes (vaping) increasingly replacing smoking in adults and children and young people. SF said that work is ongoing on this subject and given the very live agenda around potential bans, it was decided to revisit this topic. **Action to remain open with an update to be brought to the ICB Board in early 2024.** **SF**

The actions agreed for closure were the following;

- **29/03/2023 – Min 8.9, Board Assurance Framework (BAF) -** 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.
- **29/03/2023 – Min 12.11, Health Inequalities -** Healthy Communities and Individuals and the Care Programme Group teams had addressed these issues as part of the ICB/ICS work on health inequalities.
- **31/05/2023 – Min 12.11, Digital Strategy -** A resourced plan on digital inclusion was place and included engagement with Healthwatch.
- **31/05/2023 – Min 12.11, Digital Strategy -** An item on AI & Healthcare had been added to the ICB Board Development session forward plan.
- **26/07/2023 – Min 9.21, Maternity -** An item on Maternity had been added to the Board / Board development plan.
- **26/07/2023 – Min 9.21, Glos H&S Care Framework -** Gloucestershire Health & Social Care Framework had been added to the Board / Board development plan

5. Questions from member of the public

5.1 There were three questions from members of the public:

- Conflicts of Interests related to board members (Tracey Cox read out the question and answer).
- Attention Deficit Hyperactivity Disorder (ADHD) Shared Care Arrangements (Andy Seymour read out the question and answer).
- In vitro fertilisation (IVF) (Mark Walkingshaw read out the question and answer).

The full answers to the questions would be emailed to the individuals, the Q&A incorporated in the minutes and included on the ICB's website see here:
ICB-Board-QA-log-for-web-publication-september-2023-updated.pdf (nhsglos.nhs.uk)

6. Improvement Story – Warmth on Prescription

6.1 KH introduced the team who had worked on the scheme and informed the Board that a Health Improvement Story would be brought to the ICB Board on a regular basis. The items would showcase how multi-disciplinary teams were working together in Gloucestershire, to make tangible improvements in the development and delivery of services. The stories demonstrated how the ICB was able to deliver better health and care to the local population. The presentation contained information about how Severn Wye was working alongside the ICB and partner organisations to deliver Warmth on Prescription to those people who were most in need of the scheme.

6.2 NP spoke about the Strategic Housing Partnership and explained how the Warm and Well scheme had been running for a number of years, the intention was to test another hypothesis which was working with an external agency, Severn Wye, to improve the physical and mental health of patients over the winter. This would be achieved by providing funding for people to be able to pay their fuel bills, maintaining a level of heat within their homes and thus reducing some of the health impacts associated with living in cold and damp conditions. Funding was made available via the Housing Support Fund and also from some charitable involvement. Severn Wye was involved when the patient received a Warmth on Prescription referral from their GP

6.3 HLR worked with one of his patients diagnosed with severe Chronic Obstructive Pulmonary Disease (COPD) and recognised that there would be benefits for the patient if he were to opt into this proactive scheme. KH demonstrated a video which had been shown on the BBC's One Show last winter which illustrated how this preventative scheme would deliver greater benefits to the NHS; by preventing hospital admissions and assisting those patients on low incomes to get through the colder winter months.

6.4 NP commented that there had been a good deal of media coverage around the scheme which had been very well received. Evaluations showed that both the physical and mental health of people had improved just by having a warmer house. The Continuing Healthcare Team would be referring patients with multiple conditions and those using expensive medical devices in their homes to aid their conditions. NP explained that there had been some heartfelt comments from people who were so grateful to the scheme and what it could offer in terms of preventative intervention. Funding will also be made available for home insulation and improvements in heating systems. This also supported with the delivery of sustainability targets across the county. The scheme will support 300 households from which data could be extracted this year.

6.5 KH explained that there was a clear ambition for Gloucestershire to become a front-runner in improvement led delivery and how leading, enabling and energising partners to collaborate continued across the county. This work had involved partners in self-assessment and learning to bring the whole programme together. Updates would come to the ICB Board as the programme progressed. There was a proposal to hold an Improvement Conference in Gloucester next year to which Board members would be invited.

6.6 HLR stated that this scheme also linked to the Population Health Management approach in prevention, intervention and rehabilitation. Through this programme links had been made between deprivation and ethnicity which led to new ways of engagement and collaborative work. The team was thanked for presenting their work to the Board.

7. <u>ICB Chief Executive Officer Report</u>

7.1 MH discussed key points within the Report:

- Gloucestershire had been chosen as a case study site for the national evaluation of social prescribing link workers. This national evaluation would be delivered by the Applied Research Collaboration and funded by the National Institute for Health and Care Research. The research would be led by colleagues from the University of Manchester, along with academics from the Universities of Bristol, Newcastle, Edinburgh and Glasgow.
- The new Fit and Proper Persons Framework (FPPF) had been published following the Kark Review (2019) the framework was designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member and applied 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. The new framework was operational from 30 September 2023 and detailed the comprehensive requirements required of board members.
- Delegation of Specialised Commissioning would most likely commence from 2025/26 when more information was made available to ICBs. The ICB had formally responded to NHS England on the delegation timeline for Specialised Commissioning. This led to Gloucestershire along with other South West systems agreeing that, particularly in the absence of detail regarding allocations and the needs-based formula/pace of change, that there should be a delay with moving to 'fully devolve' from 2024/25 and agreement to extend the current joint arrangements for a further year (overseen by the newly appointed independent chair).

7.2 JC referenced the ICB Annual Assessment Summary from Elizabeth O'Mahoney which contained many constructive comments albeit there are some areas of work still to be done. JC thanked the team and colleagues in the system for what had been achieved so early on in the life of the ICB.

7.3 The Board was asked to approve the extension of the ICB Procurement Strategy until 31st March 2024.

7.4 The Board was asked to agree the Sexual Safety in Healthcare Organisational Charter and the 10 principles and actions to achieve this.

RESOLUTION: The Board:

- **unanimously agreed the Sexual Safety in Healthcare Organisational Charter and the 10 principles and actions to achieve this.**
- **approved the extension of the ICB Procurement Strategy until 31st March 2024.**
- **noted the verbal update on the Chief Executive Officer Report.**

8. Integrated Finance, Performance, Quality and Workforce Report

8.1 The Chair informed the Board members that some additional verbal updates would be given during the update following additional comments made at the Strategic Executive.

8.2 MW updated on the Performance element of the Report:

- An autumnal review was planned to determine whether the Integrated Performance Report in its current format, was meeting the needs of Board members. Feedback will be invited so that iterations and improvements could be made.
- Urgent and Emergency Care (UEC) performance remained fragile but there had been significant progress in the reduction of long stay and No Criteria to Reside patients which was down to the hard work of colleagues in the system.
- Diagnostic imaging access performance remained strong, but this had an impact on reporting of scans leading to a backlog in a number of areas, which Gloucestershire Hospitals NHS Foundation Trust (GHFT) colleagues were tackling. Turnaround times must not impact on access standards including cancer performance.
- Echocardiography performance should improve in the coming weeks – locums appointed by GHFT had started to make inroads into those waits.
- Endoscopy performances determined by flexi sigmoidoscopy and endoscopy procedures, had led to a strong task and finish group being formed, enabling the easing of those pressures.
- Significantly, the national Elective Recovery Fund (ERF) target had been met at Quarter 1, a significant achievement with input from colleagues across the system and in the independent sector. Maintaining this performance will be vital in order to support the medium-term financial plan.
- Cancer performance remained strong with the two week waits and 28 day targets being consistently met.
- Primary Care performance remained really strong within the system and underpinned delivery across many of the standards, despite demand continuing to be significantly above pre-pandemic levels.
- Mitigations for periods of Industrial action had drawn focus away from other areas of work. The high numbers of cancellations of elective procedures and appointments had impacted on the system's ability to attract additional funding for elective work. Colleagues had however, shown resilience and fortitude in seeking to maintain high levels of performance during these times.
- Due to an extensive validation exercise undertaken in GHFT, waiting lists had dropped and so investment in this work would continue with clinical teams, who were best placed to make decisions on clinical pathways, where necessary.

TC highlighted developments in the Report around Workforce:

- A recent bid was made to NHSE for some monies to support the recruitment of overseas staff in the care sector. The ICB was successful in obtaining £350k which had then been match funded with some local s256 monies, enabling some 150 care staff to be brought into the Gloucestershire system.
- The 'We Want You' outreach project scoping had been completed, with strategic priorities set and delivery commenced, with a plan to work with 19 schools.
- A revised workforce dashboard had been produced enabling data to be more accessible and will facilitate easier tracking of performance and progress over time. Work will continue around data feeds and measures following feedback from the Strategic Executive.

MAE highlighted details on Quality:

- The Standardised Hospital Mortality Indicator had remained within expected levels since November 2022, but as weekend mortality figures had shown some statistically higher rates of mortality, the Mortality Group would be reviewing those cases. Any death of a child who died within county would be given the very close scrutiny of the Child Death Overview Panel. There were also robust systems in place around Freedom to Speak Up and a future update was planned for the Board on those arrangements.
- A staffing review would take place within GHFT to ensure that the right staff were in post and were efficiently placed in order to deliver quality care.
- Mental health services had had a very successful period of recruitment and staffing numbers were almost at the required level.
- DL informed the Board that 28 new midwives would join the Trust between now and the end of January 2024. These consisted of new graduates and also some more senior staff. An update would be given at the November Health Overview and Scrutiny Committee (HOSC) meeting around re-establishing access to the Cheltenham birthing unit, hopefully in early 2024. Some Matrons and band 7s had also been recruited and will enable the embedding of senior leadership within Maternity Services.
- The Care Quality Commission (CQC) had issued a S29A letter to the Trust around safeguarding training for junior doctors where regional work had been undertaken, so that doctors could undertake their training with them.
- Out of Hours services provided by PPG continue to be closely monitored to ensure that those services were maintained to the required standards.

CL updated the Board on the finance aspect of the Report:

- There was a year to date overspend of c£2.8m but the forecast was still a break even position. This was however a high risk forecast with financial pressures including:
    - 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.
    - Slippage in the delivery of savings plans.

There was a financial recovery plan in place which included work around Primary Care prescribing, where a number of plans would be taken to the Operational Executive for the ICB, with a view and consideration as to how these could be progressed. Within GHFT

there was a significant programme of work in a number of areas, particularly within the medicines division. E-rostering for nursing was being fully implemented and had resulted in good progress for Gloucestershire Health and Care NHS Foundation Trust (GHC).

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

Elective recovery funding was dependent upon performance with 105% delivery having been delivered. There had been a significant contribution from the independent sector and performance will need to be sustained. Rostering will lead to reductions in agency spends.

The year to date capital expenditure was £11.8m behind plan due to early year slippage across a number of schemes but it was anticipated that this will catch up. There was a small risk around International Financial Reporting Standard (IFRS) 16, which related to leases particularly within GHFT, which would be discussed with region.

RESOLUTION: The Board members noted the Integrated Finance, Performance, Quality and Workforce Report.

9. One Gloucestershire People Strategy 2023 – Final Version

9.1 TC presented the final version of the One Gloucestershire People Strategy for 2023 to the Board. Engagement had taken place across the system since January 2023 regarding the Strategy. This high level Strategy described the ambitions for the next five years and was designed to support all sectors across health and social care, incorporating the voluntary and community sector partners and Primary Care. It was brought to the attention of the Board members that although it was the intention to work collaboratively most of the time, there may be instances where this might not be possible.

9.2 There will be strong links with the Integrated Care Partnership Strategy particularly around employment which was one of the strong themes reflected within the strategy. Recent presentations in this forum suggested that there was more work to be done with districts and the voluntary sector partners around pinpointing opportunities for collaborative working.

9.3 TC explained that this strategy would not negate individual organisational strategies, but the intention was to focus on areas where value could be added by system level collaboration to improve sustainability and potentially reduce duplication of effort.

9.4 TC stated that the strategy detailed four areas of focus:

- Improvement and Retention;
- Enabling innovation in care delivery;
- Valuing and looking after our staff;
- Education, training and talent development and future demands and requirements of the NHS workforce plan.

Workforce planning will be an important part of delivery with a high focus also on Equality, Diversity and Inclusion (EDI) to incorporate this thread through all areas.

9.5 More work would need to be accomplished around digital data and technology with a separate more detailed piece of work around workforce and the ICB's digital strategy to follow on.

9.6 Leadership and culture will also be pivotal to the work detailed in the strategy. Approaches and intent had been mapped against the NHS Workforce Plan and correlated against the four people promises.

9.7 ZP drew the Board's attention to the fact that there were three sub-groups around Workforce, Education and Training and Organisational Development and each of the these areas fed into the strategy. Health and Wellbeing was also an important part of the strategy and an important component of any workforce strategy.

9.8 TC explained that there were some risks to delivery and there will be infrastructure requirements needed around the delivery of the NHS Workforce Plan and what that might look like. Much of the People Team currently in situ in Gloucestershire, as in other systems, was supported by Workforce Development funding that had been made available each year on a non-recurrent basis. This year would be the last for that funding and there was a capacity risk that had been flagged by ICBs across the South West and nationally which could affect delivery.

9.9 JB responded she would like to see more information in future on Primary Care vacancies. 60% of GPs in Gloucestershire were over the age of 50 and 35% were over the age of 55. GPs who were resigning were not being replaced and this would significantly affect the local workforce.

9.10 TC replied that a deep dive analysis had been conducted around the Primary Care position and some field work had been undertaken, talking to GPs as part of understanding what would make them want to come and work in Gloucestershire, and what they liked about the county. There had been 120 responses from newly qualified GPs which illustrated the concern about this and how Primary Care could be supported.

9.11 MAE was concerned that this was the final year of receiving Continuing Professional Development (CPD) monies. It will be a further 6-8 months before more details will be known. There was as yet no understanding of what the profile of funding would look like. Regional colleagues were going to undertake a series of co-production workshops with the ICB, the first one taking place in November, so that responses could be used in the development of the Workforce Plan.

9.12 ZP responded that where there was an imbalance of funding across regions, this would be addressed as a concern. JC stated that she had spoken to colleagues across the country and there were not many Integrated Care Systems (ICS) that had a Workforce Strategy and she extended thanks to TC and the team for putting the strategy together in a short space of time.

9.13 JC was grateful for the tribute in the strategy to Clive Lewis, before his sad passing, for his leadership and inspiration to the work on the strategy and his wider contributions to the work of the ICB.

RESOLUTION: The Board members approved the final version of the One Gloucestershire People Strategy 2023.

10. Committee Updates

10.1 **Chairs verbal report on the Primary Care & Direct Commissioning Committee meeting held on 3rd August 2023**

10.1.1 CG stated that agreement had been given for a new surgery in Hucclecote. Gloucestershire County Council had capital funded for this new surgery, for which there was grateful acknowledgement.

10.2 Chair's verbal report on the Quality Committee meeting held on 17th August 2023 and latest approved Committee minutes

10.2.1 JC reported that there had been various policy approvals during the April meeting. There was a good discussion at the last meeting on 17th August about quality system risks and issues and relationships had been strengthened between the System Quality Group, Local Maternity and Neonatal Service (LMNS) and the System Quality Committee. Maternity was discussed and there was now closer linkage with the sub-groups around safety, effectiveness and patient experience.

10.3 Chair's verbal report on the Resources Committee meeting held on 7th September 2023

10.3.1 JCo reported that there had been a focus on financial planning at the recent meeting and there was agreement to move from organisational system recovery. There was discussion on potential methods to enhance decision-making into the programme areas going forward.

10.4 Chair's verbal report on the People Committee meeting held on 20th July 2023

10.4.1 JC reported that a deep dive had taken place on Primary Care workforce at the last meeting. Quite some time was also spent on the Workforce Strategy, detailed above.

10.5 Chair's verbal report on the latest Audit Committee meeting scheduled 27th September 2023

10.5.1 JS reported that the meeting had had to be moved to 4th October and there would be an update at the next ICB Board Meeting.

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

11. Any Other Business

11.1 JC thanked Colin Greaves, who was leaving the Board, on behalf of the Chair and the Board for his time, knowledge, and commitment that he had provided to Gloucestershire in his role in the Clinical Commissioning Group (CCG) and in the ICB. A lunch would be held on 5th October to show appreciation of Colin and to wish him well in his retirement. Colleagues expressed their support and thanks to Colin in the traditional manner.

The meeting concluded at 14.02 hrs.

Time and date of next meeting

The next Board meeting will be held on Weds 29th November 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

November 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**

Agenda Item 7

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Clinical Programmes Update**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
	Strategic Executive						
Executive Summary	This paper provides an overview of the clinical programme approach. The paper describes some key areas of success, an update on our approach and how this is helping us to achieve strategic aims of the ICS, including prevention, pro-active care and tackling health inequalities.						
Key Issues to note	The clinical programme approach is successful in achieving whole system improvements across a range of areas. The approach relies on transparency of information sharing and has a fundamental aim of delivering high value care- which relies on high levels of transparency and data sharing across the system. It also requires a high level of engagement from clinicians and patients in ensuring that we are delivering the best possible outcomes for the population.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	This paper is updating on the programme of work and risks are reflected in each clinical programme group.						
Management of Conflicts of Interest	All clinical programmes follow a robust declaration of interest process.						
Resource Impact (X)	**Financial**	x	**Information Management & Technology**	x			
	Human Resource	x	**Buildings**				
Financial Impact	N/A for the purpose of this paper.						
Regulatory and Legal Issues (including NHS Constitution)	N/A for this paper						

Impact on Health Inequalities	The paper describes the approach being taken across CPGs to tackle health inequalities.		
Impact on Equality and Diversity	N/A for this paper		
Impact on Sustainable Development	N/A		
Patient and Public Involvement	N/A for the purpose of this paper		
Recommendation	The Board is requested to: • Note the contributions of the CPGs to delivery against key strategic objectives. • Continue to support the approach, and dedication to continued engagement by system partners with the CPGs.		
Author	**Gemma Artz**	**Role Title**	**Deputy Director, Strategy & Transformation. Clinical Programmes and healthy communities and individuals.**
Sponsoring Director (if not author)	**Ellen Rule, Deputy CEO & Director of Strategy and Transformation**		

Glossary of Terms	**Explanation or clarification of abbreviations used in the paper**
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
Add more as required	

One Gloucestershire
Transforming Care, Transforming Communities

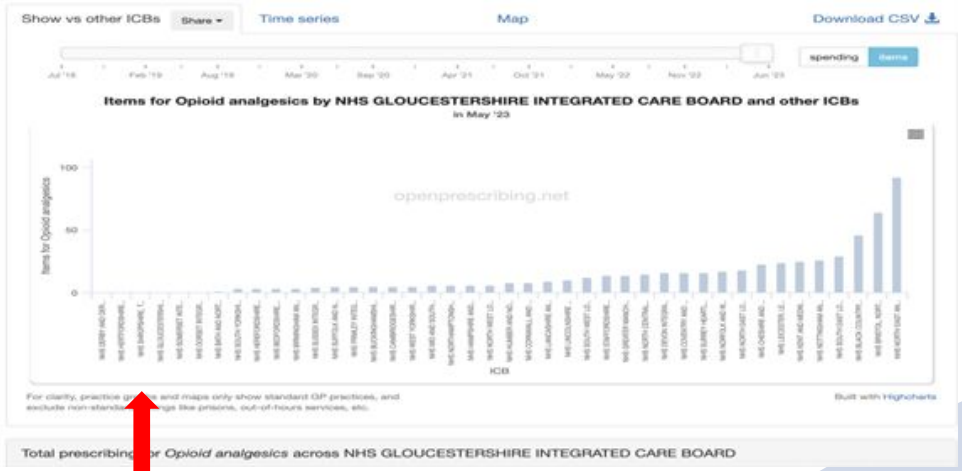
Clinical Programme Groups Update
Gloucestershire Integrated Care Board

Gemma Artz

November 2023

@One_Glos
www.onegloucestershire.net

Living Well with Pain Programme : Working together



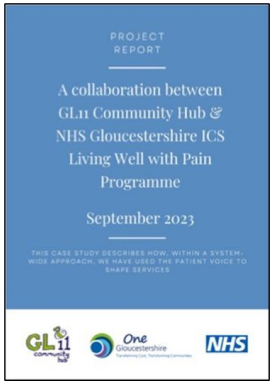
One of the lowest prescribing rates in the country for opiates

To minimize prescribing of harmful medicines

To grow and develop non-medicines offers for pain

To enable health care professionals to have better conversations about pain

To find out what is important to people living pain to support improving outcomes and develop services



Artlift

It's your move

PEAK HEALTH COACHING

GL11 community hub

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CPGs impact in numbers….

Know Your Numbers Campaign – September - 345 community blood pressure checks, 80 signposted / in last year - 8690 new diagnoses of hypertension

650 patients assessed and managed by the Long Covid service

Top ICB in south west, and 6th nationally for Lower Gastrointestinal (LGI) 2 week wait referrals with a FIT test in the preceding 21 days

4416 individuals registered onto the National Diabetes Prevention programme in 22/23 to support type 2 remission

10,000 people registered for getUbetter app with personalised support for people with MSK conditions

87 people with chronic pain accessed "Its your Move" – with over half reporting reduced pain, improved energy levels, and increased physical activity levels

£1 million savings and in top 3 nationally for prescribing switch to Ongavia use in Eye Health

Ranked top ICB nationally for green inhaler use, blood glucose strips and polypharmacy

37% fewer admissions, 50 % length of stay reduction and reduced use of intensive care for children supported by community respiratory physiotherapy

15% reduction of Ophthalmology e-referrals following implementation of Community Ophthalmic Link

6000 appointments delivered through Acute Respiratory Infection (ARI) hubs reducing pressure on acute services, primary care and 111

Over 1,500 patients attended a 'pre-hab' service for cancer treatment showing reduction in post-operative length of stay and complications

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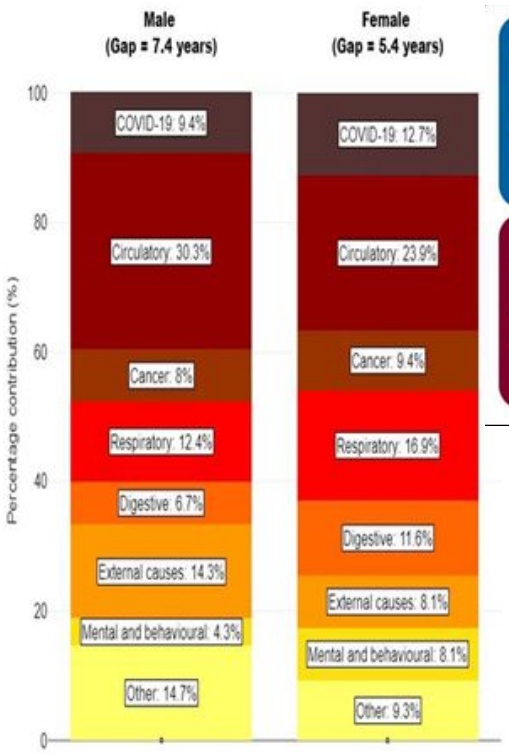
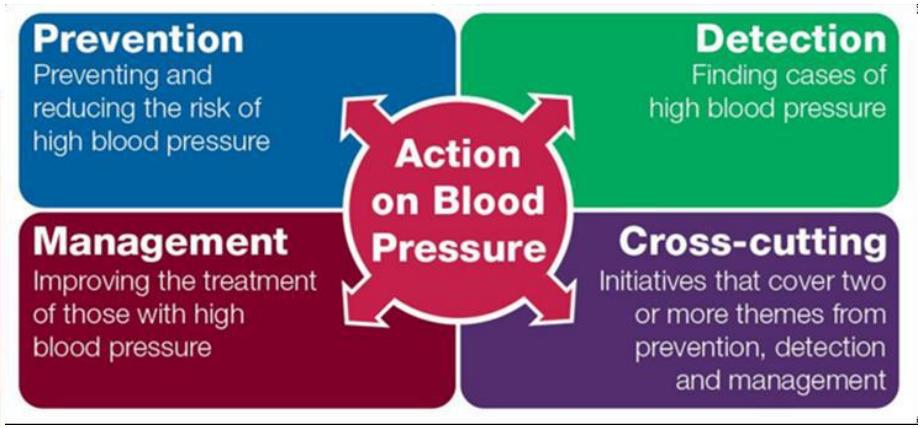
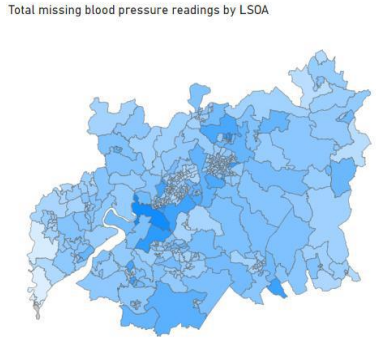
Clinical Programmes: Prevention and Health Inequalities Focus: Cardio Vascular Disease (CVD) Example





Missing BP (Cohort 1)
- Younger patients
- Mixed ethnicity patients
- Cheltenham

High/Uncertain BP (Cohort 2)
- 70+ patients
- Black or Black British patients
- Gloucester



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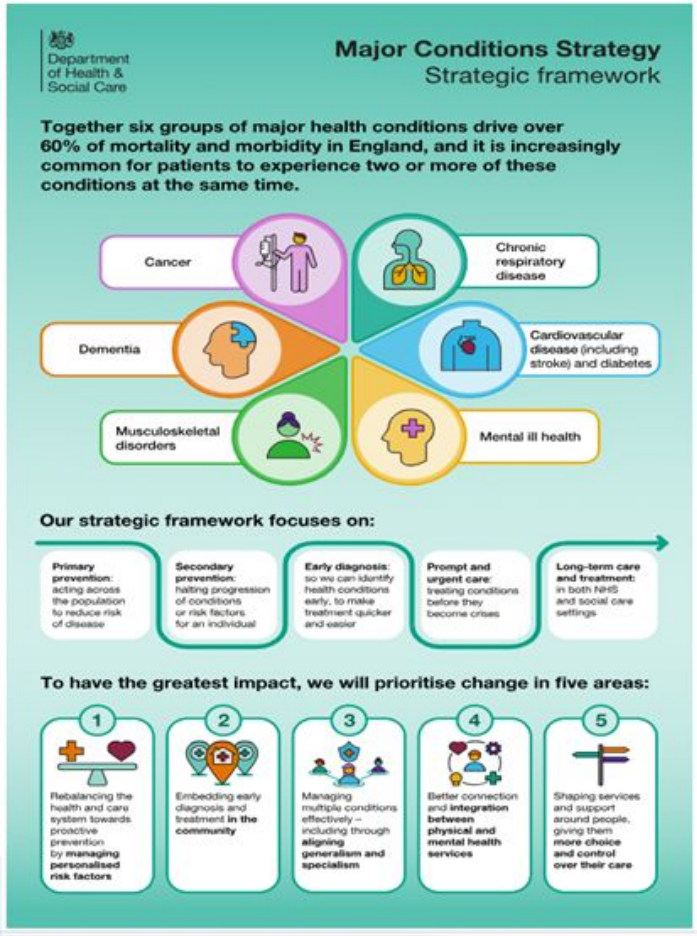
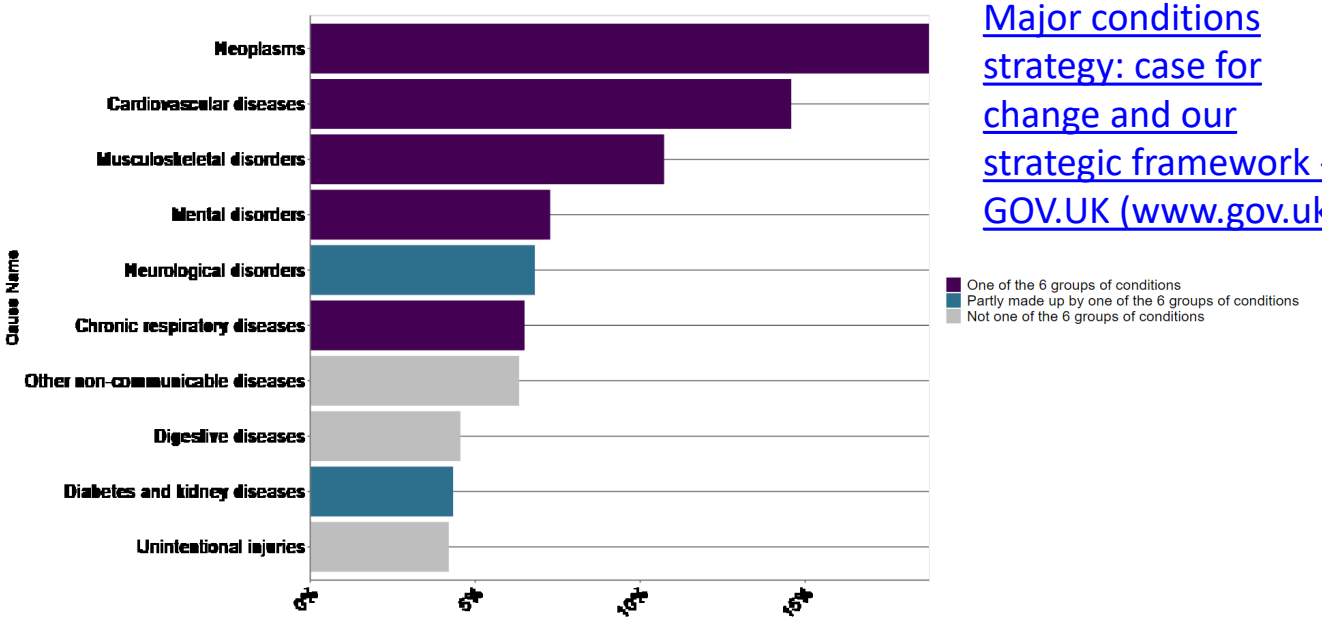
National Major Conditions Strategy 2023 : Ahead of the game?



- Our Clinical Programme Group approach and programmes perfectly align with the recently published major conditions strategy
- Teams will be reviewing the insights in this document against the priorities at a programme level



[Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)]

Figure 1: the proportional contribution of major health conditions to the total DALY burden in England (2019)

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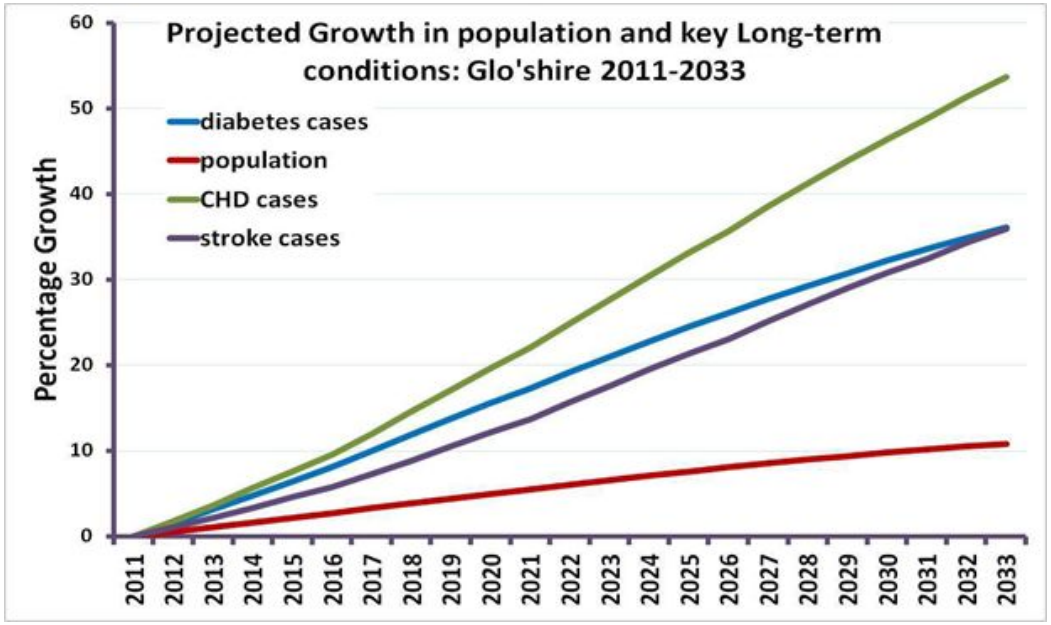
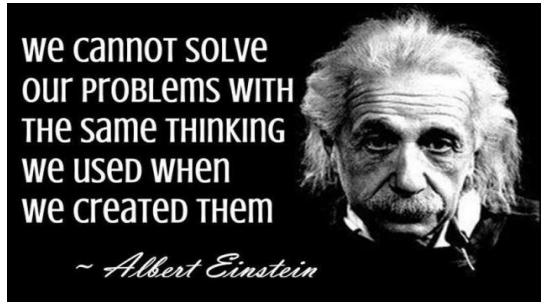
More of the same will not do..

To summarise - CPGs act as systemwide networks of expertise across a specific area or pathway. We:

- Are clinically led, and patient focused
- Use the networks and data to inform and identify opportunities for improvement
- Use co-design and improvement science to develop tests of change
- Use evaluation techniques to understand the impact of the change and 'Plan Do Study Act' (PDSA) cycles to adapt and improve
- Are responsive to new developments at pace- COVID response, virtual ward pathways, community diagnostics pathways, technology funding bids
- Align generalism and specialism to support connections between clinical pathways and cohort specific programmes such as frailty, children and young people, learning disability and autism
- Continue to strengthen and improve cross –system ownership including working with integrated locality partnerships, PCNs, Public Health, voluntary sector partners and the Health and wellbeing partnership





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Questions

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Appendices

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Appendix 1: Current Clinical Programmes

Respiratory	Diabetes	Circulatory	Frailty	Palliative and End of Life Care
Cancer	Musculoskeletal	Living Well with Pain	Eye Health	Mental Health Adult and Children
Learning Disabilities and Autism	Children and Young People	Neurology	Renal	Dementia

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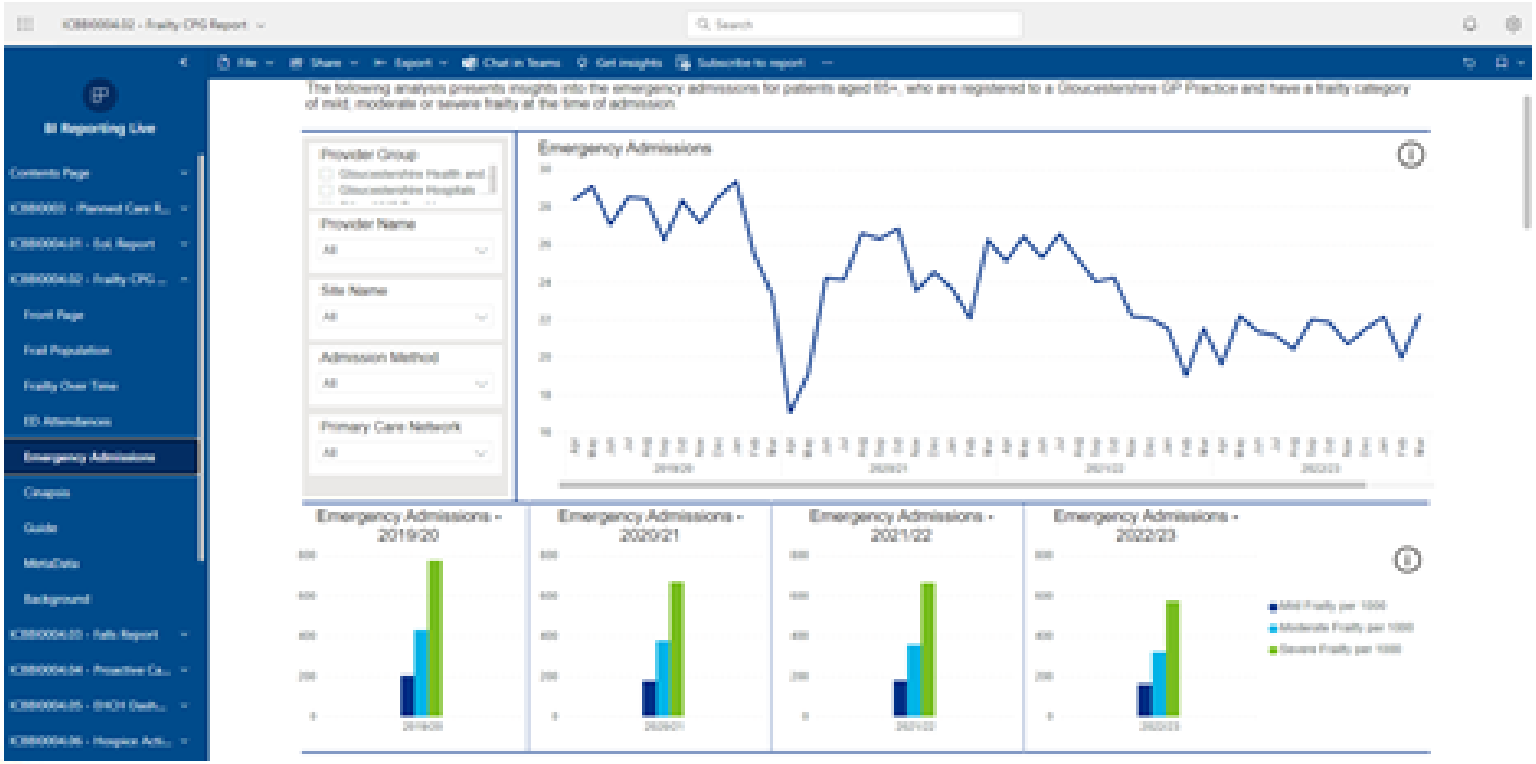
Appendix 2: Frailty Dashboard



The Frailty data set on PowerBI illustrates trends for individuals with mild, moderate and severe frailty. It provides vital information on emergency admission trends, ED attendances, Cinapsis Frailty Assessment Service, the overall Frail population in Gloucestershire and trends in Frailty over time. The Frailty data set is a standing agenda item on the Frailty & Dementia CPG for discussion and information. The Ageing Well team also use this data set frequently to inform business planning and monitoring.

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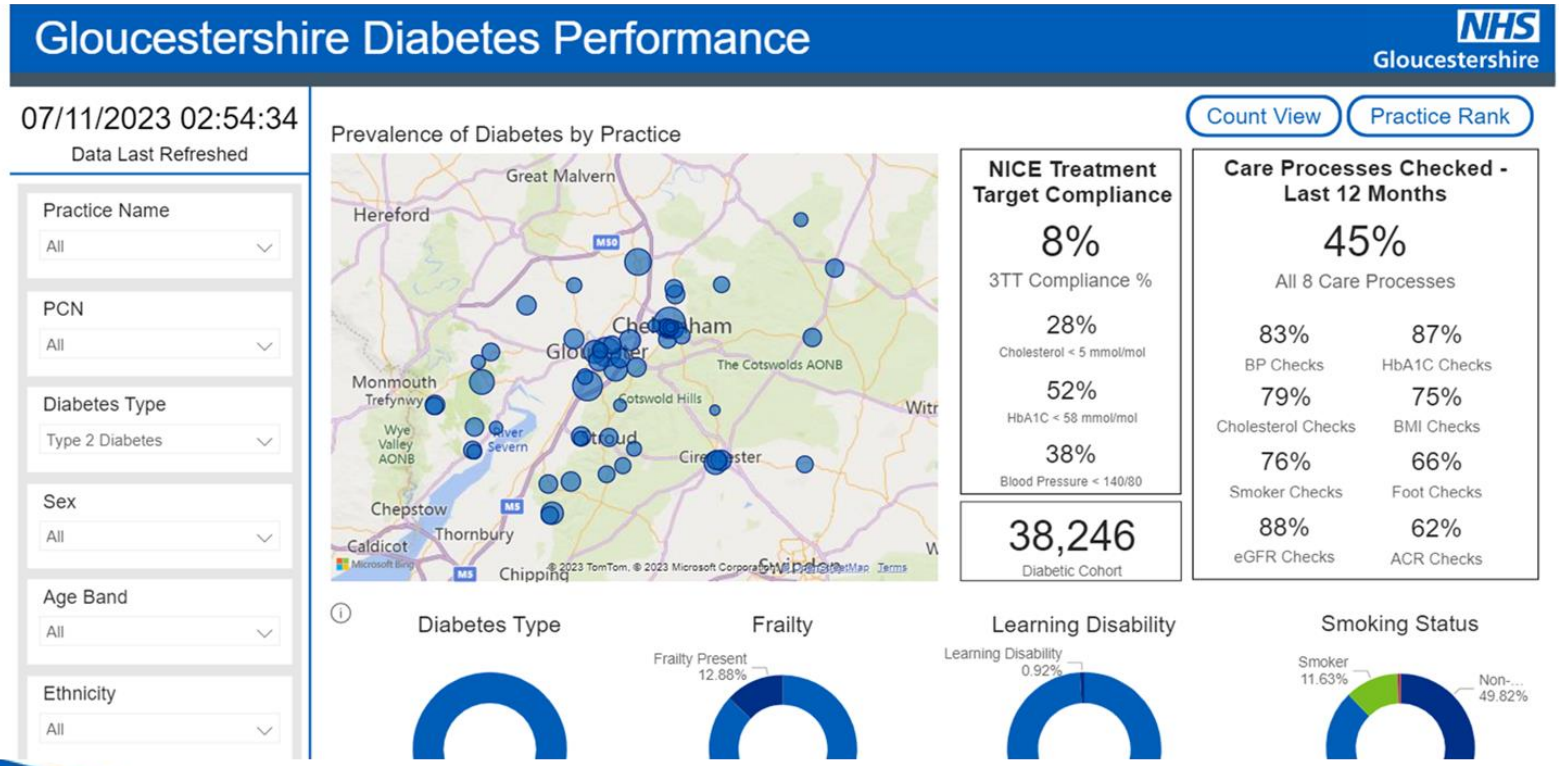
Appendix 3: Diabetes Direct Care Dashboard



The Diabetes Direct Care Dashboard was designed by clinicians for clinicians. It brings together information from services that deliver care for people with diabetes, contributing to an integrated and seamless care pathway. It aims to improve continuity of care and performance outcomes across the county.

It supports quality improvement work by presenting performance against national and local targets for patients with diabetes. It also serves to inform the direct care of patients with diabetes, and to enable more proactive and targeted care of individuals and at-risk groups.

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Appendix 4: Using STAR in Chronic Obstructive Pulmonary Disease (COPD)- to identify opportunities to make services equitable, sustainable and transparent

Data and evidence collection on the pathway:

- >**500** COPD patients completed a preferences survey
- >**64** publications were part of the literature review
- >**100** data points were collected looking at costs, activity and health gain.

Collaborative workshops to value the pathway and identify improvements:

- **28** attendees contributed to two in-person workshops
- Attendees included patients, COPD clinical specialists, public health, finance, informatics, analysts and transformation managers.

Model pathway improvements in terms of costs and population health:

- **12** pathway improvements were modelled
- **Five** improvements were recommended due to the modelled cost and population health gain, including Pulmonary Rehabilitation (PR)

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Appendix 4: Impact on Pulmonary Rehabilitation

- STAR process allowed the **sharing of data** to allow us to understand some of the issues with the current PR offer in Gloucestershire.
- Further deep dive with GHC **revealed specific issues** around retention and recruitment of key staff groups for the current model.
- Workshop held with all system partners including the VCSE, district council reps and patient users to consider options for better ways of working and increasing the offer across the county, **maximising the current offer** and **improving partnership working**.
- We know that improving earlier diagnosis and management of COPD in the community improves outcomes, and reduces hospital admissions.

The Benefits of Pulmonary Rehabilitation - YouTube

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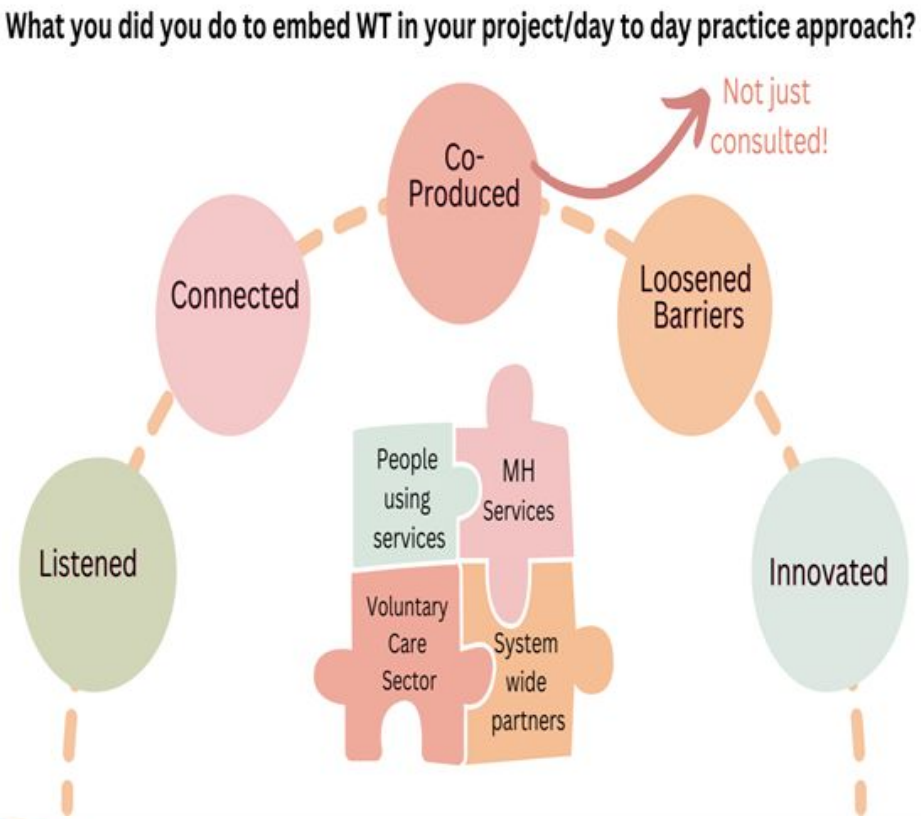
12

Appendix 5: Mental Health: Co-production for complex emotional needs (CEN)



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Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Board Assurance Framework (refreshed and updated November 2023)**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting						
	ICB, ICS & Partners			**Date**		
Executive Summary	This paper provides an overview of the current strategic risks facing the ICB and have been aligned to the ICS Three Pillars / Strategic Objectives / Priorities for 2023-24 as agreed by ICS partners.					
Key Issues to note	The BAF has been refreshed and updated to align with the strategic objectives for 2023-24 and the key priorities as well as the three pillars; • 10 strategic risks listed under 6 strategic objectives • 3 Red Rated risks (workforce – 20, primary care 16 and finance 16) • 7 Amber Rated risks					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without a BAF and the identification of strategic risks the Board would not know about emerging and potentially damaging risks to the ICB. 5x4 if there was no BAF reporting within the ICB 5x1 residual risk after risk mitigation					
Management of Conflicts of Interest	There are no conflicts of interests involved in producing this report.					
Resource Impact (X)	**Financial**	X	**Information Management & Technology**			
	Human Resource	X	**Buildings**			
Financial Impact	See the Finance risk ref 3.					
Regulatory and Legal Issues (including NHS Constitution)	The ICB has a host of legal duties and responsibilities around financial management and provision of services which relate to the risks (NHS Act 2006 as amended)					
Impact on Health Inequalities	See strategic risks that are aligned to the following strategic objectives. BAF1 The failure to promote and embed health inequalities and prevention initiatives across our delivery programmes BAF3 The risk is that the ICB has insufficient resources and capacity to effectively tackle long term entrenched health inequalities arising from the wider determinants of health					

Impact on Equality and Diversity	See health inequalities risk		
Impact on Sustainable Development	There are no risks on sustainability		
Patient and Public Involvement	There is no public and patient involvement in creating the BAF		
Recommendation	**The Board is requested to:** • **Note the Board Assurance Framework**		
Author	**Christina Gradowski / Ryan Brunsdon**	**Role Title**	**Governance Team**
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**		

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

Strategic Risks – Refreshed Board Assurance Framework November 2023

Summary November 2023

Pillar	Risk ID	Strategic Risk	Date of Entry	Last updated	Lead	Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Committee
Pillar 1	**Strategic objective 1: Increase prevention and tackle the wider determinants of health and care**								
Making Gloucestershire a better place for the future	BAF1	The failure to promote and embed health inequalities and prevention initiatives across our delivery programmes	13/11/23	13/11/23	Dir Operational Planning & Perf	**3x3=9**	**3x3=9**	**2x2=4**	ICP Resources Committee
Pillar 2	**Strategic Objective 2: Take a community and locality focused approach to the delivery of care**								
Transforming what we do	BAF 2	The risk is that our delivery structures and limited capacity are insufficiently focused on community and locality transformation	14/11/23	14/11/23	Dir of Integration	**4x3=12**	**4x3=12**	**4x1=4**	JCPE PCDC Committee
	Strategic Objective 3: Achieve equity in outcomes, experience, and access								
	BAF 3	The risk is that the ICB has insufficient resources and capacity to effectively tackle long term entrenched health inequalities arising from the wider determinants of health.	13/11/23	13/11/23	Dir Operational Planning & Perf	**3x3=9**	**3x3=9**	**2x2=4**	ICP Resources Committee
	Strategic Objective 4: Create a One Workforce for One Gloucestershire								
	BAF 4	Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan	01/11/22	13/11/23 (refreshed)	Dir of People, Culture & Engagement	**4x4=16**	**5x4=20**	**3x2=6**	People Committee

	Strategic Objective 5: Improve quality and outcomes across the whole person journey								
	BAF 5	The risk is that the ICB fails to assure care provision and identify opportunities to improve quality and outcomes across the system	07/11/23	07/11/23	CNO & CMO	**5x2 = 10**	**5x2=10**	**5x1=5**	Quality Committee
Pillar 3	**Strategic Objective 6: Address the current challenges we face today in the delivery of health and care**								
Improving health and care services today	BAF 6	Risk that the ICB fails to deliver and/or sustain the transformational improvements in our UEC Transformation (Working as One) Programme	13/11/23	13/11/23	Deputy CEO / Dir Strategy & Transformation	**5x4=20**	**4x3=12**	**4x2=8**	People Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 7	Risk of instability and resilience in primary care due to high workload demands, workforce pressures and increased costs	15/11/23	15/11/23	Director of Primary Care & Place	**4x4=16**	**4x4=16**	4x1=4	Primary Care & Direct Comm Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 8	Failing to deliver increased productivity requirements to meet both backlogs and growing demand	01/11/22	15/11/23 (refreshed)	Director of Operational Planning & Perf	**3x4=12**	**3x4=12**	**3x2=6**	Quality Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 9	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes	01/11/22	14/11/23 (refreshed)	Director of Integration	**4x3=12**	**4x3=12**	**4x1=4**	People Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 10	Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity	01/11/22	21/11/23 (reviewed)	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16**	**4x2=8**	Resources Committee / Audit Committee

Strategic Risks

Pillar 1: Making Gloucestershire a better place for the future					
Strategic Objective: Increase prevention and tackle the wider determinants of health and care					
2023-24 key priorities: Continue to increase the focus on prevention for health and care – for people of all ages; Work with wider partners and communities to enable people to take an active role in their own health and care.					
Risk Ref: BAF1 Strategic Risk	**The failure to promote and embed health inequalities and prevention initiatives across our delivery programmes** **Due to:** long-term, entrenched and multi-faceted social, economic and racial inequalities in Gloucestershire, which have been further exacerbated by the adverse effects of Covid-19 and the economy moving into recession. This has profoundly impacted racially minoritized and socially marginalised communities and will continue to do so. Multiple disadvantage manifests in our system as health inequalities. Health inequalities are avoidable. They arise when people experience barriers to access and uptake of services, and difficulties achieving best practice management of their conditions (e.g. due to cultural barriers or delayed diagnosis). **Impact:** This can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions, and ultimately higher mortality. All of this is associated with greater cost – to the individual, to society and to the health and social care system.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Cautious**	**3x3=9**	**3x3=9**	**2x2=4**	**NEW**
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	GHC GHFT GCC				
Aligned to current ICB Risks					
Committee	**ICP/ Resources Committee**	**Review Date:**	**13th November 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• • Prevention Delivery Group has been convened to provide oversight for the development and implementation of an approach to prevention in Gloucestershire. •Work on health inequalities embedded into the work of transformation programmes. This includes activity in Gloucester City ("Core20"), activity on race relations ("PLUS") and activity across the 5 nationally identified clinical areas. •Baseline work underway for children and young people (Children's Core20Plus5). •Support taking place with BI and Prevention Teams. Analysis taking place across ICS with BI supporting programmes with information and interpretation to define key health inequalities and support addition of actions addressing health inequalities into programmes and projects across transformation, people and prevention. •Health Inequalities Improvement Manager now in place to support and coordinate the ICBs approach to identifying and responding to health inequalities. • Health inequalities is a standing item at the Planned Care Delivery Board, with particular consideration given to the impact of health inequalities on elective care access.	• Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. Social value policy to guide proportionate universalism in funding allocations	Some health inequalities measures built into strategic outcomes framework with Board-level assurance, Programme of health inequalities analysis commenced to report into board and inform specific actions to reduce health inequalities across all delivery areas.	• Coordinated reporting on both longitudinal health inequalities and medium term control impact (e.g. Core20Plus5). Public reporting of health inequalities not fully established. • Difficulties monitoring effectiveness of interventions around prevention and health inequalities. • No monitoring of the impact of prevention interventions on health inequalities

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
1. Prevention Delivery Working Group are taking a paper to the Health and Wellbeing Partnership setting out Gloucestershire's approach to prevention.	**Newly articulated risk**

2. •Prevention Delivery Group and Health Inequalities Improvement Manager have completed a stocktake of prevention and health inequalities work being undertaken across the system to enable the identification of gaps and opportunities. 3. •Operational plan finalised May 2023 with extensive ambition on health inequalities detailed for key programme areas, especially relating to national priorities including inclusive elective recovery. 4. •System representation at King's Fund workshop on inclusive elective recovery. 5. Development work for reporting on health inequalities workstreams and progress is ongoing. 6. •ICB SROs for health inequalities confirmed as Siobhan Farmer (Director of Public Health) and Douglas Blair (CEO for Gloucestershire Hospitals NHS Foundation Trust). 7. • Work commencing to understand the impact of health inequalities on late presentation to Elective Care and to identify areas for improvement.	
	Relevant Key Performance Indicators: • Under development. Health inequalities narrative at programme level to be included in bi-monthly integrated performance report.

Pillar 2: Transforming what we do					
Strategic Objectives: Take a community and locality focused approach to the delivery of care					
23-24 key priorities: Continue to support improvements in outcomes for people at every stage of life – delivering care that is closer to home and person-centred.					
Risk Ref: BAF2 Strategic Risk	The risk is that our delivery structures and limited capacity are insufficiently focused on community and locality transformation **Due to: Multiple and competing demands to transform services, couple with i**ncreased demand for services and challenging staffing recruitment and retention. **Impact:** waiting times and service delivery across primary and community care. The ability for the community providers to meet increasing demand and the ability to deliver transformation is diluted.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**4x1=4**	**NEW**
Strategic Risk Owner (Director)	**Benedict Leigh, Director of Integration** **Helen Goodey, Director of Primary Care & Place**				
Aligned to other system partners risks (include ref no.)					
Aligned to current ICB Risks					
Committee	**Quality Committee**	**Review Date:**	**14th November 2023**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Neighbourhood Transformation Steering Group in place to oversee the transformation of care at neighbourhood level, integration of health & care workforce and the introduction of new models of care • UEC prevention workstream adopting a population health approach to support those at greatest need and risk of deterioration.	• Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. • Project management support and capacity	• Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG) • Reporting through the UEC prevention programme. • Ongoing monitoring	• Availability of data from community providers

• Working with BI colleagues to understand our cohorts. • Robust metrics to understand impact Developing team in teams at neighbourhood level			

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
• Board development session at end of October considered an approach to support integrated working using the prevention of frailty as a worked example. • Oversight and assurance of UEC prevention workstream through UEC Transformation Board & Steering Group	• GNTG members invited to share the finalised paper with individual organisational Boards with a request to endorse this proposed way of working and giving permission for staff, at Neighbourhood level, to work differently. By end November." • A proposal on implementation together with a roll plan and timeframes will be presented for discussion at our next GNTG meeting on 22nd November.

	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Ill health prevention Outcomes data (November 2023 IPR Report) Ageing well KPIs

Pillar 2: Transforming what we do					
Strategic Objectives: Achieve equity in outcomes, experience, and access					
23-24 key priorities: Reduce unfair and avoidable differences in health and care – including improving outcomes for specific groups of our population.					
Risk Ref: BAF3 Strategic Risk	The risk is that the ICB has insufficient resources and capacity to effectively tackle long term entrenched health inequalities arising from the wider determinants of health **Due to:** long-term, entrenched and multi-faceted social, economic and racial inequalities in Gloucestershire, which have been further exacerbated by the adverse effects of Covid-19 and the economy moving into recession. This has profoundly impacted racially minoritized and socially marginalised communities and will continue to do so. Multiple disadvantage manifests in our system as health inequalities. Health inequalities are avoidable. They arise when people experience barriers to access and uptake of services, and difficulties achieving best practice management of their conditions (e.g. due to cultural barriers or delayed diagnosis). **Impact:** This can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions, and ultimately higher mortality. All of this is associated with greater cost – to the individual, to society and to the health and social care system	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Cautious**	**3x3=9**	**3x3=9**	**2x2=4**	**NEW**
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)					
Aligned to current ICB Risks					
Committee	**ICP/Resources Committee**	**Review Date:**	**13th November 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• Health inequalities Improvement Manager in place to support and coordinate the ICBs approach to identifying and responding to health inequalities. •Work on health inequalities embedded into the work of transformation programmes. This includes activity in Gloucester City ("Core20"), activity on race relations ("PLUS") and activity across the 5 nationally identified clinical areas. • Commitment to patient participation in all workstreams. • Insights Manager for ED&I collects feedback and experiences from seldom heard communities and liaise with ICS colleagues to ensure this data informs service development and delivery. • Funding has been received from the Research and Engagement Network to build on the programme already in place to increase and improve engagement with underserved communities in Gloucestershire around research. This will enable understanding of how health and care services can become more accessible and responsive to communities who are most impacted by health inequalities. • ILP are PCNs are utilising Population Health Management to understand factors underpinning inequalities in thier communities and identify areas for improvement.	• Many initiatives are funded non-recurrently which provides limited opportunity to embed, understand learning and explore scaling up.	• Quarterly activity reporting to NHSE. • Oversight by SROs. • Children's CPG to have oversight of the data for the Core20PLUS5 for CYP	• Lack of granularity around health inequalities reporting. • Lack of clarity around where governance for Children's Core20PLUS5 priorities sit. • Lack of reporting. Being addressed by improving outcomes reporting at a board level (put in action plan).

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• improve health inequalities outcome reporting at a Board level. • Work with information teams to collate and analyse data related to the Core20PLUS5 for adults and children and young people to inform targeting of resources.	NEW

• Stocktake of prevention and health inequalities initiatives to understand the breadth of work being carried out to tackle health inequalities and identify gaps and opportunities for improvement has been completed. • System representation at Regional Inequalities Group and inks with local and regional networks to share information, best practice and learning around tackling health inequalities and to take a coordinated approach to making improvements in population health outcomes. • Citizen's Panel being recruited to provide anonymous feedback which will be used to shape health and care services and support. The Panel will include people who live in priority areas of the county; where people experience greater health inequalities. • Insights Hub being developed, where all reported feedback from local people and communities can be kept together to assist the ICB to access current insight from across the areas.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)

Pillar 2: Transforming what we do					
Strategic Objective Create a One Workforce for One Gloucestershire					
23-24 key priorities: Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.					
Risk Ref: BAF4 Strategic Risk	**People & Culture**: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan **Due to:** High levels of vacancies across many staffing groups **Impact**: Increased pressure on existing staff, impacting staff morale and wellbeing and leading to higher bank and agency usage.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Cautious**	**4x4=16**	**5X4=20**	**3x2=6**	↔
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	**GHFT SR3** Inability to attract and recruit a compassionate, skilful and sustainable workforce (risk rating 20) **GHFT SR4** Failure to retain our workforce and create a positive working culture (risk rating 20) **GHFT SR8** Failure to ensure opportunities and capacity for staff to engage and participate (risk rating 12) **GHC ID4** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives (risk rating 16) **GHC ID5** There is a risk that we are unable to consistently ensure the health and wellbeing of colleagues, particularly during periods of exceptional demand (risk rating 9)				
Aligned to current ICB Risks	**ICB Risk Ref 1113:** Risk of industrial action: There is a risk that industrial action will be taken impacting delivery of services. (Residual score 4x5=20) **ICB Risk Ref 2216**: Risk of insufficient expansion of UEC workforce. (Residual score 4x4=16)				
Committee	People Committee	**Review Date:**	**1st November 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• Utilisation of HEE monies for Continuing Professional Development to support staff training & development • Some leadership learning and development programmes in place • Shared and targeted recruitment initiatives including international recruitment • Further promotion of resources and support available to staff including The Wellbeing Line • Development of summary delivery plans focusing on agreed priority areas for action in 23/24 for each Steering Group.	• Lack of an adequately defined and resourced system-wide and medium-term plan for staff and leadership development (recruitment or role to map current leadership development offers across ICS)	• Reporting to the People Board, People Committee and the Board of the ICB • On-going monitoring progress on key workforce metrics through Integrated Performance Report (see below)	• Implementation details relating to now published NHS Workforce Plan.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
The system continues to develop and embed targeted initiatives: 1. Delivery of existing HEE funded projects e.g., new roles and new ways of working e.g. upskilling of Optometrists, mentoring support (on-going) 2. On-going system focus on international recruitment inc options for a shared approach. 3. Retention programme pilot (NHSE Funded) (started April 2023) 4. Implementation of five high-impact actions for recruitment 5. ICS People Framework to enable cross-organisational working (in place). 6. Initiation of system-wide project on agency spend - Mobilise: March 2023 7. On-going recruitment activities at organisational level and at system level & development of a system wide recruitment campaign "Be in Gloucestershire" 8. On-going focus on health and Wellbeing initiatives for staff		**Updated November 2023** 1.Bids from Clinical Programme Groups for 2023/24 workforce transformation funding have now been finalised 2. Proposed bid under development for System wide housing support role to assist with needs of international recruitment. 3. Retention lead is completing diagnostic position for system to inform future retention plan. 4. No change 5. Staff passporting – work is progressing with the support of digital 6. System wide meeting on agency spend took place on 30/5/23 to share approaches across system. 7. Provider appointed to help develop campaign, diagnostic phase underway. 8. The ICS continues to support the Gloucestershire Wellbeing Line and of the organisations have detailed wellbeing plans and initiatives in place – information and resources shared via system wide Health and Wellbeing Group.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Staff Engagement Score (Annual) • Sickness Absence rates • Staff Turnover % • Vacancy Rates • Bank and Agency Usage • Apprenticeship levy spend and placement numbers		

Pillar 2: Transforming what we do					
Strategic Objective: Improve quality and outcomes across the whole person journey					
23-24 key priorities: Increase support for people living with major health conditions – shifting to a more preventative approach and earlier diagnosis.					
Risk Ref: BAF5 Strategic Risk	The risk is that the ICB fails to assure care provision and identify opportunities to improve quality and outcomes across the system. **Due to:** Lack of robust oversight arrangements to ensure high quality care is delivered by organisations with NHS contracts. **Impact:** Patients and citizens will be put at risk and have a poor experience if those with NHS contracts are unable to deliver high quality care	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Zero**	**5x2 = 10**	**5x2=10**	**5x1=5**	**NEW**
Strategic Risk Owner (Director)	**Dr Marion Andrews-Evans, Chief Nursing Officer** **Dr Andy Seymour, Chief Medical Officer**				
Aligned to other system partners risks (include ref no.)	**GHFT SR2** Failure to implement the quality governance framework (risk rating 16) **GHFT SR 5** Failure to implement effective improvement approaches as a core part of change management (risk rating 16) **GHC ID 1** There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support; (ii) address variability across quality standards; (iii) embed learning when things go wrong; (iv) ensure continuous learning and improvement, (v) ensure the appropriate timings of interventions (risk rating 12)				
Aligned to current ICB Risks					
Committee	**System Quality Committee**	**Last Review & Update Date:**	**7th November 2023**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput. • • •Reporting from and attendance at Provider Quality Committee. • Learning from Case Reviews • System Quality Group • System Effectiveness Group • System IPC Group • System Mortality Group	• Our ambition to develop a System Safety Group linked to the development of the new Patient Safety Incident Response Framework remains. Informal networks are making good progress. • Development work of the System Effectiveness Group is currently underway. The Group's chair will shortly change the CMO with the System Mortality Group reporting to the SEG	• Reporting to Quality Committee • Quality Assurance discussions • Contract Management Boards • Regulatory reviews	• We are assured that the governance process in place mean that we have full oversight.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Actions to mitigate risk & implementation dates • ID 27: Work with National and Local VCS providers to develop range of community options to be used to facilitate discharge. • ID 44: Expansion of a nurse training service to meet the growing needs of training within non-heath care settings (eg schools) • NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. • System Safety and Learning Group to be instigate by 31st December. • PSIRF to be ratified by Quality Committee in February 2024		**Refreshed and updated**	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Summary Hospital-Level Mortality Indicator (SHMI) • NHS staff survey safety culture theme score • Percentage of patients describing their overall experience of making a GP appointment as good • National Patient Safety Alerts not declared complete by deadline • Consistency of reporting patient safety incidents		

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Support improvements in the delivery of urgent and emergency care					
Risk Ref: BAF6 Strategic Risk	Risk that the ICB fails to deliver and/or sustain the transformational improvements in our UEC Transformation (Working as One) Programme **Due to:** Insufficient improvement capacity and / or capability, insufficient staff engagement, or prioritisation of available resource on operational flow pressures. **Impact:** Continued pressure on our staff, performance commitments and system finance plan. Risk patients will have a poor experience of urgent and emergency care services.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↑
Risk Appetite (include colour)	**ZERO**	**5x4=20**	**4x3=12**	**4x2=8**	⟷
Strategic Risk Owner (Director)	**Deputy CEO / Director of Strategy and Transformation**				
Aligned to other system partners risks (include ref no.)	**GHFT SR1** Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System (risk rating 25) **GHFT SR5** Failure to implement effective improvement approaches as a core part of change management (risk rating				
Aligned to current ICB Risks	**ICB Risk Ref 1145**: Risk of insufficient access to alternative pathways to ED (Residual score 3x4=12) **ICB Risk Ref 2231**: Risk of failure to meet core UEC performance metrics. Risk of failure to meet National Ambulance Response times, Risk of non-delivery of reduction in hospital length of stay & Risk of failure to meet National targets for UEC waits: Emergency Department (ED) and Ambulance Handovers [UEC ED Flow]) (Residual score 4x4=16)				
Committee	**People Committee**	**Review Date:**	**13th November 2023**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• .Strong system wide governance for system operational issues (daily and	• Further development of governance structures to ensure leadership oversight and	• Reporting to the Board of the ICB on key metrics via	• Further development of the performance and benefits realisation trajectories

weekly rhythm), supported by System Control Centre. • Leadership identified for system flow and Transformation, alongside programme leadership for identified areas of UEC. • Agreed reporting on priority improvements in place • System approach to operational and winter planning for 2023/24 agreed: linking UEC transformation and operational optimisation. • Strong governance through system meetings (eg UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG). • Use of demand and capacity, additional capacity, discharge and BCF funds to deliver improvements within UEC system flow • Transformation capacity and capability identified, UEC Transformation Programme Board and governance structures in place, key Transformation leads recruited. Transformation Steering Group, Workstream Delivery Groups and Benefits Monitoring Group in place • Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. Transformation programme Board to be in place May 2023, with delivery resource mobilised from early summer. • System wide operating plan submission to align with Transformation priorities for 2023/24 • Priority Transformation programmes to be articulated April 2023, built from existing schemes where work is underway and impact already starting to be seen.	accountability, complemented by enhanced outcome and performance reporting across governance structure (to be enabled by digital platform). Agree funding for improvements as part of the 23/24 operating and financial planning process.	Integrated Performance Report • Ongoing monitoring of agreed system wide risk mitigation plan- this has been superseded by the current recovery plan asks suggest we say monitoring against UEC operational planning targets via TEG/SEG • NHSEI Reporting • Benefits Realisation for UEC programme in place	required for some measures (Partial assurance)

• Learning from winter 22/23 to be factored into Transformation programme •			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Transformation Workstreams continue to deliver priority Trials at pace to agreed schedule, all workstreams to have completed a trial by December 2023. • 2. Learning from Systemwide Event (Sept 2023) being factored into Transformation Programme • 3. Benefits realisation being developed, Programme metrics to be finalised by December 2023. • 4. Communication and Engagement plan developed, core narrative and supporting materials to be shared in November 2023.		This risk has been refreshed and updated	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) IPR Reporting for Acute, Winter monitoring and Ambulance metrics		

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Support a resilient and accessible primary care for the public and increasing workforce recruitment and retention.					
Risk Ref: BAF7 Strategic Risk	Risk of instability and resilience in primary care due to high workload demands, workforce pressures and increased costs **Due** to the changing nature of general practice There is a general concern about workforce resilience and retention across all roles within primary care. GP Locum shift fill is becoming much more difficult and expensive. Practices are facing financial challenges due to the increase in costs associated with staffing, energy, goods and supplies. **Impact:** These challenges could result in waiting times increasing for patients to see primary care professionals; practices facing financial hardship leading to instability, poor morale and hence higher turnover of staff.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ⬇ ⬆
Risk Appetite (include colour)	**Cautious**	**4x4=16**	**4x4=16**	4x1=4	⟷
Strategic Risk Owner (Director)	**Helen Goodey, Director of Primary Care and Place**				
Aligned to other system partners risks (include ref no.)	**GHC ID4** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives (risk rating 16) **GHC ID5** There is a risk that we are unable to consistently ensure the health and wellbeing of colleagues, particularly during periods of exceptional demand (risk rating 9) **GHC ID8** There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities (risk rating 9)				
Aligned to current ICB Risks	ICB 1122 There is a general risk that the ICB's requirements of providing Primary Medical Services for practices that are facing resilience challenges (RED 15) ref 1123, 1124, ref 2240, ICB 2300 Current and future GP Training Capacity will be reduced due to challenges with GP educators and estate (RED 16).				
Committee	**People Committee**	**Review Date:**	**15th November 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• Primary Care Team continues to provide on-going support to practices and provide resilience funding where this is required • Primary Care Strategy is in place with associated plans • Primary Care Workforce Strategy is in place and is being implemented with a vast array of projects and initiatives including supporting new roles ARRs, recruitment and retention schemes, open days and campaigns • Workforce data is analysed on a monthly basis to ascertain early any problems with staffing and support is provided to practices where required • There is a monthly review of practices to assess the issues that have arisen and where additional support is needed • ARR underspend process completed to enable PCNs to maximise recruitment.	• Continue to seek clarification for funding for 2024/25 from NHSE	The Primary Care Operational Group receives regular reports on practice resilience and the schemes and initiatives to support practices including workforce reports. The Primary Care and Direct Commissioning Committee receives those reports from PCOG and provides oversight and scrutiny.	• None
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Further Admin and Reception Staff Training Events - planned - conflict resolution and customer service • Primary Care Induction Sessions - supporting knowledge and training of those new to general practice. • Collaboration with the Wellbeing Line to support staff and retention within roles • Joint working with Gloucestershire Skills Hubs to support people returning to work. • Working with ICS 'We Want You' Programme to support promotion of Primary Care roles to secondary school age children. • Collaborating with Gloucestershire College on T-Level Placements & working on bespoke apprenticeship opportunities with practices		• .	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Reporting on Access to Primary Care • Quarterly surveys and data relating to primary care.		

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities improve access to care – reducing backlogs for people waiting for assessment as well as hospital treatment.					
Risk Ref: BAF8 Strategic Risk	Failing to deliver increased productivity requirements to meet both backlogs and growing demand. **Due to**: Waiting list backlogs generated through Covid as elective services were stood down for long periods of time. On-going impact of staff sickness/absence and general workforce shortages in both medical and nursing posts affecting smaller specialties such as haematology, rheumatology and Cardiology. UEC pressures on elective bed availability continue to be an issue although some elective ring fencing has been possible with new ward reconfigurations. There has also been a growth in 2ww referrals across a number of big cancer specialties such as Lower GI which has diverted all elective capacity towards seeing and treating them at the expense of routine patients. **Impact**: Most elective specialties have a level of long waiters >52 weeks and the total waiting list size is growing at nearly 1000 a month. Clearance of non-admitted patients generates additional admitted patients, and the shape of the waiting list curve is such that waves of long waits come through at different times making PTL management difficult. The increase in cancer work for specialties such as Lower GI and Urology has made it difficult to maintain routine elective activity and so these patients continue to wait longer than we would want. Prioritisation of waiting lists for cancer and urgent P1-2 categories often pushes the P4 routine waits further and further back.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Zero**	**3x4=12**	**3x4=12**	**3x2=6**	⟷
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	GHC 3 There is a risk of demand for services beyond planned and commissioned capacity				

Aligned to current ICB Risks	OP&P 5: Risk of failure to comply fully with NHS Constitution standards for planned care waiting times OP&P 7: Risk of services not delivering to commissioned standards or provider failure		
Committee	**Quality Committee**	**Last Review & Update Date:**	**15th November 2023**

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

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
1) 23/24 plan in place and submitted nationally. Monitoring progress through Planned Care Delivery Board (ICS level meeting with GHFT represented). 2) Additional capacity investments via ERF approved and recruitment underway.	**Updated: 15/11/2023** 1) Plans have been created jointly with system partners and are detailed, robust and achievable.

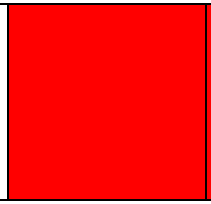
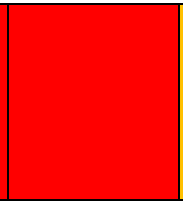
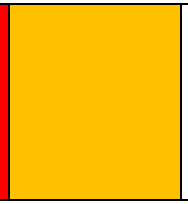
3) Additional capital investment (new theatres) with associated revenue funding agreed. 4) Additional elective activity planned for 2023/24 (e.g. endoscopy, WLI GLANSO lists as well as insourcing and outsourcing). 5) Roll out of CDC activity (new building to come online in December 2023), additional activity in place for several modalities including Echocardiography which will be provided by locums while substantive roles are resourced. 6) Additional activity to be commissioned from ISPs as part of 23/24 delivery. 7) 19/20 baseline adjustment in place for 22/23 monitoring and 23/24 plans. 8) Learning from other systems around waiting list prioritisation to be scoped with clinical leads and plans for task and finish work to improve booking/ prioritisation will be developed according to the findings of this exercise.	2) Plans meet all elective operational plan targets with the exception of a 25% reduction in follow ups. 3) Two additional theatres at CGH now operational. Further TIF bid approved for an additional orthopaedic theatre in 2 years. 4) Specialty plans in place in GHFT to assist with delivery of the 23/24 plan. 5) CDC on track for delivery as planned. 6) IAPs with ISPs agreed and signed off. 7) Planning monitoring set up underway – assurance taking place through Planned Care Delivery Board monthly. 8) NHS Gloucestershire colleagues attended King's Fund workshop in elective recovery and waiting list prioritisation to learn from national research and other areas experience in this area (June 2023). 9) Industrial action has significantly impacted elective recovery, with Junior Doctors and Consultant action causing a large number of elective cancellations. Work is underway to develop a revised plan and recovery trajectory reflecting the challenges associated with industrial action, which is due to be submitted to NHSE on 22nd November 2023. Outpatient Transformation Group being established within GHFT including a focus on improving booking processes and clinical utilisation.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Elective recovery as a % of 2019/20 • ERF achievement • Long waiters' performance • % of diagnostic tests completed within 6 weeks • Early diagnosis rates for cancer • Waiting Time Performance in 2 week waits • % of patients with cancer receiving first definitive treatment within 31 and 62 days

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 Key priorities: Improve mental health support across health and care services.					
Risk Ref: 9 Strategic Risk	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes **Due to:** Number of vacancies across CAMHS and adult mental health services and difficulties in recruiting to vacant posts. **Impact:** Waiting list for treatment remains high for children and adults Urgent referral to treatment times have improved and routine waits have reduced but there are a number of people waiting over a year.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↑
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**4x1=4**	↔
Strategic Risk Owner (Director)	**Benedict Leigh, Director of Integration**				
Aligned to other system partners risks (include ref no.)	**GHC ID3** There is a risk of demand for services beyond planned and commissioned capacity, which cannot be managed through usual mechanisms, resulting in services not meeting the expectations of our community (risk rating 16) **GHC ID4** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives (risk rating 16) **GHC ID9** There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs (risk rating 6)				
Aligned to current ICB Risks	ID 25 -Increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals PC & E 1Lack of workforce in key services across the ICS				
Committee	**People Committee**	**Review Date:**	**14th November 2023**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• Eating Disorder Programme including system wide prevention through to crisis workstreams established. • •CAMHS recovery plan including within service provision and system wide to support improvements. • •Neurodevelopmental business case and plan in place. Funding identified to reduce some of current waits • Adult Community Mental Health Transformational programme.	No significant gaps identified as a monthly system-wide multi-agency meeting is well established and any and all matters of programme management around and performance against the trajectories within the action plan for eating disorders are progressed. If the programme is of trajectory, then the matter is escalated. •No significant gaps identified as a monthly meeting is in place with CAMHs and s system wide multiagency meeting monitors progress bi monthly. No significant gaps in the Adult Mental Health Transformational programme There is a gap in control around UEC mental health including acute psychiatric inpatient due to lack resources	• Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput. • • Waiting times for urgent and non urgent referrals are reducing for eating disorders • There is in place a significant recruitment and retention plan to tackle issues around capacity • Robust governance arrangements in place for community mental health with experts by experience included. • Rapid quality review of Wotton Lawn	No gaps in assurance
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Ongoing monitoring of the mitigations and engagement with service review around increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals. • •Proposal to commence 3 year contract for both TIC+ and Young Gloucestershire to enable security and retention of staff and ensure business continuity. • •Regular reporting to the Children's Mental Health Board and Adult Mental Health Board • •NHS Gloucestershire Board has been appraised of the need to focus on SEND, Operational Executive paper to be discussed regarding key areas of work and future investment. • Work is progressing in this area.		***Refreshed and updated***	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)		

	Improving Access to Psychological Therapies Eating Disorder Access Perinatal mental health -% seen within 2 weeks CYP access

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Creating a financially sustainable health and care system.					
Risk Ref: BAF 10 Strategic Risk	**Financial Sustainability** Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity. **Due to:** – increasing demand for services, increased inflation, ongoing impact of the covid pandemic on a wide range of services and staff and new service requirements – Lack of delivery of recurrent savings and productivity schemes – Recruitment & retention challenges leading to high-cost temporary staffing – Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost – Decrease in productivity within the system – Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding **Impact**: – underlying deficit position within the system as a whole revenue and the system is unable to achieve breakeven recurrent position – Increased requirement to make savings leading to inability to make progress against ICS strategic objectives – Capital costs growth meaning that the system is unable to remain within its capital resource limit	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**4x4=16**	**4x4=16**	**4x2=8**	↔
Strategic Risk Owner (Director)	**Cath Leech, Chief Finance Officer**				
Aligned to other system partners risks (include ref no.)	GHC: 8 There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care				

	GHC 9 Funding - National Economic Issues There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs (risk rating 6) GHFT: SR9 - Failure to deliver recurrent financial sustainability (risk rating 16)				
Aligned to current ICB Risks	F&BI 18 - The ICB does not meet its breakeven control total in 2023-24 (noted that these risks are to be updated on ICB risk management system) F&BI 21 - The ICS does not meet its breakeven financial duty in 2023-/24 (noted that these risks are to be updated on ICB risk management system) F&BI 22 - ICB Headquarter Lease Capital Funding Access F&BI 23 - The ICS does not achieve a breakeven position against its Capital Resource Limit				
Committee	**System Resources Committee Audit Committee**		**Last Review & Update Date:**	**21st November 2023**	
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**		**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**	
• Governance in place in each organisation and System-wide Financial Framework in place • Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC • Financial plan aligned to commissioning strategy • ICS single savings plan in place managed by PMOs & BI teams across the system forming part of the monthly finance review process • Contract monitoring in place • Robust cash monitoring with early warnings • System Financial Improvement Plan in place and further development in progress • Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme	• Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. • Methodology on realisation of productivity not in place • Capacity of teams through the system to deliver programmes of work required to transform system is limited particularly in times of ongoing urgent care escalation		• Reporting into Board of the ICB and relevant Committee for each organisation. • Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position. • Capital monitoring is produced monthly and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system. • Annual internal audit reviews on key financial controls	• Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk	
Actions to mitigate risk & implementation dates			**Director's update on actions to date (quarterly update)**		

• GHFT internal financial improvement plan being updated further with additional measures & controls and implemented in order to mitigate financial pressure. reporting through to the GHFT Finance Committee. • System Financial Improvement actions in place, ongoing updating for additional actions to improve the system financial position.		**Reviewed 21st November 2023** • Work underway within GHFT on changes in productivity since 2019/2020 key areas of focus identified and programmes in outpatients and theatres progressing; • Actions to identify non recurrent slippage to help offset the financial position progressed and now included in financial forecast; • GHFT financial improvement plan actions in place and impact in M7 reviewed.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Delivery of Full year efficiency target Achievement of Elective Services Recovery Fund Target Delivery of in-year breakeven financial position	

5x5 Risk Matrix

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

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

The five levels of risk appetite with appropriate descriptors are as follows that can be applied to the system wide strategic risks and input into the 4Risk system. To note suggested risk appetite scores included.:

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

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 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: • **Flu update** • **Thriving Social Prescribing** • **Community Health and Wellbeing Day** • **NHSE Annual Assessment of Public and Patient Involvement 2022/23**						
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**		**Buildings**	
Financial Impact	The schemes and initiatives included in this report will have associated financial plans that have been approved through established groups and committees.						
Regulatory and Legal Issues (including NHS Constitution)							
Impact on Health Inequalities	N/A						
Impact on Equality and Diversity							

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**
Sponsoring Director	**Mary Hutton, ICB Chief Executive Officer**

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

NHS Gloucestershire Integrated Care Board (ICB)

Chief Executive Officer Report

Wednesday 29th November 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. Flu Vaccination Programme

2.1. This year's Flu vaccination programme is building on the lessons learned from previous campaigns. There is a particular focus this year in trying to overcome the effects of vaccine fatigue from the last couple of years where there has been a lot of publicity about the advantages of vaccinations. We are looking at ways to better support the vulnerable groups of people that have a lower uptake of all vaccinations. A good example of this is the fabulous work of the Gloucestershire Health and Care NHS Foundation Trust Outreach team which is going out to more deprived areas, those living in rural locations and harder to engage demographic groups such as homeless people.

2.2 Here they are offering not only flu vaccinations but also health checks at the same time. 'Access For All Gloucestershire', where we are a national demonstrator site, has taken an innovative approach this year to vaccine delivery of young children and has had a successful campaign by taking Flu vaccine out to nursery schools.

3. Thriving social prescribing networks

3.1.1 We have a well-established Green and Blue Social Prescribing Network, open to all social prescribers in PCNs and the Community Wellbeing Service, as well as VCSE groups across our county, that meets on a quarterly basis. This network shares knowledge and information on activities/research related to 'green' (nature) and 'blue' (water), and brings community partners/ activity providers into the network space to share information and create cross-sector relationships. This network is hugely successful; it fosters a culture of best practice and supports the continual development of skills and relationships across social prescribers and the VCSE sector. This network is now owned and ran by the social prescribers that attend, meaning it is self-sustaining, and has created a number of informal ambassadors across the county.

3.1.2 Following the success of this network we are developing two new networks: social prescribing and physical activity (first meeting 23rd November), and social prescribing and creativity (development talks in progress). We hope these networks build resource and relationships, lead to increased activity provision for those accessing social prescribing, and create ambassadors for physical activity and creativity across the county.

3.2 **Community Health and Wellbeing Day**

3.2.1 To mark Black History Month, various teams at the ICB worked together with the Clinical Programme Groups and the Afro-Caribbean Community-led Engagement Group to organise a Community Health and Wellbeing Day at the All Nations Community Centre. The aims were to:

- empower the Black community to seek medical advice and start a conversation about certain conditions amongst the community.
- highlight the support services available in Gloucestershire for a range of conditions.
- capture the views of the Afro-Caribbean community to help inform and shape future work and service delivery that suits the needs of the community.

The Afro-Caribbean Community-led Engagement Group were key in shaping the event, helping the ICB understand what teams the community wanted to see on the day, firming the logistics of the day and leading on a communication strategy to encourage the community to attend.

3.2.2 Overall, the day was a success! 16 teams shared information and advice, and approximately 100 members of the community attended on the day. 5 referrals were made to the Healthy Lifestyles Programme and 3 referrals were made by the Carers Hub, as well as referrals to other organisations in attendance. Several unfamiliar faces visited, as well as several men, who we are trying to reach increasingly across our programmes. Responses to the feedback survey have also been positive, with the community requesting more events of this nature.

4. **ICB Annual Engagement Assessment for 2022/23**

4.1 ICBs have a statutory duty to make arrangements to involve the public as set out in section 14Z45 the National Health Services Act 2006, as amended by the Health and Care Act 2022. An ICB that is meeting its legal duties on public involvement and is building effective partnerships with its communities in line with the statutory guidance should be able to demonstrate how it is delivering the 10 principles of good engagement1 which are set out below.

4.2

1. Ensure people and communities have an active role in decision-making and governance
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities
5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners
6. Provide clear and accessible public information
7. Use community-centred approaches that empower people and communities, making connections to what works already
8. Have a range of ways for people and communities to take part in health and care services
9. Tackle system priorities and service reconfiguration in partnership with people and

communities
10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

4.3 The commitment of NHS Gloucestershire to working in partnership with people and communities is demonstrated by the very positive key findings from the NHSE Assessment review for NHS Gloucestershire as summarised below:

- clear evidence the ICB is delivering the 10 principles of Engagement (above). This has been brought to life with examples and highlights from the past year, such as the ICB's engagement with the Healthy Lifestyles South Asian Women's Group.
- commendation for the ICB on its use of different and targeted approaches towards public engagement including but not limited to the 'Get Involved in Gloucestershire' online participation platform, NHS information Bus, use of online and print engagement booklets or surveys, use of social media, and attendance at PPG Network Events, intent to capture the outcomes of some of this engagement work via a new online 'Insight Hub'.
- commendation for the ICB's efforts to ensure that information about its services is clear and accessible to the public through the promotion of the NHS 'Accessible Information Standard'.
- recognition that the ICB 'Insight manager' has been working hard to map and then reach out to underserved communities across the ICS.
- recognition of the proactive approach the ICB is taking towards engagement of the Health Overview and Scrutiny Committees (HOSC), including the agreement of a Memorandum of Understanding with the local HOSC.

This work demonstrates the importance and priority of working with partners across the Gloucestershire system on engagement activities.

A more detailed update will be made to the ICB Board in February / March 2024.

5 Recommendation

5.1 The Board is asked to note the CEO report.

Agenda Item 10

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Integrated Performance Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	N/A						
	ICB Internal	**Date**	**System Partner**	**Date**			
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for November 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. This report also includes the new 'Health Outcomes' section, which will be included every 6 months. This incorporates further measures and trajectories from across the system for 23/24, as confirmed in operational planning and as set out in the Joint Forward Plan. This is to provide the Board assurance of delivery against longer-term outcomes through joint work with public health.						
Key Issues to note	Areas of key exceptions have been included at the front of the Integrated Performance Report.						

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

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Integrated Performance Report

November 2023

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Integrated Performance Report Contents

Gloucestershire
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Health Outcomes Report

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Outcomes Comparison

Health Outcomes

- Overall, health outcomes in Gloucestershire are above the national average. Deaths from the major diseases like heart disease and strokes are below the national average and generally following a downward trend, although it is worth noting the under 75 mortality rate for all causes and cardiovascular disease increased in 2020 before falling in 2021 (reflecting the impact of the COVID-19 pandemic on those with multimorbidity). In 2020/21 circulatory diseases were the leading cause of death for both men and women in Gloucestershire (second to respiratory diseases for women (16.9%), and external causes (e.g. trauma) for Men (14.3%)).
- Life expectancy at birth and at 65 years of age is better in Gloucestershire compared to England overall[1]. Although less pronounced than the England average, there is a gap in life expectancy between our most and least deprived areas. In Gloucestershire (2018-2020), inequality in life expectancy at birth is 7.6 years for males in the most deprived areas of the county when compared to the least deprived, and 5.8 years for females[2]. Nationally the gap in life expectancy between those living in the most and least deprived areas has increased in recent years, locally the gap in life expectancy remain largely unchanged. Healthy Life expectancy in 2018-2020 was 67.4 years for men and 66.4 years for women, which is significantly better than England averages.
- However, there are areas of the county where residents' outcomes fall well below national averages and where, as a result, local people are more likely to depend on the services we provide. 19,415 people (3.1% of the county's population) live in areas amongst the most deprived 10% in England[2]. We also have an ageing population. The proportion of people in Gloucestershire aged over 65 has increased from 18.7% of the population in 2011 to 21.7% of the population in 2021[3]. The proportion of people over 65 is set to increase by over 50% from the 2018 baseline by 2043[4], highlighting the ongoing need for effective preventative interventions across the life course that will help people to age well.
- The pandemic has impacted on many people's mental health and under 75 mortality for those with a Severe Mental Illness is higher than average and has been for some time. The emergency admission rate (162.9 per 100,000) for intentional self-harm remains comparable to the national average (163.9 per 100,000), but we see a higher rate in Gloucester City (225.7 per 100,000).

Outcomes Comparison

Health Outcomes

- Screening and immunisations are both effectiveness interventions to reduce morbidity and inequalities in outcomes in relation to infectious diseases and cancer. Overall, screening and immunisations uptake in the county is good. However, both nationally and locally there has been a reduction in uptake of cervical screening and Measles, Mumps and Rubella vaccination. Although Gloucestershire's 89.3% uptake of both doses of MMR by age 5 (89.3%) is higher than the national average of 84.5% it is lower than the national target of 95%.
- Although more challenging to routinely identify in data, evidence shows that some individuals may be more likely to experience poorer health outcomes than others often linked to other vulnerabilities or disadvantages in their lives. This includes, but is not limited to people from ethnic minorities, those with disabilities, LGBTQ+ individuals, people facing socio-economic disadvantage and people with mental ill-health. Understanding and addressing these inequalities should remain a priority.
- The included population outcomes dashboard displays a selection of indicators that support the above narrative, including inequalities in outcomes between different parts of the county (which can be hidden if just considering the county averages). This dashboard is not exhaustive and there are other areas that stand out as needing additional focus and/or understanding. For example, we exceed our statistical neighbours' average for late diagnosis of HIV, rates of smoking at time of delivery in pregnant women, and hospital admissions caused by unintentional and deliberate injuries in children aged 0-14.
- The dashboard highlights that there are opportunities for improved secondary prevention, as well as primary prevention. For example, our urban centres (Cheltenham and Gloucester) saw a significantly lower proportion of patients diagnosed with hypertension receiving a blood pressure check than the county and national average (2022/23).
- Our collective understanding of need in the local community is set out in our Joint Strategic Needs Assessment (JSNA) which is a strategic planning tool that brings together the latest information on the health and wellbeing of people who live in Gloucestershire. Health and Wellbeing | Inform Gloucestershire

Outcomes Comparison

Outcomes Comparison with the National Average and CIPRA comparator local authority areas

Section	Indicator	Latest Value		Rank compared to nearest neighbour (1 is best out of 15)	Trend compared to previous year
		Gloucestershire	England		
Life expectancy and health inequalities	Inequality in life expectancy at birth (male), 2018-2020	7.6	9.7	8	Similar
	Inequality in life expectancy at birth (female), 2018-2020	5.8	7.9	7	Similar
	Inequality in healthy life expectancy at birth (male), 2009-2013	11.2	Not available	7	N/A
	Inequality in healthy life expectancy at birth (female), 2009-2013	11	Not available	6	N/A
	Under 75 mortality rate from all causes, 2021 per 100,000	309.7	363.4	7	Similar
	Under 75 mortality rate from cancer, 2021 per 100,000	118.0	121.5	8	Similar
	Under 75 mortality rate from cardiovascular disease, 2021 per 100,000	65.8	76.0	8	Similar
	Excess under 75 mortality rate in adults with SMI (2018-20) per 100,000	580.2	389.9	15	Similar
Ill-health prevention	Smoking Prevalence in adults (18+), 2022	11.5	12.7	6	Similar
	Smoking Prevalence in Routine and Manual Occupations, 2022	23.3	22.5	10	Similar
	Percentage of adults classified as overweight or obese, 2021/22	62.4	63.8	5	Similar
	Reception: Prevalence of obesity, 2021/22	8.7	10.1	6	Improved
	Year 6: Prevalence of obesity, 2021/22	20.7	23.4	10	Similar
	Percentage of physically inactive adults, 2021/22	18.8	22.3	2	Similar
	Percentage of adults who feel lonely often/always or some of the time, 2019/20	20.4	22.3	5	Not available
	Percentage uptake of IMMR (2 dose by age 5) (2022/23)	89.3*	84.5	8	Worsened
	Percentage coverage of Flu immunisations in at risk groups (2022/23)	57.2	49.1	2	Similar
Cancer and Screening	Percentage of cancers diagnosed at Stage 1 and 2, 2020	52.4	52.3	8	Similar
	Percentage Cervical screening coverage: aged 25-49 years old, 2022	75.0	67.6	4	Worsened
	Percentage Breast cancer screening coverage, 2022	71.9	65.2	4	Improved
	Percentage Bowel cancer screening coverage, 2022	74.6	70.3	4	Improved
CVD prevention	% of patients 18+ with GP recorded hypertension & bp reading in last 12m (2022/23)	87.2	86.9	Not available	
	Treatment to target: % of patients aged 18+ (2022/23)	66.2	68.1	Not available	
Mental health and wellbeing	Emergency admissions for intentional Self-Harm (DSR per 100,00) (2021/22)	162.9	163.9	8	Not available

* Although MMR (2 dose) uptake is higher than the England average it is below the national uptake target of 95%

Outcomes Comparison

Outcomes Comparison within County (compared to the National Average)

Section	Indicator	District latest value compared to the England average					
		Cheltenham	Cotswold	FOD	Gloucester	Stroud	Tewkesbury
Life expectancy and health inequalities	Inequality in life expectancy at birth (male), 2018-2020	9	1.1	5.8	13.5	4.7	6.5
	Inequality in life expectancy at birth (female), 2018-2020	8.4	-1.0	3.8	10.2	2.9	7.4
	Inequality in healthy life expectancy at birth (male), 2009-2013	N/A	N/A	N/A	N/A	N/A	N/A
	Inequality in healthy life expectancy at birth (female), 2009-2013	N/A	N/A	N/A	N/A	N/A	N/A
	Under 75 mortality rate from all causes, 2021 per 100,000	314.7	264.5	302.9	394.5	266.3	319.5
	Under 75 mortality rate from cancer, 2021 per 100,000	116.9	102.8	114.3	133.1	112.2	125.3
	Under 75 mortality rate from cardiovascular disease, 2021 per 100,000	69.0	49.8	73.2	85.7	47.5	76.9
	Excess under 75 mortality rate in adults with SMI (2018-20) per 100,000	N/A	N/A	N/A	N/A	N/A	N/A
Ill-health prevention	Smoking Prevalence in adults (18+), 2022	12.6	6.3	11.3	18.1	8.7	9.3
	Smoking Prevalence in Routine and Manual Occupations, 2022	23.7	6.9	21.1	31.5	25.8	15.6
	Percentage of adults classified as overweight or obese, 2021/22	55.6	51.6	62.3	70.6	64.8	67.5
	Reception: Prevalence of obesity, 2021/22	9.2	8.1	8.7	9.6	7.9	8.3
	Year 6: Prevalence of obesity, 2021/22	19.9	15	24.2	24.6	17.8	20.8
	Percentage of physically inactive adults, 2021/22	19.0	12.6	20.1	22.2	19.6	18.0
	Percentage of adults who feel lonely often/always or some of the time, 2019/20	24.5	18.9	18.3	19.8	17.9	22.8
	Percentage uptake of IMMR (2 dose by age 5) (2022/23)	Not available	Not available	Not available	Not available	Not available	Not available
	Percentage coverage of Flu immunisations in at risk groups (2022/23)	Not available	Not available	Not available	Not available	Not available	Not available
Cancer and Screening	Percentage of cancers diagnosed at Stage 1 and 2, 2020	54.0	53.7	54.1	52.6	46.8	54.2
	Percentage Cervical screening coverage: aged 25-49 years old, 2022	73.4	76.2	75.9	69.6	78.9	78.8
	Percentage Breast cancer screening coverage, 2022	73.1	72.2	73.3	64.1	73.9	75.3
	Percentage Bowel cancer screening coverage, 2022	73.2	75.4	75.4	71.0	76.7	75.9
CVD prevention	% of patients 18+ with GP recorded hypertension & bp reading in last 12m (2022/23)	85.0	88.7	88.4	85.7	88.3	90.5
	Treatment to target: % of patients aged 18+ (2022/23)	64.2	70.3	67.7	62.6	68.3	68.3
Mental health and wellbeing	Emergency admissions for intentional Self-Harm (DSR per 100,00) (2021/22)	287.2	111.1	94.4	225.7	151.5	154.1

Outcomes Comparison

Key	
	Significantly better than the national average
	No significant difference to the national average
	Significantly worse than the national average

Outcomes data is infrequently updated. This report will be updated and recirculated every 6 months.

A detailed excel template with detail of tends and comparators are available on request from the author

[1] Public Health Outcomes Framework, OHID Public Health Outcomes Framework - OHID (phe.org.uk)

[2] IMD 2019, MHCLG and Mid 2020 Population Estimates ONS

[3] 2011 Census and 2021 Census, ONS

[4] 2018 based sub-national population projections, ONS

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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)

Feedback from Committees

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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	17 November 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Finance: In Year Recovery (M6)	Limited	Letter received from NHSE, outlining priorities. 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 and the work being undertaken on the financial recovery plan to mitigate these pressures.	M7 report to be shared with the committee. Letter from NHSE to be reviewed and compared with the priorities held locally.	December 2024
Planning	Limited	Updates provided on the Medium-Term Financial Plan, Joint Forward Plan, Operational Plan and the Non-Recurrent Schemes within the system. The revised, collaborative approach was discussed and approved by the committee.	Planning team to continue with their proposals, keeping to the timeline determined by NHSE.	December 2024

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	26 October 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
On-going threat of industrial action	Limited	Notification of intention for BMA on 6 November to issue a ballot for industrial action for SAS doctors	Business continuity planning as per usual arrangements	December 2023
Band 2/Band 3 Pay issue	Significant	Further discussions with regional Unison/Unite representatives', agreement still needs to be reached regarding the proposed apportionment of compensatory payments and the methodology used to determine eligibility.	Re-worked proposals to be put forward to Staff Side	December 2023
Inadequate workforce supply & challenges with recruitment and retention of health & social care staff across a variety of roles/ settings	Limited	All organisations continue to focus on a range of recruitment and retention initiatives. Deep dive on retention at October People Committee.	Work continuing on system wide campaign Be in Gloucestershire.	Planning to go live in early 2024.
Loss of Workforce Development Funding WFD) in 2024/25	Not assured	NHSE have formally notified ICBs there will be no WFD monies in 2024/25. (Historic value has been £310k inc. monies for Training hub). These monies support targeted education and support for staff and key infrastructure roles in the People Team.	CPOs across SW have written to Regional People Director to highlight the risks and consequences of loss of funding inc. impact on delivery of NHS Workforce Plan. Mitigation for impact on staffing roles being sought.	Q1 2024/25
Loss of Continuing Professional Development Funding WFD) in 2024/25	Limited	Indication of no further CPD funding for nursing and allied professional staff in 2024/25	Discussion at Education & Training Steering Group on risks and impact.	Impact 2024/25

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	19 October 2023

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Wotton Lawn Hospital	**Significant**	Good progress has been made and Wootton Lawn has been stepped down out of enhanced surveillance.	Ongoing monitoring moves to BAU.	-
Adult Social Care	**Limited**	Mental health social work and occupational therapy are now listed as risks for Adult Social Care.	Sessions at the ICB Board and GCC Scrutiny will be requested to further expand on the risk. Regular updates and assurance will be brought to the Quality Committee due to much of the work being system related.	TBC
GHFT 'Learning From Deaths' report	**Limited**	GHFT had not fully complied with NQB guidance on the tabling of 'Learning from Deaths' reports at full Trust Board, though report had gone to quality committee.	Reports will be sent to Board with the Trust committing to comply with NQB guidelines.	November
Maternity	**Limited**	A Section 29A notice was received on 8th September in connection with two issues; training compliance for Children's Safeguarding and the timely closure of clinical incidents.	The trust expects significant improvement by 10th November, with full compliance by December. The CQC had been invited to spend some time at the Trust.	December

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	N/A

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- Referrals into GHFT for suspected Lower GI cancer from Primary Care are now accompanied by FIT results in 79% of cases – ahead of the improvement trajectory planned for 23/24 and achieving the 6th best performance in the country.
- Additional ICB investment in the adult's and children's Autism and ADHD pathways has been agreed to increase capacity in line with demand. The new integrated Autism and ADHD pathways will have a clear route for all referrals, one provider coordinating the multi-disciplinary assessments and a process for transition of care into adult services where required.
- Elective Recovery Performance continues to meet our system target, despite industrial action causing significant numbers of cancellations. The system position for M1-5 (to August 2023 – latest available validated data) is 105.8% of value weighted activity (compared to 2019/20 levels).

Areas of Focus

- Diagnostic turnaround times are an area of concern for diagnostic performance – in particular imaging diagnostics associated with cancer referrals and GP tests have not met expected thresholds for a number of months and are starting to impact other targets (e.g. cancer access).
- Cancer access targets have been missed for the first time in 23/24 with challenges in breast, skin and Lower GI specialties (staffing and diagnostic test turnaround time) driving the reduction in performance .
- GHFT have declared 18 78 week wait breaches for elective treatment in September with more likely moving into October. This is due to the capacity losses across the system throughout August and September due to industrial action in particular.
- UEC performance has struggled to recover from the deterioration seen at the start of September, with ED performance declining in October and despite some improvement seen in the month, ambulance Category 2 response times and time lost to handover delays remaining longer than any other month in 23/24 to date.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

NHS Funding

Support For Care Leavers

- The ICB has received £40k of non-recurrent funding for the NHS universal family care leavers covenant programme, a nationally sponsored initiative aimed at increasing the number of care experienced people employed by the NHS.

Reducing Health and Care Support Worker Vacancies

- Both GHFT and GHC have submitted Expressions of Interest for an opportunity to bid for £15k per organisation for initiatives to support a continued reduction in vacancies numbers for HSCWs.

Mental health crisis training

- EOI submitted to NHSE for £25k for system-wide mental health crisis training.

People Promise Manager (Phase 2)

- GHC offered a People Manager post, with the aim of improving staff experience and retention by focusing on all elements of the People Promise, following success of wave 1 sites.

Leadership

- System-wide Leadership programme mapping commenced

Systems Thinking

- Systems Thinking masterclass cohorts 3 and 4 commenced, applications heavily oversubscribed with respect to available places.

EDI

- Reciprocal Mentoring cohort 2 expressions of interest launched
- Inclusion Allies cohort 2 completed, and evaluation underway

Areas of Focus

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

- Continued focus on increasing (more cost-effective) bank staff usage over agency staff usage. Review of potential tools to support this and ensuring system wide tender opportunities maximised.

System-wide Development Programmes

- Reciprocal Mentoring Cohort 2 planning (2023) for delivery in 2024.
- Systems Thinking masterclass cohort 5 TBC in 2024 – dates and delivery following interest in programme.
- Agree details of system Leadership development offer/conference in 2024 with system partners. This will be in collaboration with the Improvement Community Steering Group.

Please note: The Quality report is updated bimonthly.

Quality

Quality – Safety, Experience and Effectiveness

Key Achievements

- Wotton Lawn stepped down from 'enhanced surveillance.'
- The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has continued to reduce, remaining within expected levels since November 2022.
- PTAC have shown improvement in call wait times. Last week, the average waiting time was 12.01mins, down from 21.26mins previous week and down from 28.16mins the week before that.
- The commitment of NHS Gloucestershire to working in partnership with people and communities is demonstrated by very positive key findings from the NHSE Assessment review for NHS Gloucestershire including commendation for the ICB on its use of different and targeted approaches towards public engagement.

Areas of Focus

- Demand for repeat prescription via OOH services - work underway to support Primary Care.
- Establishment of the System Safety Group and patient experience group.
- Provider Patient Safety Incident Response Framework plans 'PSIRP' expected to be received by the ICB in February 2024.
- Weekend vs Weekday mortality will be examined in the next System Mortality Group.
- Work is progressing around the UEC transformation, focus on quality metrics to commence in the new year.
- CQC paid an unannounced visit to Berkley House. We held a Rapid Quality Review as a result and the Trust is delivering on an action plan, supported by an ICB Quality Improvement Group.

Finance and Use of Resources

Finance

- The ICS finance position as at month 7 2023/24 is:

	Year To Date (£k) (Overspend)/Underspend	Forecast Outturn(£k) (Overspend)/Underspend
GICB	(2,788)	0
GHFT	(2,418)	0
GHC	1,176	0
Total Surplus/(deficit)	**(4,031)**	**0**

- The ICS continues to face a number of significant financial pressures across a number of areas, within this position the work on mitigations, including recovery plans in place, is now starting to realise results and these are being worked through into a revised financial forecast for all organisations. As at month 7 reporting, the forecast remains breakeven.

- Mitigating actions include non-recurrent savings and identification of slippage against programmes and budgets, implementation of additional controls and productivity improvements within GHFT, with some impacting 23/24, and others next year in 24/25 and bringing forward plans for other areas; again, these will have a limited impact on 2023/24 but will lead to earlier delivery in 2024/25.

- Year to date capital expenditure has a variance of £5.8m underspend against budget for the year, mainly relating to early year slippage against schemes, schemes are forecast to recover the slippage by the year end. There is a risk to the capital forecast relating to a finance lease that has recently been identified which is not eligible for national funding, work is ongoing across the system to ensure that 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 7 have fallen below the straight line value of the agency cap for the system. Actions are underway to further reduce the expenditure within both Trusts, however, Industrial Action is one of the factors impacting on this spend.

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Detail of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Urgent & Emergency Care

- October Emergency Department performance was 72.0% (seen and treated/admitted within 4 hours) – with MIIU performance at 99.5% and Type 1 ED performance at 57.1%. While Gloucestershire as a system and GHFT remain in a stable position in rankings of ICS and acute trust performance (around the national median position), performance across the whole country has declined in October.
- Ambulance: October Ambulance Category 2 response time performance was 70.9 minutes (a deterioration from September at 46.7 minutes). Category 1 response times were 11.0 minutes on average, with a range from 14.1 minutes in the Cotswolds to 7.8 minutes in Gloucester localities. There were 5582 hours lost to handover delays in October (186 hours on average per day), which is the most seen monthly in 23/24 to date, however both Category 2 and handover delay times have been improving throughout October.
- A focussed action plan has been developed to improve patient experience and timely care, and this is overseen at executive level weekly across the system. Particular emphasis is being placed on the enhanced weekend plan – which is supporting increased patient discharges across the weekend to help resolve congestion in the acute hospital.
- There is continued focus on system pressure planning to proactively manage wider strategic plans including the mobilisation of the new Forest of Dean hospital into 2024 to mitigate the impact these have on system flow. The expanded Surgical Assessment Unit is going live in December which will see an improved pathway for patients attending ED with abdominal pain and likely in need of surgery – freeing up space in ED and improving use of acute bed capacity. Expansion of virtual wards to support surgical patients will also be rolled out with 40 beds planned by March 2024 in this area.
- NHS111 has seen a significant improvement in call answering during October, with proportion of calls abandoned dropping to 9.8% (down from 20% average in September). Practice Plus Group have been trialling a new contract to improve evening and weekend shift fill and increase the resilience of the service – this will be kept under review, but initial performance appears encouraging.
- All workstream leads for the UEC transformation programme are now in place, with trials in all areas identified and up and running in most cases:
    - Prevention: Admission avoidance for GPs, Falls Prevention, Integrated Proactive Neighbourhoods
    - Community Urgent Response and Front Door: SWAST pathways to Rapid Response, Front Door – Frailty Pathway
    - Acute Hospital Flow and Decision Making: Model Ward, Complex Discharge Process
    - Intermediate Care: Home First and Reablement, Pathway 2 Length of Stay
    - Access to Care Packages: Sourcing delays and target market capacity, Optimal handed care

Improving Services & Delivering Outcomes

Elective Care

- Elective Recovery Fund performance year to date, based on Freeze data (M1-5) is 105.8%, thus achieving the new revised target of 105% but still below the submitted plan of 109%. Pathways avoided are contributing c.4% on top of activity recovery. The projected full year outturn is delivery of 102.9% (up from 102.3% last month). NHSE have confirmed the national target will be further relaxed to reflect the impact of industrial action with all systems receiving their full funding allocation.
- In September, long waits for elective care have stabilised (52 week waits for the ICB are at 3,166, slight decrease from August position of 3,242) with ENT and Oral Surgery accounting for more than 50% of these long waits. 65 week waits for the ICB also decreased slightly from 809 in August to 793 in September. GHFT have reported 18 over 78 week waits 16 Gloucestershire patients and two out of county). Overall, there were 18 over 78 week waits for ICB patients in September (up from 19 in August). RTT performance (% patients on the waiting list, waiting less than 18 weeks for consultant led treatment) in September was 64.9% across all providers, 64.6% at GHFT. The waiting list has increased slightly, with 79,669 pathways open for Gloucestershire patients at the end of September 2023.
- GHFT are continuing to increase the use of Patient Initiated Follow Up to reduce unnecessary follow up outpatient appointments, with overall performance at 12% (patients discharged to PIFU) against a national target of 8%. Use of Advice and Guidance remains strong, with work ongoing to support specialties where there is an A&G backlog (Haematology and Dermatology). Outsourcing for Haematology A&G has been procured, and will commence in November; Dermatology is working on an action plan to improve A&G turnaround time, including a reset week to address some of the backlog of requests.
- 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 – this will particularly focus on productivity and will link into the medium term financial plan.
- The Theatre Delivery Board at GHFT has been focussing on the theatre utilisation rate, which has improved to 79%. It is exploring the variation between theatre utilisation at core and community sites and how to introduce bespoke booking to reduce early finishes for theatre sessions.
- Role out of the Patient Initiated Digital Mutual Aid System (PIDMAS) has now gone live, with GHFT contacting ~2400 patients waiting over 40 weeks without an appointment booked to offer the option of exploring alternative providers for their treatment in line with national commitments. A small number of patients have expressed an interest in this option.
- An updated version of G-Care, which helps support GPs with referrals into secondary care, will launch this month, with proposed closer working between secondary care clinicians going forward to support G-Care with timely updates to optimise the interface between primary and secondary care.

Improving Services & Delivering Outcomes

Cancer

- In September, performance against the 2 week wait (2ww) and 28 day Faster Diagnosis (FDS) standards was missed for the first time in 23/24. 2ww performance was 90.1% and FDS performance was 74.3%. The majority of breaches were in suspected lower gastrointestinal cancers, suspected breast cancer and suspected skin cancers. This performance deterioration was driven by staffing issues and turnaround times for diagnostic tests; a breast recovery plan is already in place with performance expected to recover in January 2024, and Skin and Lower GI specialties are currently reviewing requirements for a recovery plan.
- 31 day first treatment performance for the ICB decreased in September down to 88.7% from 90.5% in August, missing the 96.0% target. ICB 62 Day performance decreased in September from the August position to 60.3%. This is still below the 85% target which has not been met since Jan 2021. 62 Day breaches are mainly being driven by Urological, Gynaecological, and Head and Neck as backlogs in these specialties continue to challenge performance. 104 day waits have increased in September to 27 from 21 in August. The majority of waits over 104 days are for Urological cancers (16 of 27). 195 patients at GHFT were waiting more than 62 days for treatment (or exclusion of cancer) in September – above the planned 180 committed in the operational plan. This is the result of the prolonged industrial action as ability to provide cover has decreased. There is ongoing work to continue to reduce the backlog and prevent new patients tipping over 62 days.
- Non specific symptom (NSS) referrals in September were at 28 – 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. Overall 273 referrals into the service have been made, with 7% of patients receiving a cancer diagnosis. More than 60% of patients have been discharged with reassurance.
- Breast Cancer Awareness month took place across October 2023 with events including: public promotion Gloucester town by the information bus supported by a cross organisational multi-disciplinary team; Breast Cancer Talks at a variety of venues, particularly aimed at supporting ethnic populations who may be less likely to come forward with cancer symptoms – including refugee groups; Combined breast cancer and prostate cancer awareness event (held at the All Nations African Caribbean Community Centre). November 2023 is Lung Cancer Awareness Month, with events planned in the Forest of Dean throughout the month at various venues and supported by GHFT Lung Cancer Nurses.

- *Note: from October 2023, the new simplified Cancer Wait Time standards have been launched, performance will continue to be reported against the current standards until October data is available (December).*

Improving Services & Delivering Outcomes

Primary Care

- There continues to be significant public demand on primary care, with 375,067 appointments carried out in September 2023. The activity for the financial year 2023/24 to date is 211,080 appointments above plan (11.8% over planned levels of activity).
- The #BeKind Campaign has launched in Gloucestershire, highlighting how GP surgery staff deserve to work without fear and that any abuse or violence directed at NHS staff is unacceptable. #BeKind thanks local people for treating staff with respect.
- The seasonal vaccination programme began on Monday 11 September, for both Influenza and COVID-19 vaccinations. Residents in care homes and those who are housebound are being prioritised. Engagement and communications work is ongoing to promote vaccination particularly among groups less likely to take up the vaccination offer. To date 54.8% of the eligible population have received their COVID-19 booster.
- Use of Fecal Immunoprecipitation Testing in primary care is ahead of trajectory to reach the 80% compliance target for 23/24 – data for October shows that suspected Lower GI cancer referrals into GHFT with an accompanying FIT results are at 78.9% - ahead of the 72.5% forecast for October 2023 and is the leading performance in the SWAG cancer alliance region and 6th ICB nationally.
- Dental Services – following the delegated responsibility for the planning and commissioning of primary, community and acute dental services to ICBs, NHS Gloucestershire is currently exploring additional urgent dental capacity both in and out of hours with some capacity due to be delivered from November 2023, as well as medium term plans to increase routine and urgent capacity in the county.
- A regional Supervised Toothbrushing programme has been procured by NHSE and will be rolled out in Gloucestershire in November. The aim of the scheme is to enable children in early years education settings to brush their teeth with fluoride toothpaste each day they attend under supervision from staff. This will be achieved by the Provider training the early years staff in each setting and a named member of staff being the Oral Health Champion in each setting. The staff will then supervise the children brushing their teeth during the nursery or school day. This new programme is aimed at Early Years settings and children in reception class in areas classified as IMD deciles 1 to 6. We anticipate the inclusion of 115 primary schools and early years settings attached to those schools across the county with information being sent to schools from December 2023 onwards.

Improving Services & Delivering Outcomes

Diagnostics

- Diagnostic performance has stabilised with September overall performance at 16.7% (compared to 17.6% in August) of patients waiting over 6 weeks for a diagnostic test at the month end. GHFT overall performance at 17.7% (therefore both the ICB and GHFT missed the 15% target for 23/24 for diagnostic recovery).
- Endoscopy is the main driver of the long waits in the system – with the colonoscopy waiting list rising to 905 in September (nearly double the average monthly activity) and 555 breaches of the 6 week target. Flexi sigmoidoscopy activity has reduced substantially – there is less demand for the pathway since the decommissioning of the bowel scope screening during the COVID pandemic, however activity has fallen well below current demand and it is clear that current capacity is not meeting demand. 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. Gloucestershire workforce strategy will also feed into endoscopy recovery, as well as review of county wide services and how they are utilised. As a short term measure, additional funds have been requested from NHSE to run outsourcing lists to support backlog clearance with a decision expected imminently. NHSE have offered a support visit which has been accepted for the 14th December to review our endoscopy services.
- Echocardiography performance continues to be below plan. With two additional locums now in place, performance has stabilised (306 people are waiting over 6 weeks for this test – 28.8% of the waiting list) and the waiting list size is beginning to reduce. The cardiology service have implemented an action plan to mitigate these performance issues.
- Focus on Diagnostics month has been taking place throughout October and into November. The Gloucestershire system has identified Endoscopy, CDC utilisation and histopathology as areas for particular focus. Webinars and learning events to support improvement projects and share good practice across region have been taking place. CDC activity monitored weekly and is positive in most areas. Histopathology 10-day turnaround times are not meeting targets and a six point improvement plan is in place, regularly reviewed at GHFT. Support from the histopathology network is in place with the lead scientist working with GHFT Ultrasound performance was highlighted as a focus for the South West region, however GHFT performance in this modality is the best in the South West with consistently high activity and stable performance (under 5% of the waiting list waiting more than 6 weeks throughout 2023).
- Turnaround times for imaging are similarly challenged (as with Histopathology), in particular three day turnaround for suspected cancer and seven day turnaround for urgent GP requests – there have been issues with the implementation of the new PACS system which has caused delays. A system upgrade is due 2nd week November which should improve stability and help to improve turnaround times.

Improving Services & Delivering Outcomes

Mental Health

- Improving Access to Psychological Therapies (IAPT) access has increased slightly to 1152 in September– though remains below plan. Referrals have decreased after seeing an uptick in July and August, meaning October access is likely to remain below plan. Work continues on the extensive rebrand (to “Talking Therapies”) and advertising campaign to increase referral rates. Recruitment and retention of high intensity therapists is a particular challenge currently, particularly as some staff are choosing to join providers offering a fully online service – which the IAPT service has explored and feels is not right for Gloucestershire.
- Out of Area placement provision has increased to 179 days across Q2 of 2023/24 (up from 62 in Q1). This brings the total YTD to 241 against the YTD target of 600. The annual target is 800. The increase in external placement has been due to increases in need for mental health beds – with limited additional capacity in the system to respond to demand fluctuations, additional beds have had to be purchased to manage pressure.
- Eating disorders – the proportion of patients assessed within target has improved significantly in 23/24 to date. The August position (latest validated data) shows that for adults, 91.6% received treatment within the 16 week target. The CYP service has achieved 100% of referrals beginning urgent treatment within a week, and 77% of routine referrals beginning treatment within 4 weeks in August. The triage of new referrals has contributed to this improved performance by ensuring guided self-help can be introduced much earlier into the patient’s pathway. The service continues to work with additional providers (BEAT, ORRI and TiC+) to support patients and their families either on the waiting list or with appropriate therapy.
- Uptake of physical health checks for people with Serious Mental Illness (SMI) remain stable, with Q2 performance at 50.1%. There is ongoing work to ensure community mental health teams 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.
- Additional ICB investment in the adult’s and children’s Autism and ADHD pathways has been agreed to increase capacity in line with demand. The new integrated Autism and ADHD pathways will have a clear route for all referrals, one provider coordinating the multi-disciplinary assessments and a process for transition of care into adult services where required. This will improve the experience for individuals and their families and be a more efficient use of resources and professionals’ time. The details of the Service Specifications are being finalised. The services have initiated recruitment and will continue to build their teams over the next year. Neurodiversity dashboards are being developed by GHC to enable timely reporting to the ICB and for wider system assurance.
- CYP access performance against the operational plan target was reported as under plan during Q1 of 23/24 – this was due to a data issue which has now been resolved, however due to the cumulative methodology for the reporting of this KPI, performance is likely to remain below plan until Q4. Waiting times for core CAMHS have been reducing steadily with several contributing factors: staffing numbers have very recently improved, demand has levelled out and there are a number of initiatives alongside wider services for children and young people within schools, the voluntary and community sector and social care, addressing emotional wellbeing and mental health needs.

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Recruitment and Retention

- International Recruitment – £350k Local (Section 256) + £350k NHSE funding approved for Domiciliary Care International Recruitment. Eligibility criteria for care providers has been agreed, care homes informed and expressions of interest invited. This project is being aligned with nationally funded (by DHSC) project for Pastoral support for International Care workers that is being led by GCC. Scoping of InterN app (provided local information) for international recruits in social care has been undertaken and investment approved.
- Accommodation – a proposal for a SW regional collaboration is being developed consisting of 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 preceptorship gold quality mark now achieved for GHFT, GHC and Primary Care. Midwifery preceptorship updated and will work towards gold mark for Spring 24. AHP national framework still awaited.
- ICS Legacy Mentors – Lead LM role appointed to as well as nursing LMs in Primary Care, GHC, GHFT, Midwifery and AHP LMs in SaLT - delivery commenced. Remaining AHP LM roles in dietetics and radiotherapy still to be appointed.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Valuing and looking after our people

- The Health and Wellbeing group are developing a system-wide Health & Wellbeing Strategy, the vision statement has been drafted.
- The Health and Wellbeing group are developing a system-wide 'early starter conversation', 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.
- GHC awarded gold Armed Forces Covenant - Employer Recognition Scheme (Aug 23) and ICB applying for bronze award.

Education Training and Development

- Facilitating the easy movement of staff between organisations has a number of elements, one of which is a "Staff Training Passport", there is a national solution that is being rolled out for this (Digital Staff Passport) and both Trusts are undertaking readiness assessments for the implementation wave 4, originally planned for Jan 2024, now delayed (nationally) until July 2024.
- Audit and Research Evaluation Course has been advertised (1st cohort - 20 places)
- The University of Gloucestershire and the ICS are offering two funded PhD opportunities. Together they are supporting the opportunity for staff to apply for funding to undertake an area of doctoral study and research as part of the University's new Arts, Health and Wellbeing Centre

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

Workforce Planning, Digital & Data, EDI, Leadership & Culture

- System Leadership development programme lead post has commenced in post - initial tasks are to undertake a baseline mapping and scoping of the existing organisational/regional leadership offers.
- An evaluation of cohort 1 of the reciprocal mentoring programme has been completed and has fed into the design of cohort 2 which has been advertised and expressions of interest invited. Cohort 2 will commence December 2023.
- The Inclusion Allies Programme has been completed and evaluation commenced.
- A review and alignment of national and local EDI action plans has been undertaken to avoid duplication of effort and streamline actions. This will be discussed at the next OD Steering group.
- Cohorts 3 and 4 of the Systems Thinking Masterclass programme have commenced. Due to the popularity a 5th cohort is being planned to commence early 2024.
- Collaboration with the countywide Improvement Community Steering Group on a programme of system-wide leadership conferences programme in 2024.

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Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The Clinical and Quality Directorate have not yet received the Q2 POD Integrated Quality Report. NHSE SW have advised that the report will be incorporated into the monthly information pack on a quarterly basis and therefore we expect data for Q2 to be available with the October pack - due to be received by the ICB in November.

- A second POD delegation workshop event was held in Taunton on 12th October. The Clinical and Quality Directorate attended along with primary care commissioning, pharmacy and finance colleagues and gave opportunity for networking with SW ICB and Collaborative Commissioning Hub (CCH) colleagues. The day commenced with the presentation of five case study deep dives to celebrate success stories and learning followed by subgroup discussions focussing on ways of working. Discussions centred on CCH and ICB priorities, decision making, risk register, monthly activity packs and complaints processes.

Urgent and Emergency Care

- Work is progressing around the UEC transformation, focus on quality metrics to commence in the new year.

- The ICB are continuing to work proactively with PPG (out of hours GP service). Work is underway alongside Medicine Optimisation colleagues to review demand for repeat prescription ordering via 111 & OOH to support and improve awareness and safety.

Patient Transport Advice Centre (PTAC)

- Since we last reported on PTAC considerable work has been undertaken to improve the call answering times. This includes the onboarding of new staff and the development of new ways of working. Over the last three weeks the average waiting times have reduced consistently. Last week, the average waiting time was 12.01mins, down from 21.26mins previous week and down from 28.16mins the week before.

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Quality – Safety, Experience and Effectiveness

Assurance

Community and Mental Health

- Following discussion at the recent System Quality Group meeting on 17th October, the decision was made to formally stand down the period of enhanced surveillance and quality monitoring for Wotton Lawn hospital.

- Following recent CQC concerns regarding the standards of care at Berkeley House, a rapid quality review meeting, chaired by the ICB Executive Chief Nurse, was held on 24th October. The decision was made to place Berkeley house on a period of enhanced surveillance with the first meeting of a Quality Improvement Group scheduled to take place on Friday 10th November.

Maternity

- GHNHSFT are awaiting the publication of the latest CQC report with the LMNS receiving monthly progress updates. The ICB is liaising closely with the NHSE Maternity Safety Support Programme Advisor allocated to GHT.

- Though there remain a number of Midwifery vacancies, there are new midwives joining the Trust over the next few months. Maternity vacancies are on the trust risk register. Recruitment and retention plans are in place. Exit interviews are being conducted to monitor reasons.

- Dedicated team now appointed at GHT to work through all actions plans for Ockenden, Saving Babies Live and Maternity Incentive Scheme Y5. The LMNS will approve and sign off submissions to NHSE and will report through the System Quality Group. Work continues to develop one single action plan, including the 3 Yr Delivery Plan for maternity & neonatal care

- First trimester screening Serious Incident (SI) action plan is in place, with reviews by NHSE/LMNS/GHT. Its on the Trust & ICB risk register. The Joint safety Forum with BSW LMNS – sharing learning from incidents and good practice have considered this incident.

- Cheltenham Birth Unit & Stroud postnatal beds remain closed due to extreme staffing challenges.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

There were no Never Events reported in September or October.

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.

Learn from Patient Safety Events (LFPSE)

- To support PSIRF NHSE have launched the new LFPSE system. Unfortunately both GHFT and GHC have been affected by an issue with Datix (the provider of their local risk management system). This means they have not yet managed to transition to LFPSE.
- This is a known issue and NHSE SW region are fully aware.
- NHSE have also rolled back the use of LFPSE with new incidents under the new Patient Safety Incident Response Framework. They have now directed that upon transition providers should continue to use the Strategic Executive Information System (STEIS).
- We are also waiting to see the results of the promised enhancements to the data access app. Until reporting improves, LPFSE will have limited use for the ICB.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Patient Safety Incident Response Framework (PSIRF)
The provisional timescale for the implementation of PSIRF has been adjusted to fit with provider board arrangements. System partners have now agreed to switch from the Serious Incident Framework to the new PSIRF on 1st March 2024.

- Patient Safety Incident Response Plans (PSIRPs) will go to provider boards in January
- PSIRPs will then be sent to ICB Quality Committee in February for ratification.
- Formal Switch on March 1st
- This means that the last SI could be declared on Feb 29th meaning that the closedown of the last SI is expected by 28th May.
- Once we have transitioned, the role of assurance will sit with provider boards and not the ICB. Our role will change to be around the assurance of systems and spreading learning across the ICS.

System Safety Group
As part of the switch from SIs to PSIRF the ICB will formally instigate a System Safety Group.

This group will have two main functions:
1 – To support 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.

One of the first priorities of the System Safety Group will be to develop a system to spread learning and cross system Patient Safety Investigations.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

		Apr-23 Provider	May-23 Provider	Jun-23 Provider	Jul-23 Provider	Aug-23 Provider
GHT Inpatients	% Positive	93%	93%	93%	94%	92%
	% Negative	4%	3%	3%	3%	5%
GHT A&E	% Positive	83%	81%	78%	79%	78%
	% Negative	12%	11%	14%	12%	13%
GHC Mental Health	% Positive	87%	83%	87%	82%	89%
	% Negative	7%	6%	6%	7%	5%
GHC Community	% Positive	94%	94%	95%	94%	95%
	% Negative	3%	3%	3%	3%	2%

The Friends and Family Test (FFT)

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

- GP Practices are encouraged to promote the FFT to their patients. Approximately one third of Gloucestershire practices consistently submit no monthly FFT data. However, those who do submit data consistently receive a higher percentage positive response than the England average (see below).

Name GP Practice Friends and Family Test Responses	Total Responses	Percentage Positive	Percentage Negative	Total Responses	Percentage Positive	Percentage Negative	Total Responses	Percentage Positive	Percentage Negative	Total Responses	Percentage Positive	Percentage Negative	Total Responses	Percentage Recommended	Percentage Not Recommended
ENGLAND	387,189	91%	5%	376,210	91%	5%	509,530	91%	5%	550,044	91%	4%	570,025	91%	5%
GLOS ICB AREA	5,159	87%	9%	5,134	93%	3%	6,552	93%	4%	5,557	93%	4%	6,815	92%	4%

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

System Clinical Effectiveness Group

The System Clinical Effectiveness Group (SCEG) is due to meet on Monday 13th November. The ICB Chief Medical Officer (CMO) is consulting with the CMO's at Gloucestershire Health Care and Gloucestershire Hospital Trust to extend an invitation and encourage representation for senior medical leadership at the meeting.

The plan is to move Clinical Effectiveness under the new CMO in order to encourage wider participation and to widen the scope of the meeting. From a governance perspective, the System Mortality Group will report into the SCEG, which will report in the Quality Committee.

Mortality

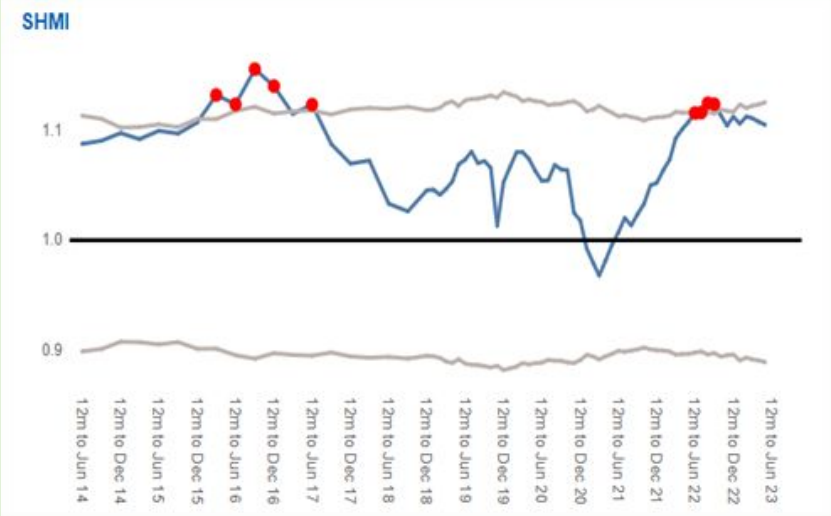
The Standardised Hospital Mortality Indicator (SHMI) at GHNHSFT has continued reduce, remaining within expected levels since November 2022.

At the last System Mortality Group, weekend mortality rates were discussed. Data appears to show statistically better that average weekday rates and worse that average rates for those admitted over the weekend. Current data shows:

- Weekend Mortality at GHFT = 8.2%
- Weekend Mortality in Peer Group = 7.8%

- Weekday Mortality at GHFT = 6.3%
- Weekday Mortality in Peer Group = 7%

While there is always an expected difference, the size of the gap is significant and is due to be discussed art the next mortality group on 29th November.



One Gloucestershire
Transforming Care, Transforming Communities

NHS

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 2023/24 financial plan is breakeven for the system, this includes a high level of savings and a number of non recurrent financial savings, efficiencies and income.

- The ICS year to date financial position at month 7 2023/24 is an overspend versus plan of £4,031k. This is primarily attributable to ICB prescribing cost increases, continuing health care, the net cost of industrial action incurred within GHFT, pay costs within GHFT, including the pay award cost pressures including GMS services, and PFI inflationary indexation charges within GHFT.

- The year end forecast out-turn is breakeven versus plan. The ICS continues to face a number of significant financial pressures across a number of areas, within this position the work on mitigations, including recovery plans in place, is now starting to realise results and these are being worked through into a revised financial forecast for all organisations. In addition the System has implemented System review of investment requests above a specified level.

- The GHFT year to date position to date is being mitigated by a deep dive review into areas including theatres and outpatients. Additional measures have been taken and are continuing to be developed in response to the position to deliver savings in year and in 24/25. These include:
  - Rostering controls within GHFT
  - Grip and control measures within GHFT
  - Holding year to date underspends within budgets across the system
  - Implementation of the revenue Investments triple lock process across the system
  - Looking at measures to bring forward savings; this is unlikely to impact on 23/24, however, these should reduce the recurrent expenditure going into 24/25

- The System ERF plan is dependent on delivery of elective activity as per the plan. The national target was reduced by 2% to enable systems to cover the cost of industrial action in April to 105%. The overall risk of clawback for the system is 16%, (£4.1m) if there is underperformance. Year to date performance, based on NHSE Freeze data (M1-5) is 105.8%, thus achieving the new revised target of 105%.

Finance and Use of Resources

Financial Overview & Key Risks

Key Financial Risks

- Workforce is a key driver of financial performance particularly within GHFT. Vacancies, absence, operational pressures and 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 is implementing 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 bank and agency shift use. E-rostering for nursing is in place within both organisations with cross system working 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. Other GHFT controls in place are:
    - Ongoing monitoring of temporary staffing Standard Operating Procedures (SOP) to ensure adherence to controls and compliance.
    - Approval given to commence a full procurement exercise for the implementation of a medical e-rostering system.
    - All non-clinical temporary staffing use is to come through the centralised Bank Service, providing a single oversight of demand and supply, on a robust platform of governance and control.

- 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 should deliver an increase in substantive staffing and a reduction in agency costs in 24/25. The Trust have also focussed on ways to improve the training of international recruits to increase the pass rate so that staff are then able to move from super numerary roles to fill substantive vacancies.

- The cost of recent industrial action is impacting predominantly within GHFT. The year to date net cost is £2.3m. No assumptions have been made on the cost of future industrial action and this therefore represent a financial risk.

- GHC continues to monitor agency usage through its Sustainable Staffing Group and has significantly reduced its usage of off framework agency, and seen a sustained reduction in its monthly spend on agency in recent months.

Finance and Use of Resources

Financial Overview & Key Risks

- 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.

- Delivery of recurrent savings plans remains a major risk for the system, a reduction in recurrent savings in 2023/24 will impact on the level of savings required in 2024/25. 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).

- The year to date capital expenditure is £5.8m 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. A risk has been identified in respect of a Renal Contract Analysis Lease, and work is underway within the System to mitigate this cost pressure. This has recently been classified as a Finance Lease, and is not eligible for IFRS 16 CDEL funding*.

- The system is developing a more detailed medium term plan following on from the Joint Forward Plan with an underpinning medium term financial plan. The second draft of this was submitted to NHSE on the 29th September and the plan will continue to be developed over the coming months; this process will include more detailed planning for 2024/25 with the aim of delivering breakeven financial plan. The focus within the plan is on both reviewing and reducing the recurrent expenditure (underlying run rate) in 2023/24 going into the future years and the development of savings plans for the period covered.

- **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

- The system is currently reviewing the implications of the NHSE letter dated 8th November 2023 outlining priorities for the remainder of the financial year following discussions with Govt. These priorities are:
  - Achieve financial balance
  - Prioritise emergency performance & capacity
  - Protect urgent care, high priority elective & cancer care

- ICBs and Trusts will respond to NHSE with their agreed steps to live within financial allocations and deliver the priorities outlined, with appropriate Board sign off, by 22nd November 2023.

- The system is actively working to evaluate the impact of the above, and will be briefing Boards shortly.

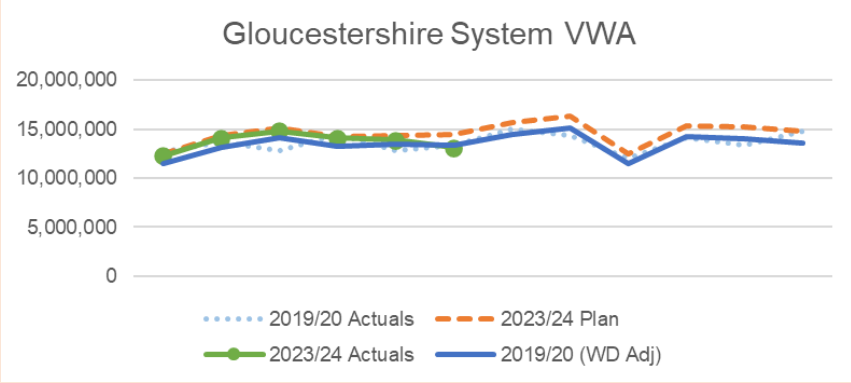
Finance and Use of Resources

Financial Overview & Key Risks: Elective Recovery Fund

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 the potential for further industrial action in the future.

- Available activity for month 7 reporting is based on fixed data for April to August, and flex data (subject to change) for September. This shows YTD performance based on Freeze data (M1-5) is 105.8%, thus achieving the new revised target of 105%, although below the submitted plan of 109%. ICB commissioned freeze activity is at 102% of the value weighted fixed target with under delivery by GHFT at (97%) and out of county NHS providers of (91%), offset by Independent Sector providers overperformance of (141%). GHFT is reporting low recovery rates in Day cases and Inpatient spells.



Finance and Use of Resources

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	4,097,128	4,905,888	4,958,373	4,704,327	4,955,994	4,599,948						
		107.8%	112.3%	101.6%	105.2%	114.1%	100.9%						0.0%
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	3,329,303	3,662,950	4,004,858	3,795,438	3,447,815	3,077,939						
		98.8%	90.7%	101.6%	96.4%	77.7%	78.6%						0.0%
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	2,964,596	3,450,003	3,578,442	3,393,066	3,399,987	3,473,954						
		106.8%	111.6%	103.1%	108.3%	111.9%	105.4%						0.0%
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	1,378,370	1,497,280	1,650,625	1,631,504	1,577,459	1,546,904						
		95.9%	98.5%	95.0%	100.8%	102.2%	100.8%						0.0%
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	11,769,396	13,516,121	14,192,298	13,524,335	13,381,256	12,698,745						
		102.9%	103.3%	100.7%	102.2%	99.6%	94.9%						0.0%
	incl.Pathways	107.1%	107.7%	105.2%	106.4%	103.1%	97.8%						0.0%

- At M6 Flex Gloucestershire ICB commissioned VWA is 97.8% of 2019/20 against a plan of 108.3% including pathways avoided.
- Year to date performance, based on Freeze data (M1-5) is 105.8%, thus achieving the new revised target of 105% but still below the submitted plan of 109%.
- Pathways avoided are contributing c.4% on top of activity recovery.
- The projected full year outturn (assuming IA remains the same each month for the remainder of the year) is delivery of 102.9% (up from 102.3% last month)
- There were c.3,800 cancellations due to Industrial Action between April and August, equating to c.£1.9m elective activity lost (based on average tariff). Inclusion of this activity could potentially push the System year to date position up to 108.7%.

Independent Sector providers are delivering YTD higher activity volumes (141%) than GHFT (97.3%) and OOC NHS Providers (91%).

Finance and Use of Resources

Finance and Use of Resources: Dashboard

Statement of Net Income & Expenditure Position (£'000)						
Month 7 2023/24 - October	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	(6,911)	(9,329)	(2,418)	0	0	0
Gloucestershire Health and Care NHS Foundation Trust	249	1,425	1,176	0	0	0
Gloucestershire Integrated Care Board	0	(2,788)	(2,788)	0	0	0
System Surplus/(Deficit)	**(6,662)**	**(10,693)**	**(4,031)**	**0**	**0**	**0**

Efficiency Programme (£'000)								
Month 7 2023/24 - October	Month 7 Efficiency Plan	Month 7 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	16,346	15,130	(1,216)	34,721	34,721	0	100%	AMBER - Medium Risk
Gloucestershire Health and Care NHS Foundation Trust	6,727	6,400	(327)	9,883	9,884	1	100%	AMBER - Medium Risk
Gloucestershire Integrated Care Board	7,669	7,669	0	13,128	13,128	0	100%	AMBER - Medium Risk
Total	**30,742**	**29,199**	**(1,543)**	**57,732**	**57,733**	**1**	**100%**	AMBER - Medium Risk

Other Metrics				
Month 7 2023/24 - October	GHFT	GHC	GICB	ICS
Better Payment Pratice Code (total paid within 30 days or due date by value)	92%	99%	100%	98%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	2,205	(935)	(750)	520
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 and Efficiencies

Monthly Efficiency Programme Trend Analysis (£'000)	M1 actual	M2 actual	M3 actual	M4 actual	M5 actual	M6 actual	M7 actual	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	2,862	1,733	3,492	3,655	3,828	3,725	3,675
Gloucestershire Health and Care NHS Foundation Trust	1,786	1,786	631	631	309	534	723	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**	**4,492**	**3,549**	**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 7 reporting, the year to date delivery is £1,543k behind plan, across the system. 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 continues to be made on the delivery of savings year to date at month 7. The risk of non delivery of recurring schemes by the year end has been reduced following the development of further plans. Non recurring savings have been fully identified.
    - **GHFT**: Medium - £15.1m of savings have been delivered (£11.5m recurrent, £3.6m non-recurrent). While there continues to be significant risk in the forecast position, GHFT is still forecasting delivery of £34.7m. The highest risk item 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 £8.9m, with Amber at £2.9m.
    - **ICB**: Medium – the savings programme amounts to £13.128m for FY 2023/24. The programme has been risk assessed as at Month 7 and is anticipated to deliver to plan 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.

Finance and Use of Resources

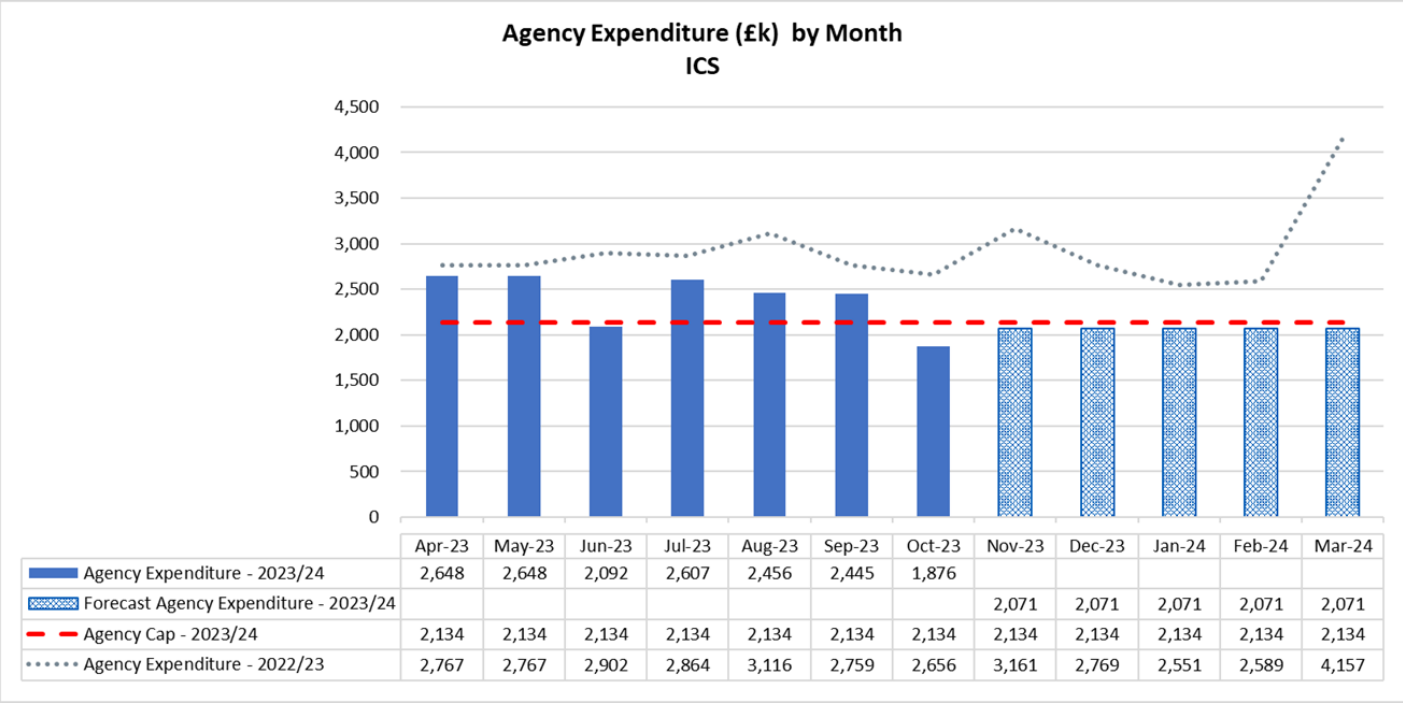
Capital: Organisational Positions, Challenges and Opportunities

Capital Expenditure (£'000)						
Month 7 2023/24 - October	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	14,929	13,475	(1,454)	25,888	26,174	286
Gloucestershire Health and Care NHS Foundation Trust	7,761	7,124	(637)	11,027	11,491	464
Gloucestershire Integrated Care Board	814	0	(814)	1,860	1,110	(750)
Total System Capital Allocation	**23,504**	**20,599**	**(2,905)**	**38,775**	**38,775**	**(0)**
Other Net CDEL sources						
Gloucestershire Hospitals NHS Foundation Trust	10,867	6,223	(4,644)	21,314	23,519	2,205
Gloucestershire Health and Care NHS Foundation Trust	886	0	(886)	1,841	906	(935)
Total System CDEL (NHS)	**35,257**	**26,822**	**(8,435)**	**61,930**	**63,200**	**1,270**
IFRS16 Lease Capital						
Gloucestershire Hospitals NHS Foundation Trust	549	4,394	3,845	1,478	6,995	5,517
Gloucestershire Health and Care NHS Foundation Trust	451	0	(451)	1,168	1,243	75
Gloucestershire Integrated Care Board	2,620	1,872	(749)	4,492	4,492	0
Total System Capital including IFRS16 Leases (NHS)	**38,877**	**33,088**	**(5,789)**	**69,068**	**75,930**	**6,862**

- Within the ICS's system capital allocation envelope, capital expenditure is showing a £2.9m year to date underspend as at month 7 of 2023/24. The forecast is for the system capital allocation expenditure to catch up in line with plan by year end.
- GHFT is reporting within the M7 PFR a forecast overspend of £8.0m (£12.2m including the renal dialysis lease) against CDEL compared to plan. £2.2m is funded via national programme capital, £0.3m is funded via system held contingency, £5.5m is the forecast overspend against the IFRS16 plan. There is a finance lease of c£4m which is not eligible for IFRS16 funding and therefore needs System CDEL funding, this represents a risk against the System Plan that is reported within the PFR purely as a note.
- The System is waiting for funding confirmation for IFRS16 capital allocations and GHFT have an overspend risk against the original value of c£5.5m.
- Internally, there are reported under/overspends on some projects but mitigations exist that should minimise these to leave a potential underspend of £1.3m on CDC national programme capital and a £5.5m overspend on IFRS16.
- GHC Capital spend on the Forest of Dean new hospital is £1.6m behind the plan year to date. The Forest of Dean new hospital build programme remains on plan but the spend is phased differently hence the variance to plan. Spend on a number of maintenance schemes has been committed and the expenditure is expected to start to catch up with the plan soon. Asset disposals are progressing well and are on track to be completed before the end of the financial year.

Finance and Use of Resources

Agency Expenditure vs NHSE Cap



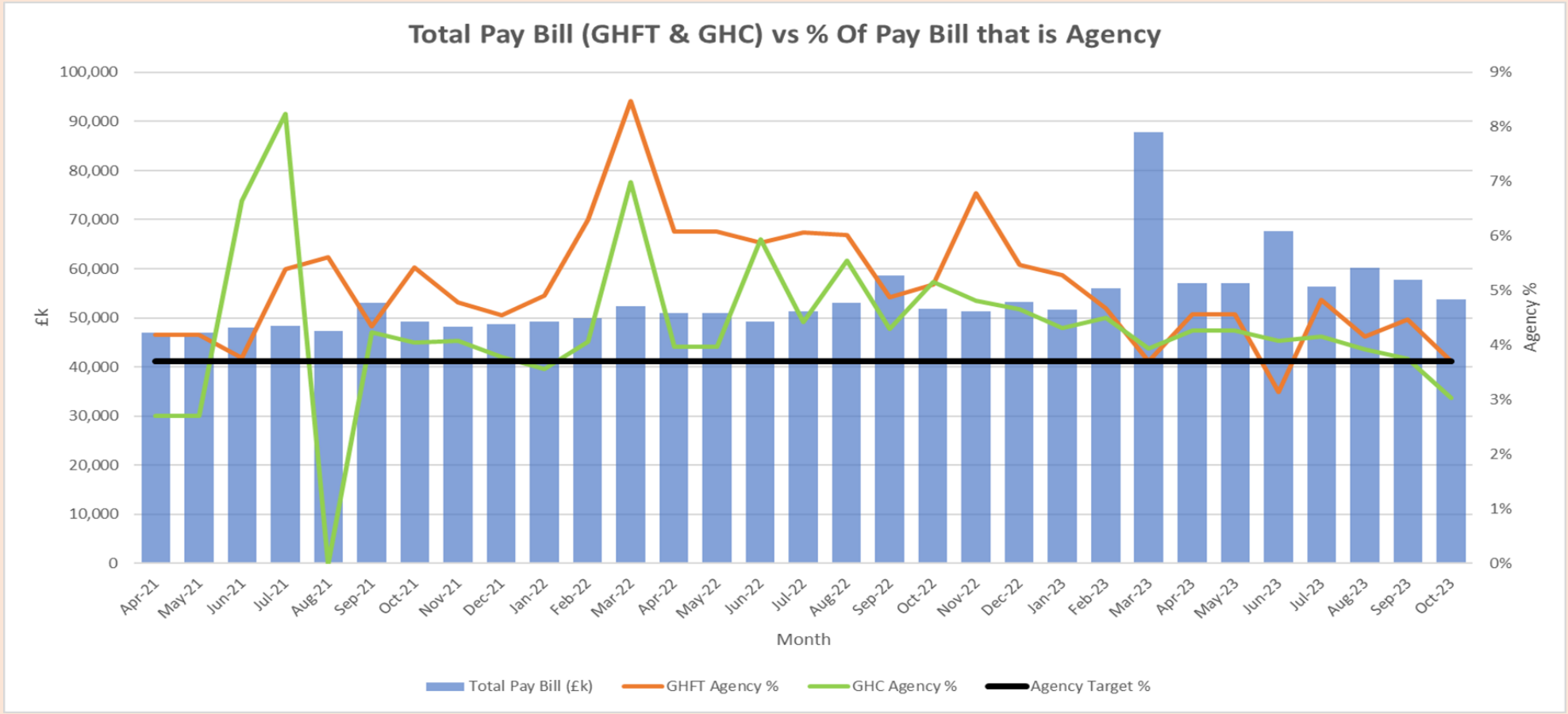
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456	2,445	1,876					
Forecast Agency Expenditure - 2023/24								2,071	2,071	2,071	2,071	2,071
Agency Cap - 2023/24	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	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	**£27.129m**
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 7, the rate of agency expenditure is below 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

Agency Spend vs Total Pay Bill



	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	Sep-23	Oct-23
GHFT Agency Spend (k)	£ 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	£ 1,743	£ 1,350
GHC Agency Spend (k)	£ 389	£ 389	£ 987	£ 1,241	-£ 3	£ 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	£ 702	£ 526
Total Agency Spend (k)	£ 1,756	£ 1,756	£ 2,237	£ 3,031	£ 1,837	£ 2,286	£ 2,459	£ 2,198	£ 2,094	£ 2,210	£ 2,809	£ 4,196	£ 2,767	£ 2,767	£ 2,902	£ 2,864	£ 3,116	£ 2,759	£ 2,656	£ 3,161	£ 2,769	£ 2,551	£ 2,589	£ 3,316	£ 2,543	£ 2,543	£ 2,302	£ 2,607	£ 2,456	£ 2,445	£ 1,876

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Integrated Performance Report - Metrics

November 2023

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Summary

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)

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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 (such as weight management; eating disorders)*
  - *Increase percentage of people dying in their preferred place*
  - *Increase percentage of cancer cases diagnosed at stages 1 or 2 (Core20Plus5)*
  - *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 (OF)*
  - *Reduce reliance on inpatient care for patients with a learning disability and/or autism per million head of population to meet an overall target of less than 30/million (total population) (OF)*
  - *Improve waiting times for assessment for Autism and ADHD diagnosis*
  - *Maintain the access rates for of children and young people accessing mental health services (OF / Core20Plus5)*
  - *Reduce the proportion of adults in mental health inpatient settings with a length of stay over 60 days (OF)*
  - *Reduce the proportion of older adults in mental health inpatient settings with a length of stay over 90 days (OF)*
  - *Maintain theatre utilisation at or above 85% for elective theatres throughout 23/24*
  - *Increase available Virtual Ward beds to 223 and increase utilisation to 80% by December 2023 (OF)*
  - *Reduce the number of inpatients with No Criteria to Reside (NCTR) to 160 or less by November 2023 (OF)*
  - *Reduce the percentage of inpatients with a length of stay of 21 days or longer to 15% or less by November 2023*
  - *Increase units of dental activity delivered as a proportion of all units of dental activity contracted (OF)*
  - *Antimicrobial resistance: Reduce total prescribing of antibiotics in primary care (OF)*
  - *Antimicrobial resistance: Reduce proportion of broad-spectrum antibiotic prescribing in primary care (OF)*
  - *Increase referrals to Community Pharmacy Consultation Service in line with operational plan*
  - *Increase GP referrals to the NHS digital weight management service*

Integrated Performance Report – Metrics

Metrics Overview

Workforce Metrics

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

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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)

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	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Latest Benchmarking: 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%	57.04 Gloucester ICS		October 2023	57.04 Gloucester ICS; 53.65 Other South West ICS	55.90 All ICS		October 2023	
	A&E 4 Hour Target - % seen, treated and discharged/admitted within 4 hours of arrival to A&E (Type 3)	High	95.0%	99.73 GHFT		October 2023	99.73 GHFT	95.31 All ICS		October 2023	
S019a	Ambulance Handovers - Total resource time lost	Low		383403 GHFT		October 2023	*Benchmarking to follow*				
	ED Assessment - % patients assessed within 15 minutes of arrival at A&E	High		40.58 Gloucester ICS		September 2023	*Benchmarking to follow*				
S103a	12 Hour ED Waits - Proportion of patients spending more than 12 hours in an emergency department	Low	8.0%	33.90 GHFT		September 2023	*Benchmarking to follow*				
	Overnight General & Acute Beds Available and Occupied	Low		94.91 GHFT		October 2023	*Benchmarking to follow*				
	111 Call Abandonment	Low	3	16.90 Value		July 2023	*Benchmarking to follow*				

Improving Services & Delivering Outcomes

Urgent & Emergency Care - Ambulance

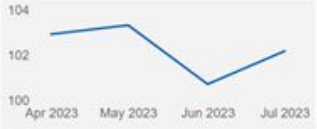
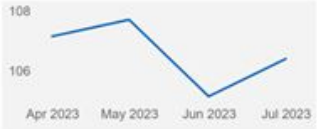
NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Reporting Period	Dashboard Link
S020a	Average Ambulance Response Times (Category 1)	Low	7 minutes	00:10:59 Gloucester ICS		October 2023	00:10:59 Gloucester ICS	00:10:02 SWASFT	00:08:40 England		October 2023	
S020b	Average Ambulance Response Times (Category 2)	Low	18 minutes	01:10:55 Gloucester ICS		October 2023	01:10:55 Gloucester ICS	00:54:58 SWASFT	00:41:40 England		October 2023	
S020c	Average Ambulance Response Times (Category 3)	Low	120 minutes	04:09:59 Gloucester ICS		October 2023	04:09:59 Gloucester ICS	02:25:58 SWASFT	02:31:05 England		October 2023	
S020d	Average Ambulance Response Times (Category 4)	Low	180 minutes	04:11:14 Gloucester ICS		October 2023	04:11:14 Gloucester ICS	02:50:03 SWASFT	02:50:10 England		October 2023	
	Ambulance Conveyance Rates (% incidents conveyed)	Low		39.72 Gloucester ICS		October 2023	39.72 Gloucester ICS	50.14 Other South West ICS	56.20 England		October 2023	

Improving Services & Delivering Outcomes

Planned Care & Elective Recovery

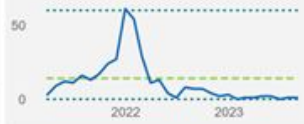
NHS Gloucestershire

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
S007a	ERF (% weighted cost activity vs 19/20 baseline Excl. A&G)	High	104.0%	99.55 Gloucester ICS		August 2023	*Benchmarking to follow*	
S007a	ERF (% weighted cost activity vs 19/20 baseline Incl. A&G)	High	104.0%	103.07 Gloucester ICS		August 2023	*Benchmarking to follow*	
	Outpatient follow up ratio	Low		0.66 GHFT		September 2023	*Benchmarking to follow*	
	Virtual Outpatient Appointments - % of outpatient activity which is virtual/telephone	High	25.0	19.80 GHFT		September 2023	*Benchmarking to follow*	
E.M.34	PIFU - % of all outpatient appointments moved or discharged to PIFU	High		*Confirming data source*				
S016a	A&G - Number of patients recieving Advice and Guidance	High		3K GHFT		September 2023	*Benchmarking to follow*	
S016a	GHFT Theatre Utilisation	High		*Confirming data source*				

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%	64.87 Gloucester ICS		September 2023	*Benchmarking to follow*	
S009a	RTT (52 week waits) - Number of patients on RTT list >52 weeks	Low	0	3166 GHFT		September 2023	*Benchmarking to follow*	
	RTT (65 week waits) - Number of patients on RTT list >65 weeks	Low	0	793 Gloucester ICS		September 2023	*Benchmarking to follow*	
S009b	RTT (78 week waits) - Number of patients on RTT list >78 weeks	Low	0	28 GHFT		September 2023	*Benchmarking to follow*	
S009c	RTT (104 week waits) - Number of patients on RTT list >104 weeks	Low	0	1 Gloucester ICS		September 2023	*Benchmarking to follow*	

Improving Services & Delivering Outcomes

Cancer

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Latest Benchmarking: Reporting Period	Dashboard Link
	2 Week Wait - % patients seen or STT within 2 weeks of referral	High	93.0%	90.27 Gloucester ICS		September 2023	76.35 Gloucester ICS	50.82 Other South West ICS	74.02 All ICS		September 2023	
S012a	28 day Faster Diagnosis - % patients recieving diagnosis or all clear within 28 days of referral	High	75.0%	73.49 GHFT		September 2023	74.32 GHFT	65.37 Other South West ICS	69.74 All ICS		September 2023	
S010a	31 day Treatment - activity	High		346 GHFT		September 2023	*Benchmarking to follow*					
	31 day Treatment - % patients recieving treatment within 31 days of DTT	High	96.0%	88.73 Gloucester ICS		September 2023	88.73 Gloucester ICS	89.51 Other South West ICS	89.68 All ICS		September 2023	
S011a	62 day Treatment - patient waiting list number beyond 62 days	Low		85.00 GHFT		September 2023	*Benchmarking to follow*					
	62 day Treatment - % patients recieving treatment within 62 days of referral	High	85.0%	60.28 GHFT		September 2023	60.65 GHFT	61.27 Other South West ICS	59.27 All ICS		September 2023	
	NSS referrals	High	85.0%	60.28 GHFT		September 2023	*Benchmarking to follow*					

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		121.37 Gloucester ICS	100 / 0 / 2022 / 2023	September 2023	*Benchmarking to follow*	
	Waiting Times - % patients waiting more than 6 weeks for diagnostic test	Low		15.5%	20 / 10 / 0 / 2022 / 2023	September 2023	*Benchmarking to follow*	
S013a	Diagnostic Activity Levels - imaging	High		7235 GHFT	10,000 / 5,000 / 0 / 2022 / 2023	September 2023	*Benchmarking to follow*	
S013b	Diagnostic Activity Levels - physiological measurement	High		1069 Gloucester ICS	2K / 0K / 2022 / 2023	September 2023	*Benchmarking to follow*	
S013c	Diagnostic Activity Levels - endoscopy	High		2032 GHFT	2K / 1K / 2022 / 2023	September 2023	*Benchmarking to follow*	

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	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Latest Benchmarking: Reporting Period	Dashboard Link
S081a	IAPT Access - Number of patients accessing IAPT in year	High	14,573	13,069 Value		September 2023	*Benchmarking to follow*				
S082a	IAPT Recovery - % patients entering recovery following IAPT	High	50	51.60 Value		September 2023	*Benchmarking to follow*				
E.H.13	SMI Physical Health Checks - % SMI register receiving/declining full health check	High	60	58 Value		June 2023	*Benchmarking to follow*				
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	624 Value		September 2023	*Benchmarking to follow*				
	Access to Core Community Mental Health Services - rate per 1,000 of patients accessing service	High	1	9.29 GHC		May 2023	9.29 GHC	61.27 All ICS		September 2023	

Improving Services & Delivering Outcomes

Maternity

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Latest Benchmarking: Reporting Period	Dashboard Link
E.H.15	Perinatal Access - % pregnant women accessing perinatal mental health service	High		60		September 2023	3.08 Gloucester ICS		9.21 All ICS	May 2023	
S021a	Continuity of Care Pathway - % of women on CoC pathway	High	51	7.09 GHFT		September 2023	*Benchmarking to follow*				
	Smoking in Pregnancy - % SATOD	Low	8	9.31 GHFT		September 2023	*Benchmarking to follow*				
S022a	Stillbirth rate	Low		2.20 GHFT		September 2023	*Benchmarking to follow*				
S032a	Neonatal mortality rate	Low		2.20 GHFT		September 2023	*Benchmarking to follow*				
	Brain Injury Rate	Low		2.20 GHFT		September 2023	*Benchmarking to follow*				

Improving Services & Delivering Outcomes

Primary Care

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
	Primary Care Activity - Total Activity	High		375067 Gloucester ICS	*Historical data to follow*	September 2023	*Benchmarking to follow*	
	Primary Care Activity - Attended Activity	High		339230 Gloucester ICS	*Historical data to follow*	September 2023	*Benchmarking to follow*	
	Primary Care Activity - % appointments booked within 14 days	High		70.94 Gloucester ICS	*Historical data to follow*	September 2023	*Benchmarking to follow*	

Improving Services & Delivering Outcomes

Continuing Healthcare

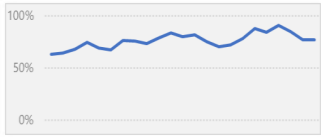
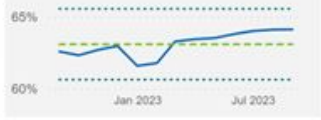
NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Reporting Period	Dashboard Link
	Referral Completion - % referrals completed within 28 days of referral	High	80.0%	74%	2022 2023	June 2023	74%		74% England	June 2023	
	Place of Assessment - % assessments in hospital	Low		0.00% Gloucester ICS	100% 0% -100% 2022 2023	June 2023	0.00% Gloucester ICS		0.00% England	June 2023	
	Long waits - number of cases waiting > 12 weeks	Low		3 Gloucester ICS	10 5 0 2022 2023	June 2023	3 Gloucester ICS		590 England	June 2023	
	Conversion Rate - % referrals converted to CHC	Low		5%	2021 2022 2023	June 2023	4.5%		17.5% England	June 2023	

Improving Services & Delivering Outcomes

Community Care & Ageing Well

NHS Gloucestershire

Indicator	Metric	Good is	National Target	Latest Performance	Trend	Latest Reporting Period	Latest Benchmarking: better than	Latest Benchmarking: worse than	Latest Benchmarking: Quartile (Q1 = High, Q4 = Low)	Latest Benchmarking: Reporting Period	Dashboard Link
S107a	2 Hour Community UCR Contacts - % cases recieving a response within 2 hours	High	70%	77%		September 2023	*Benchmarking to follow*				
	Dementia Diagnosis Rate (DDR)	High	66.7%	64.1% Gloucester ICS		September 2023	64.1% Gloucester ICS	64.3% England		September 2023	
	% people with advanced care plans in place	Low	*Confirming data source*								
	% people dying in their preferred place	Low	*Confirming data source*								

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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)

Workforce Metrics

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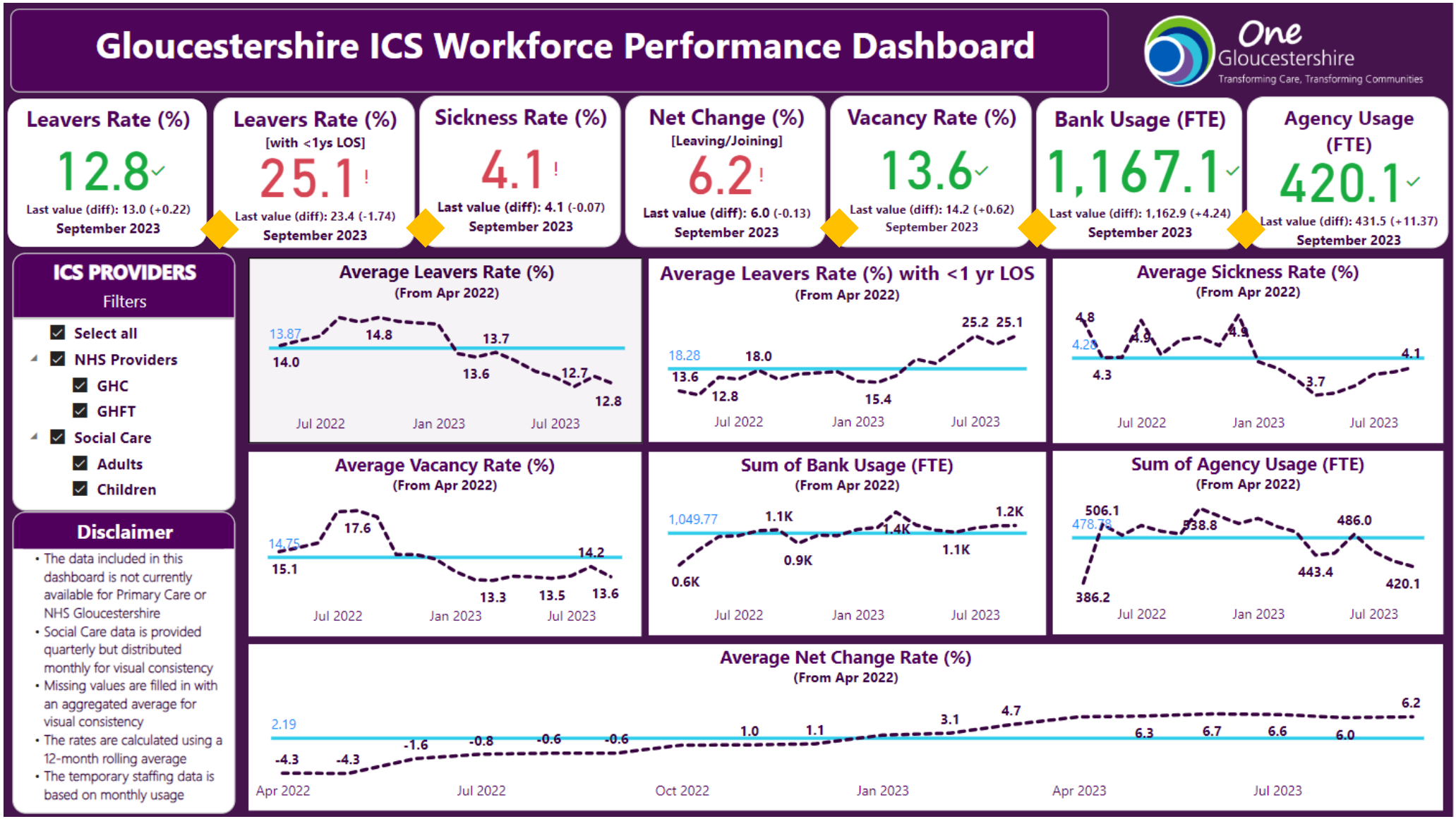
Our People (Workforce)



Our People (Workforce)

Gloucestershire ICS Equality, Diversity and Inclusion (EDI) measures

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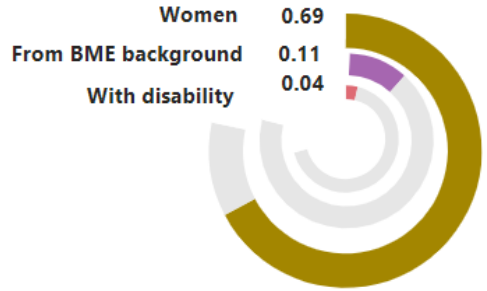
ICS PROVIDERS
Filters

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

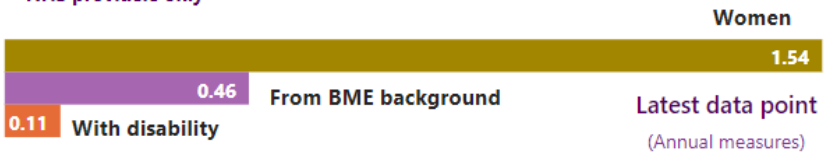
Proportion of staff in leadership roles (>= Band 8C/ RB4)



Latest data point
(Annual measures)
March 2023

Proportion of staff in leadership roles (>= Band 8C/ RB4)- benchmarked per 10,000 ICB weighted population (649,843)

Data shown is from NHS providers only



Latest data point
(Annual measures)
March 2023

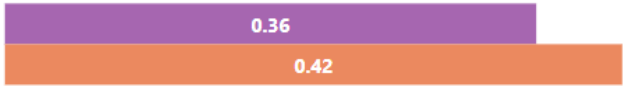
Disclaimer

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.

Likelihood of BME & White candidates appointed from shortlisting

Data shown is from NHS providers only

0.36 : 0.42



White candidates have 1.22 times greater chance than BME candidates

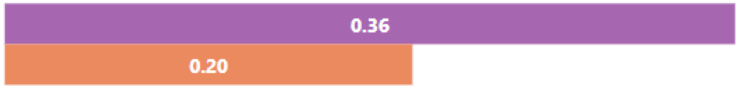
BME Candidates
White candidates

Latest data point
(Annual measures)
March 2023

Likelihood of candidates with and without disability appointed from shortlisting

Data shown is from NHS providers only

0.36 : 0.20



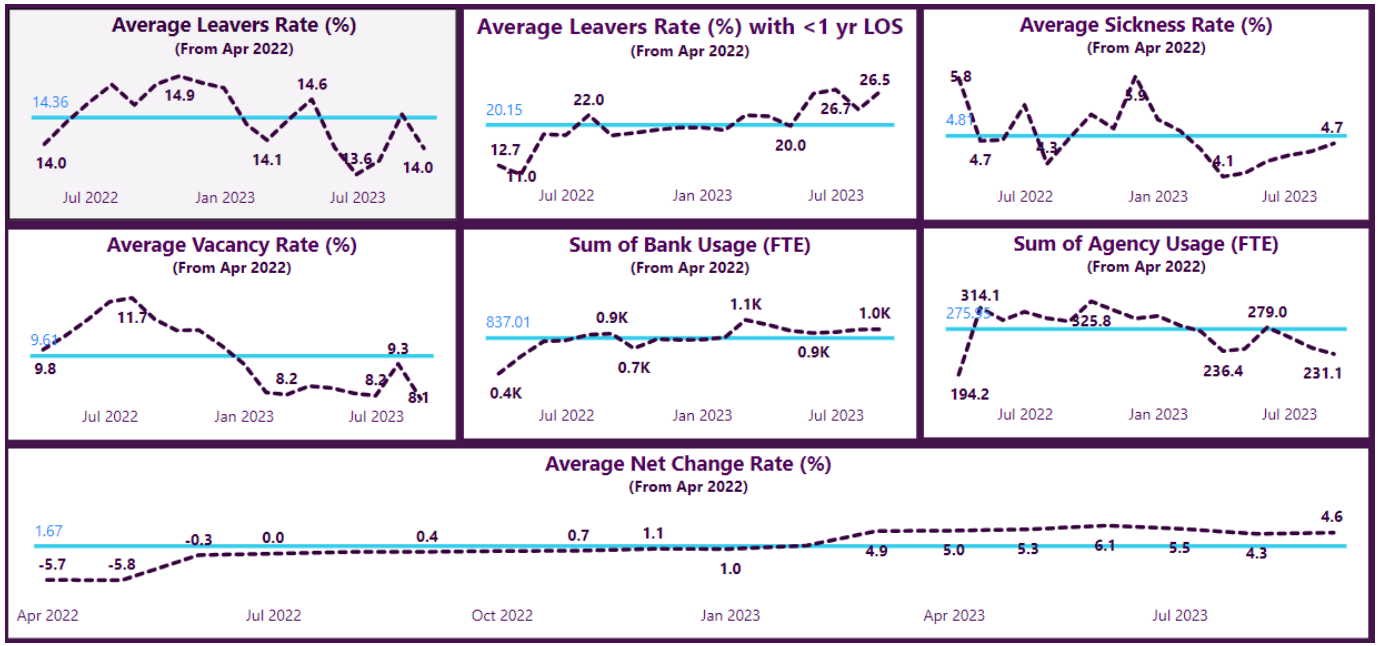
Candidates without disability have 0.82 times less chance than candidates with disability

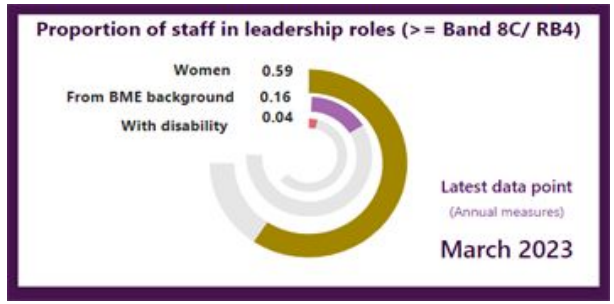
Candidates with Disability
Candidates without Disability

Latest data point
(Annual measures)
March 2023

Our People (Workforce)

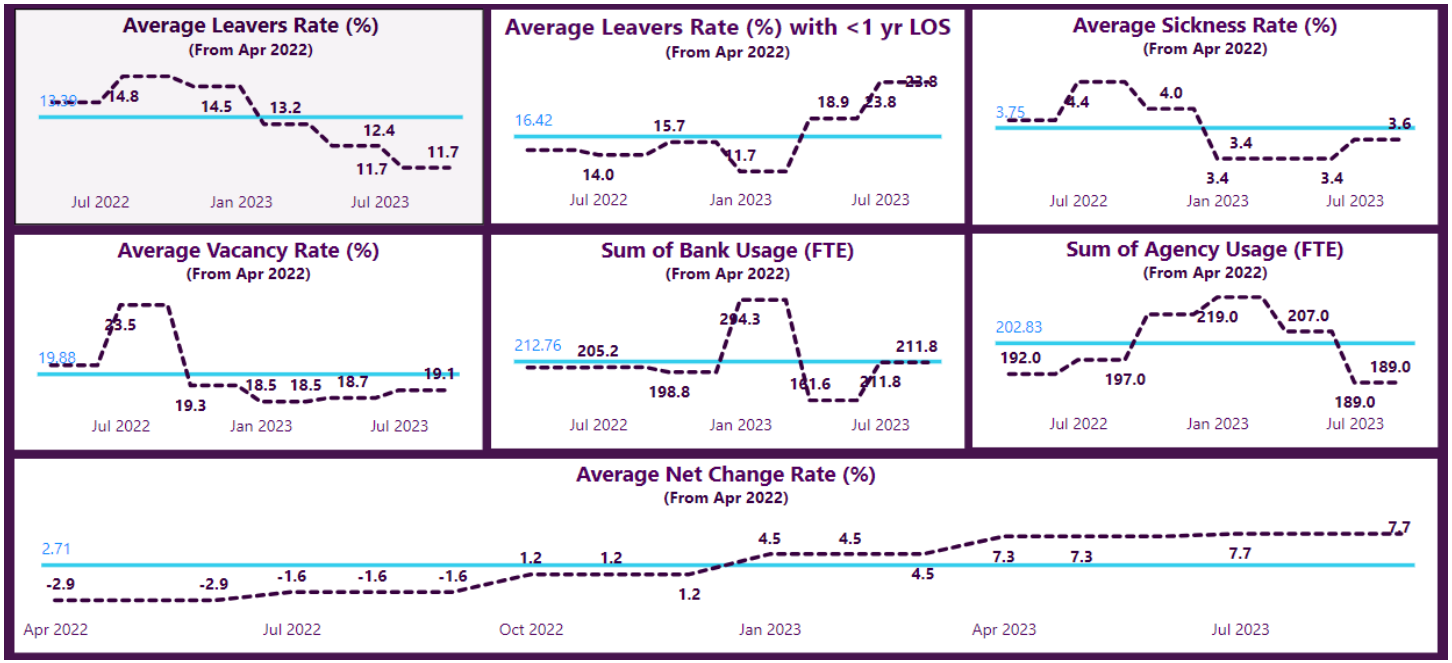
NHS Providers Data (GHC & GHFT)

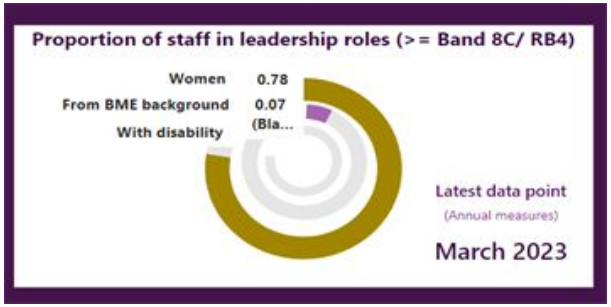




Our People (Workforce)

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 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Emergency Preparedness Resilience and Response (EPRR) Annual Assurance paper 2023/24**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
	x		**X**		**X**
Route to this meeting	The route undertaken for this paper was the NHS EPRR assurance process, submission of evidence and assurance rating from confirm and challenge meetings and feedback from NHSE held between September and October 2023. Additionally, there has been an internal audit of EPRR and Business Continuity standards by BDO Llp.				
Executive Summary	As part of the EPRR annual assurance process the ICB are required by NHSE to submit feedback to the ICB Board, on the level of assurance that has been rated from evidence submitted and subsequent "confirm and challenge" meetings held for a number of providers including: Gloucestershire Health and Care NHS Foundation Trust, (GHC) Gloucestershire Hospitals NHS Foundation Trust, (GHT) Patient Plus Group (PPG) E-Med Patient Transport Services SWASFT NHS Gloucestershire Integrated Care Board. (ICB) All organisations have a very similar number of standards that are RAG rated with all submitting both written evidence in support of their responses followed up by a face to face "Confirm and Challenge" meeting between the ICB Accountable Emergency Officer and EPRR Lead, with the partners AEO's and EPRR Leads. This informs the overall rating for all organisations concerned. We are pleased to inform the Board that all but one of the Partners has achieved a standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. Unfortunately, one organisation (E-MED PTS) has been assessed regionally as "non-Compliant". Work has already started across the South West region, with E-Med to improve their rating with action plans being taken forward for each of the unassured domains. The ICB itself has seen its overall rating fall from that obtained in 2022 (substantially assured) to a rating in 2023 of "partially assured". Please refer to NHSE letter Appendix A. This report is submitted to the Board for acknowledgement of the standards attained and areas for development,				

Key Issues to note	**Background:** On the creation of the ICB in July 2022, the organisation became a Category 1 responder, a role previously undertaken by NHSE. This places a statutory duty on the ICB to identify risks, plan, train, exercise and review risks against national, local and NHS organisational risk registers to ensure that the ICS and the Local Resilience Forum (LRF) are fit for purpose in Emergency Planning and Resilience. On taking on this role the ICB has key responsibilities for leading the health response to county-wide incidents and events. The ICB has also taken on responsibility for administering the Local Health Resilience Partnership (LHRP) which it jointly chairs with Public Health. Previously NHSE chaired and administered this meeting. In addition to this, the demands placed on all partners in the Local Resilience Forum have increased. This is mainly due to the requirements that need to be implemented following the inquiry into the Manchester bombing. The level of contingency planning for major events taking place in the county has significantly increased. Also, the requirement for multi-agency exercising has also been a priority. Despite the appointment in 2021 of a training manager for the system, this individual has had to focus a significant amount of her time in supporting multi-agency activities. This multi-agency working has meant that there has not been the level of focus on delivering the EPRR standards in the ICB especially those that relate to staff training. As a result of this the ICB attained a partial compliance rating this year. For reassurance, the ICB was only 2 standards away from being substantially assured. By addressing the improvement of training record-keeping and on-call staff training, the ICB would be at the same level as our local Trusts. Finally, it must be noted that the EPRR teams in the Trusts and ICB have been diverted away from their day-to-day work and training activities due to managing the business continuity related to the industrial action. **Developments made in 2022-23:** Following last year's assurance process it was identified that there were risks of the ICB not being prepared well enough to respond to incidents. This was due to the CCG/ICB not having up to date departmental Business Continuity plans and "on call" staff not meeting EPRR training requirements as set out in the Minimal National Occupational Standards (NOS) We are pleased to report that significant work has taken place in the last twelve months and all ICB Directorates now have undertaken Business Impact Analysis and produced business continuity plans that meet the recognised standard internationally (ISO 22301). The expectation of NHSE is that these plans will have been tested and exercised during a twelve-month period by the directorate / department that owns them. The ICB has not been able to comply with this requirement. This was partly impacted by the move to Shire Hall. It is therefore proposed to undertake annual business continuity exercising between April and June to ensure continuity of returns and standards are being achieved across the ICB. The ICS EPRR Training manager has worked with partner agencies to further develop the NHS "Principles of Health Command" course for Tactical and Strategic

<table>
<tr><td></td><td colspan="4">managers, focusing on on-call staff. This will meet the NHS EPRR Framework requirements around National Minimum Operational Standards for on-call staff at Tactical and Strategic levels. This is a shared training and learning opportunity across our ICS, with positive feedback to this approach. One key advantage is that the training bolsters understanding and good relationships across NHS Gloucestershire ICS, which means that staff in the ICS are already familiar with each other so preparing them to work together should an incident occur.

Working with the GCC Public Health team, a new Communicable Disease Plan has been produced. This covers a wide range of communicable diseases and brings together the learning from the Covid pandemic, avian flu and other outbreaks we have had in county.

Looking forward:
Following on from this year's assurance process and the completion of the internal audit of ICB EPRR, the EPRR team have developed a work plan to ensure issues identified are addressed. If this is completed the ICB will be substantially assured next year.
The key areas to be addressed are:
• Improved record-keeping to evidence training and exercising activities.
• Compliance with the requirement for all on-call staff to undertake the required training to equip them to respond appropriately should an incident occur.
• Testing and exercising of all departmental business continuity plans.
• Leading ICS exercising to test resilience in key areas such as cyber, infectious disease outbreaks and major incidents especially involving large events.

The Senior EPRR Manager for the ICB has indicated that he is retiring in August 2024. The organisation will need to recruit to this specialist post and ensure that there is the required support in the EPRR team to discharge these new and expanding duties.</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">Retirement of Senior EPRR Manager
Staff resource resilience
Ability to respond due to increase in workload due to legislative changes.
Industrial action</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">N/A</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 is submitted that the ICB considers the creation of another full time EPRR Post to support the current incumbent. The role has changed so dramatically over the past 12 – 24 months that the current post holder works hours beyond his contracted hours, particularly unsocial hours in the early morning, late evening and weekends. Additionally this post should have dedicated administrative support to take the more routine work away from the EPRR qualified staff.</td></tr>
</table>

Regulatory and Legal Issues (including NHS Constitution)	The ICB are submitting “Partial Compliance” therefore there are no Regulatory or Legal issues. Should that level decrease then there would certainly be implications including those identified within the Manchester Arena report.		
Impact on Health Inequalities	**N/A**		
Impact on Equality and Diversity	**N/A**		
Impact on Sustainable Development	**N/A**		
Patient and Public Involvement	**N/A**		
Recommendation	**The Board is requested to:** **Note the content of this report, consider the implication of not investing in EPRR resource and record acceptance of the report in the minutes of their meeting.**		
Author	**Andy Ewens**	**Role Title**	**Senior EPRR Manager**
Sponsoring Director (if not author)	**Dr. Marion Andrews-Evans.**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
BAU	Business as Usual
EPRR	Emergency Preparedness, Resilience and Response
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
ICB	Integrated Care Board
ICC	Incident Coordination Centre
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NHSE SW EPRR	NHS England South West EPRR
NOS	National Occupational Standards (sometimes called Minimum Occupational Standards)
RHRP	Regional Health Resilience Partnership

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

1. Introduction

1.1. The EPRR assurance process is an annual NHS mandated process for ensuring that NHS organisations meet statutory EPRR standards as set out in EPRR framework. https://www.england.nhs.uk/ourwork/eprr/gf/ .The process is by submission of evidence to meet the standards and confirm and challenge meetings with partner organisations and NHS regional team.

2. Purpose and Executive Summary

2.1. **EPRR Core Standard 2023 summary.**

2.2. This assurance summary has been completed by NHS Gloucestershire ICB in fulfilment of the NHSE National EPRR Core Standards assurance process. The diagram below shows the snapshot in time as it was on Monday 30th October 2023, when the ICB was assessed in a virtual meeting by colleagues from NHSE SW EPRR. Please refer to Appendix A

2.3. An amendment to the Civil Contingencies Act 2004 in July 2022, moved the ICB from what is known as a Category Two responder to a Category One responder. This puts the ICB on the same footing a the blue light services, Military, Environment Agency and local authorities in their legal duty to identify risk, plan for, train, exercise, review and maintain all risks against National, regional, local and Organisational risk registers. This change has increased the workload of EPRR, coupled with the change to the Health and Care Act 2022 which has seen NHSE SW EPRR actually withdraw from a lot of their responsibilities, which have fallen upon the ICB to fulfil.

2.4. It is submitted that this year's assurance levels reflect a more in-depth approach and growing NHS challenges from the regional team.

2.5. **NHS Feedback:** ICB outcome from the 2023 EPRR Core Standards review

2.6. This year following a tri-annual review of the National Core Standards a full assurance process took place. The table below summarises the outcome of the assurance review and provides the overall compliance rating:

Organisation	2021	2022	2023
NHS Gloucestershire ICB	Fully CCG	Substantial CICB	Partial ICB

Provider Assurance levels:

Organisation	2021	2022	2023
E-Med Patient Transport Services (PTS)	Fully Compliant	Fully Compliant	Non Compliant – assessed using different methodology this year, led by Cornwall and Isles of Scilly ICB
Practice Plus Group (PPG) formerly Care UK	Fully	Substantial	Fully
Gloucester Hospitals NHS Foundation Trust	Substantial	Substantial	Substantial
Gloucestershire Health and Care NHS Foundation Trust	Substantial	Substantial	Substantial
NHS Gloucestershire CCG / ICB	Fully	Substantial	Partial

2.7. Considering the pressures that have been ongoing throughout this assurance period, the organisations should be congratulated on their performance. EPRR assurance is a deep searching evidence based process that requires a considerable amount of preparation that could barely be spared during this past twelve months.

2.8. We have seen great improvement across all of our providers and as a commissioning body are satisfied with the standards achieved, which are based on self-assessment and then through confirm and challenge meetings during September and October 2023.

2.9. All organisations have recognised the increase in EPRR workload in the last two years and this is on a continuing trajectory. A lot has been learned through Covid, the Manchester Arena report,

and the Business Continuity challenges and risks that we are facing. Further endorsing the need for well supported and funded EPRR teams and to imbed EPRR in our cultures and departmental work plans.

2.10. Key identified ICB areas needing improvement are:

- Core Standard 5: EPRR Resourcing
- Core Standard 11: Adverse weather
- Core Standard 21: EPRR Training for on call staff
- Core Standard 23: EPRR Exercising and Testing Programme
- Core Standard 24: Responder Training to meet National Minimum Occupational Standards
- Core standard 25: There are mechanisms in place to ensure staff are aware of their role in an incident
- Core Standard 48: The organisation has in place a procedure whereby testing and exercising of Business Continuity plans
- Core Standard 52: There is a process in place to assess the effectiveness of the Business Continuity Management System

These standards form the basis of the ICB EPRR work program for the next twelve months are being addressed through the ICB EPRR work plan over the next 12 months. The reset of the "On Call" process in June 2023 left us having to provide a new training package (Principles of Health Command - PHC) which on the date of this report to the board we now have 24/32 compliant (75%). It is anticipated that by the end of 2023 with more training courses in place we will achieve 31/32 compliance with only one member of staff being extremely difficult to accommodate into our training arrangements. This level of compliance will satisfy four of the above standards and move us from Partially to Substantially assured.

2.11. **Areas of notable EPRR good practice:**

- GHFT: noted the systematic nature in which Gloucestershire Hospitals has approached its EPRR over the last year whilst running alongside the impact of Industrial Action of Nurses, Junior Doctors and Consultants has led to a substantial commitment of EPRR resource to the mitigation of the risk presented. They are to be congratulated in keeping their head above water whilst supporting business as usual within the Trust.
- Gloucestershire Health and Care: very much as GHFT. We have been particularly impressed this year with the way that GHC have presented their evidence whilst continually under the threat of Industrial Action. It is assessed that once GHC have completed their ongoing internal audit into EPRR and BC, along with achieving at least one member of staff qualified to ISO 22301 for Business Continuity that they will be very close or not at "Fully" compliant.
- The move of the ICB to Shire Hall and establishment of the new Incident Coordination Centre (ICC) at that location
- Good collaborative EPRR work.
- The flexibility of all staff to adapt to the ongoing impact of Industrial Action, the continually high levels of Covid still present within the county, change of location and significant increase in workload as a result of legal changes by statute and Public inquiry reports (Manchester Arena).

2.12. **Common challenges/issues:**

- As reported last year, Business Continuity is still a challenge across the system. It is not an attractive subject although absolutely critical with the risks that are faced by all sectors and departments within the ICB. It is a subject that has to be taken seriously by all organisations and resourced adequately.

- The common theme across all organisations was more emphasis needed on Business Continuity training and especially needing Business Impact Assessments (BIAs) in place for all key services. EPRR attendance for training and exercise needs further improvement /support. This was a key identifier in the Manchester Arena report ('too busy' is not an excuse that sits well with a Coroner or Judge)).

- Due to the age (old) of a considerable amount of GHC and GHT estates, challenges for Shelter / Evacuation, Lockdown and environmental temperature control esp. in hot weather remain. However, there is a lot more emphasis to address this in planning and work is ongoing to minimise the risk and mitigate any impacts.

3. Considerations for EPRR improvement/ development activity:

3.1. Having supported initially the CCG and latterly the ICB with one full time resource for the EPRR subject, the agenda has increased exponentially to such an extent that it is beyond one persons fair workload.

3.2. The effect of being a "Category One" responder within the Civil Contingencies Act 2004 in itself creates a full time post for the ICS / Healthcare sector. This is a considerable change to previous years in that we now have a legislative obligation to work with our Multi Agency partners, something we have done to our full requirement this year but at the expense of our own EPRR core standards.

3.3. The ICB's assurance level has dropped, we have recognised the differences this year and whilst not happy we accept matters identified. There is work to do and this has already started with the introduction of our workplan for 2024.

4. Recommendations

The Board is asked to:

4.1. Note the content of this report and record it in the minutes of the meeting.

4.2. Pay due notice to the decline over the past three years of the ICB Core standards and support an increase to the establishment of resource addressing EPRR within the ICB.

4.3. Support the introduction of Mandatory training standards for all those performing the EPRR "On Call" duty within the ICB. This training is delivered to the National Minimum Occupational Standard and should be recorded within the annual appraisals of all "On call" staff.

The compliance level for each standard is defined as: **Compliance level**	**Definition**
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating

Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Appendix A

Our Reference: Gloucestershire/NOV23

To: Marion Andrews-Evans, Executive
Chief Nurse (Accountable Emergency Officer)
NHS Gloucestershire ICB

Copy: Andy Ewens, Senior EPRR and BC Manager and Rachel Minett, EPRR Manager

Keith Grimmett
NHS England
Head of EPRR

Tel: 07783 816496
Email: k.grimmett@nhs.net

Sent by email

08 November 2023

Dear Marion,

Emergency Preparedness, Resilience and Response (EPRR) annual assurance outcome for 2023/24.

Thank you for preparing and submitting your self-assessment, supporting evidence and your engagement prior to and during the review meeting held on October 30th, 2023. This letter summarises the outcome of this year's process, capturing any agreed actions.

ICB Outcome Summary

Organisation	2021	2022	2023
NHS Gloucestershire ICB	Full	Substantial	**Partial**

Your agreed organisational compliance level for 2023 is Partial, with the assessment showing full compliance against 85.1% of applicable standards (40 of 47). See annex 1 for descriptors.

Throughout the 2023 process and as summarised during the confirm and challenge session, you demonstrated commitment to your EPRR and Business Continuity Management Systems alongside a recognition of the areas requiring improvement and development.

Partially Compliant Standards

The standards assessed as partially compliant and requiring further improvement action are as follows.

Core Standard:

- 5: EPRR resource
- 11: Adverse weather
- 21: Trained on-call staff
- 23: EPRR exercising and testing programme
- 25: Staff awareness and training
- 48: Testing and exercising (business continuity)
- 52: BCMS continuous improvement process

Deep Dive review

The focus of the deep dive for 2023 was EPRR Responder Training. Whilst these additional standards are subject to the same assessment processes as the 47 Core Standards, they are not included directly in your overall outcome scoring.

Your agreed organisational compliance level for the deep dive review is Full, with the assessment showing full compliance against 100% of the standards (10 of 10). See annex 1 for descriptors.

Advisories

NHSE provided comments against several fully compliant standards to support maintenance, general development and to achieve good practice. These comments are broadly termed ‘advisories’ and apply to the following standards.

Core Standard:
- 4: EPRR work programme
- 6: Continuous improvement
- 14: Countermeasures
- DD1: EPRR Training Needs Analysis
- DD3: EPRR staff training
- 26: Incident Coordination Centre (ICC)
- 45: BCMS scope and objectives
- 46: Business Impact Analysis / Assessment (BIA)

The detailed narrative outlining improvements actions for partially compliant standards and those with advisory comments has been shared and discussed with your EPRR leads. A plan to support these actions should now be developed and form part of the 2024 Core Standards monitoring and support programme beginning in January.

Gloucestershire System Outcome Summary

You provided an overview of the approach you have used to undertake the EPRR Core Standards confirm and challenge process for 2023, highlighting the close working relationship you have with your providers.

NHSE South-West did not have any observations or advisories to raise in relation to the confirm and challenge process you adopted to assess your providers and acknowledge the integration of work across EPRR teams as a positive area of good practice.

Organisation	2021	2022	2023
Gloucestershire Health and Care NHSFT	Substantial	Substantial	Substantial
Gloucestershire Hospitals NHSFT	Substantial	Substantial	Substantial
Practice Plus Group	Full	Substantial	Full

Additionally, you confirmed that providers operating in Gloucestershire but covering multiple geographies are assessed by an agreed lead ICB. You were engaged in that process for input and have been sighted on both the submission and the outcome as outlined below.

Organisation	2021	2022	2023
EMED	Full (EZEC)	Substantial (EZEC)	TBC
SWASFT	Full	Full	Full

Next Steps

The outcome of this assurance review will be included in the annual EPRR Regional assurance summary letter which is reviewed and endorsed by NHSE South West's Senior Leadership Team before being presented to the NHSE National Team for wider scrutiny.

New ways of working were trialled for 2023 to complete the EPRR annual assurance process, NHSE will now conduct a regional review to capture successes and challenges. We welcome your local reflections on this and will provide feedback via your EPRR practitioners.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,

Keith Grimmett
Head of EPRR
NHS England South West

Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Briefing paper to IBC on command paper "Stopping the start: Our new plan to create a smoke-free generation"**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
					x	
Route to this meeting	This briefing paper has been written in response to the recently published Government command paper titled "Stopping the start: Our plan to create a smoke-free generation"					
	ICB Internal	**Date**	**System Partner**	**Date**		
	Strategic Executive	16/11/2023				
Executive Summary	The purpose of this paper is to brief the ICB on the recently published Government command paper "Stopping the start: Our plan to create a smoke-free generation" and the associated consultation around creating a smoke-free generation and tackling youth vaping. The recommendations made in this policy document are based on the findings of the independent report conducted by Dr Javid Khan ('The Khan Review') published in 2022. This paper is divided into the following sections: **1. Outline of the proposed policy** Summarising the proposed policy and purpose of the associated consultation including the suggested legislative changes. **2. Necessity of the proposed policy** Covering the implications of tobacco for health and wealth, the relationship between smoking and disadvantage, and the addictive nature of tobacco and other nicotine containing products. **3. Feasibility and impact of proposed legislative changes** Summarising the evidence for the feasibility and workability of the proposed policy. **4. Recommendations to the ICB** Three recommendations are presented to the board for consideration and action.					
Key Issues to note	The Government command paper covers three key policy areas: 1. Creation of a smoke-free generation 2. Strengthening of support for people to quit smoking 3. Regulation of vaping The associated Government consultation focuses on the areas of the policy requiring new legislation (smoke-free generation, youth vaping and enforcement).					

Key Risks: **Original Risk (8)** **Residual Risk (6)**	The key risk associated with the contents of the paper is: 1. Risk that there is insufficient support for the Government's proposals and the legislation does not go through, meaning that the opportunity to improve the population's health and reduce health inequalities is not realised. In order to mitigate this risk a draft consultation response has been prepared by the Public Health and Communities team, to facilitate the ICB response, thereby adding to the overall support for these proposals. The risks associated with investing the funding available for local stop smoking services will be assessed during planning.			
Management of Conflicts of Interest	None identified			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource	X	**Buildings**	
Financial Impact	The Government command paper outlines a plan to provide an additional £70 million per year to support local authority led stop smoking services. This funding is planned to be delivered through a new section 31 grant through the financial years of 2024/5 to 2028/9. The command paper also outlines a plan to provide enforcement agencies with an additional £30 million per year to tackle underage sales of tobacco and vaping products. There is no financial impact identified from the provision of a response to the consultation document.			
Regulatory and Legal Issues (including NHS Constitution)	None identified			
Impact on Health Inequalities	The proposed policy has the potential to have a substantive impact on reducing health inequalities. There is an explicit recognition of the disproportionate and often compound impact smoking has on already disadvantaged individuals.			
Impact on Equality and Diversity	Equality Impact Assessments will be completed for the component projects/ commissioning activities.			
Impact on Sustainable Development	None identified			
Patient and Public Involvement	PPI undertaken by the Department of Health and Social Care suggests a high proportion of adults in the population support the proposed policy. Members of the public are invited to submit individual responses to the consultation regarding the proposed policy.			

Recommendation	The **Board is asked to:** **1. Acknowledge the "Stopping the start: Our new plan to create a smoke-free generation" policy paper.** **2. Agree to the draft response to the consultation on creating a smoke free generation and tackling youth vaping.** **3. Acknowledge support of the need for new legislation to:** **a. Raise the age of sale for tobacco products effectively meaning that children aged 14 and younger this year will not ever be able to legally purchase tobacco products creating a smoke-free generation.** **b. Regulate the sale of vaping products to make them less affordable, visible and appealing to children.** **c. Strengthen existing enforcement to prevent underage and illicit sales of tobacco and vaping products.**		
Author	**Rhiannon D'Arcy**	**Role Title**	**Specialist Registrar Public Health**
Sponsoring Director (if not author)	**Siobhan Farmer, Director of Public Health.**		

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

Briefing Paper

1. Outline of the proposed policy:

The recently published command paper "Stopping the start: Our new plan to create a smoke-free generation" outlines the ambitions of the UK Government to:

1. **Create the first smoke-free generation**

This part of the policy proposes to implement legislative change that would make the sale of tobacco products to anyone born on or before the 1st of January 2009 illegal. In effect this will mean that children turning 14 years or younger this year will never legally be able to purchase tobacco products in their lifetime. This would be achieved by incrementally raising the legal smoking age by one year, each year, until it applies to the whole population. This legislation would also make proxy purchasing of tobacco products and cigarette papers on behalf of anyone born on or before 1st of January 2009 illegal.

2. **Strengthen support for people to quit smoking**

This part of the policy addresses an increase in the funding available for local stop smoking services and additional funding for national tobacco marketing campaigns.

Gloucestershire's indicative funding allocation, based on three-year smoking prevalence, is £787,301 per annum (from 2024/25 to 2028/29). This funding will come to local authorities on top of the public health grant. The funding is to be invested in:

1. **Building capacity for local stop smoking support and services** e.g., recruiting dedicated specialist staff to provide smoking cessation; improving knowledge and skills of non-specialist staff to extend the reach of stop smoking interventions; providing access to specialist/ non-specialist advisers in locations smokers routinely attend, e.g., GP surgeries, mental health services and employers; increasing spend for stop smoking aids from the range of products recommended; and enhancing overall service infrastructure, e.g., digital and remote support, and targeted outreach efforts for local priority populations.
2. **Building demand for local stop smoking support and services** e.g., by improving referral pathways to support; increased partnerships working with relevant agencies to tackle health inequalities and increase overall demand through routine identification of smokers; providing advice on effective methods to quit; and making active referrals; and increases promotion of local stop smoking support.

3. **Regulate vaping**

This part of the policy focuses on addressing the increasing prevalence of youth vaping in the UK, while balancing the need for vaping to remain an accessible and affordable option for current smokers who are trying to quit tobacco products. Proposed options for the regulation of vaping include the taxing disposable vaping products to make them less affordable to children, making packaging and flavour names of vaping products less appealing to children, and prohibition of instore promotion and displays of vaping products so they are less visible to children.

A consultation process is currently underway to gather as many views on the policy proposals as possible from the following groups:

- The public
- The retail sector and the independent vaping industry
- Local authorities across the UK
- Clinicians and medical professionals
- Public health stakeholders and academic experts

- Employers and trade unions

The consultation will specifically focus on areas of the policy that require new legislation (smoke-free generation, youth vaping and enforcement).

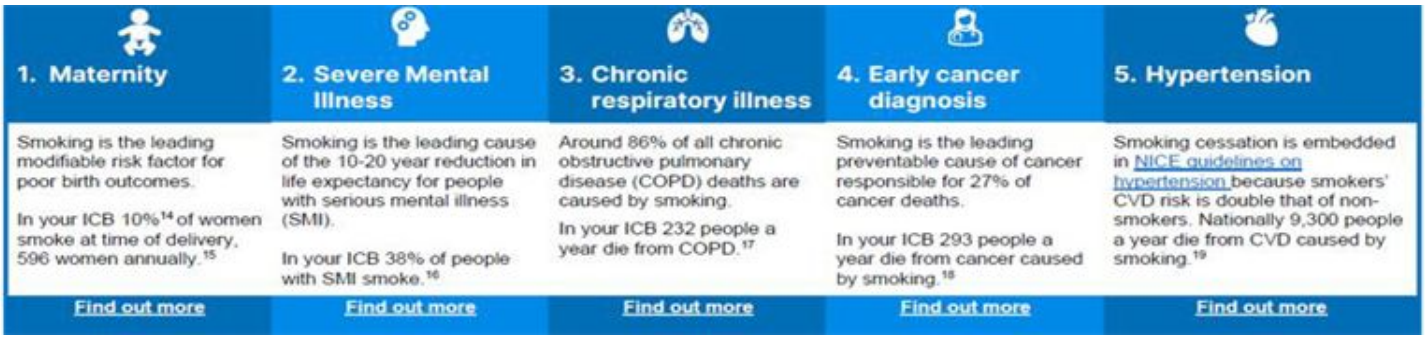
2. Necessity of the proposed policy:

Smoking, health and wealth:

Smoking is harmful to the health of both smokers themselves, and those around them through exposure to second-harm smoke.

Smoking is directly associated with a large range of harms to health all the way from conception to old age. The impacts of smoking across the five clinical areas of focus identified by Core20PLUS5 are outlined in figure 1.

Figure 1: Impact of smoking across five clinical areas of focus



Smokers are more likely than non-smokers to have a lower healthy life expectancy (time lived in good health and free from disability) and are more likely to die early (increased risk of premature mortality). Annually within this ICB smoking causes 4,563 admissions to hospital and 690 premature deaths.

A recent economic analysis of nationally available data has shown that the annual cost to society of smoking in England is 17 billion pounds based on estimated costs to the health and care sector and lost economic productivity due to smoking. In this ICB smoking costs an estimated 21.3 million pounds per year. Smoking-induced poverty is also a real a credible concern among more deprived communities with annual spend on tobacco estimated to be £2,451 per person. It is an inescapable fact that smoking creates considerable costs for both individuals and society as a whole.

There is no safe age to be exposed to tobacco, and no level of tobacco consumption that is not harmful to health**. The creation of a smoke-free generation represents an unparalleled opportunity to improve the health and wellbeing of the population while additionally reducing the economic burden of preventable smoking-related disease and reducing smoking-induced poverty.**

Smoking and disadvantage:

There are some groups of the population who are more likely to smoke, and more likely to experience smoking-related health harms. These include:

- Adults who are homeless or living in temporary accommodation
- Adults working in routine and manual occupations
- Adults with long-term mental health conditions

- Adults who are unemployed
- Adults with multiple long-term conditions (multimorbidity)
- Adults who are in prison
- Adults who are part of the LGBTQ+ community
- Children in care and care leavers
- Pregnant women with complex social circumstances
- Adults with learning disabilities
- Migrant communities with a high smoking prevalence in their country of origin (e.g., Polish and Romanian communities)
- Adults from certain ethnic groups
- Social housing tenants

In this ICB the average prevalence of smoking among adults aged 18 years and over was estimated to be 11.5%. As an average, however, this figure hides marked disparities in smoking prevalence among different population groups within this ICB:

- 23.3% of adults working in routine and manual occupations were smokers (2022 data)
- 38.1% of adults with a severe mental illness were smokers (2014/15 data)
- 22.1% of adults with a long-term mental illness were smokers (2022 data)
- 83.8% of adults admitted for treatment for substance and alcohol misuse were smokers (2022 data)

Despite all pregnant women being offered carbon monoxide screening in pregnancy and onward referral to smoking cessation services if needed, in this ICB 10.3% (2022) of pregnant women smoked at the time of delivery. National data suggests that women who smoke at the time of delivery are more likely to have long-term mental health conditions or other complex social factors.

Smoking is strongly associated with deprivation, and it both causes and exacerbates health inequalities. **The creation of a smoke-free generation will have a huge impact on reducing health inequalities among groups who already face significant disadvantages and vulnerabilities.**

Smoking and addiction:

4 out of 5 smokers (83%) started smoking before the age of 20, and evidence shows that the vast majority regret ever taking up smoking. Almost 7 out of 10 smokers want to quit smoking, however, it takes approximately 30 attempts for someone to quit successfully. This underscores the highly addictive nature of tobacco use. Indeed, tobacco is the most addictive substance that is currently legally for sale in the UK, and while many products that are legally sold have the potential to be harmful to health, tobacco is unique in both its potential for addiction and its lethality. **The creation of a smoke-free generation recognises that for most people smoking is an addiction started in childhood, and not a personal choice.**

Vaping is a key element of tobacco control, and can be an important harm-reduction strategy for those who are current smokers. There is a need to ensure that vaping remains affordable and accessible to smokers who need to use these products to quit tobacco. There is however, a genuine and growing concern about the increasing number of children and young people who are using vaping products. Data collected by Action on Smoking and Health (ASH) shows that the number of children using vapes in the past 3 years has tripled, and that two thirds of new vapers are young people rather than those trying to quit smoking. While current evidence suggests that vaping is less harmful than smoking, the long-term health impacts are currently unknown. It is vitally important that children and young people who have never smoked are protected from taking up vaping.

Although the sale of nicotine-containing vaping products to those under the age of 18 is illegal, many of the ways that vapes are sold (e.g. disposable single use) or marketed (e.g. flavoured liquids and bright coloured packaging) are known to encourage consumption among children. The proposed policy predominately focusses on addressing the promotion and marketing of vapes to children and young people at scale, and

the current consultation seeks to explore the practicalities of this. A separate paper on youth vaping will be presented to the ICB early in the new year.

3. Feasibility and impact of proposed legislative changes:

Legislation around minimum age of sale has previously been shown to be a very effective tobacco control measure for reducing rates of smoking among children. Raising the age of sale of tobacco products from 16 to 18 in 2007 helped to reduce youth smoking rates in children aged 11-15 years from 9% in 2005 to less than 1.1% in 2021. Changes to the age of sale for tobacco products builds on existing legislature, and there is very good reason to believe that it will be successful in creating a smoke-free generation. The proposed legislative changes also have strong public support (77% of adults in England support Government action to limit smoking), and importantly neither criminalises smoking nor removes the right to smoke for anyone who currently has it. Previously when changes to legislature around tobacco control have been proposed, plausible concerns have been raised about the potential for increasing black-market activity and illicit sales of tobacco. In large part due to the strengthening of enforcement measures, there was no observable increase in activity in the illicit tobacco market resulting from previous legislative changes to tobacco control, and there is no good reason to believe that this will not also be the case for the currently proposed legislative changes.

4. Recommendations to the ICB:

The following points are presented for consideration and action:

1. Acknowledge the “Stopping the start: Our new plan to create a smoke-free generation” policy paper.

2. Agree to the draft response to the consultation on creating a smoke free generation and tackling youth vaping.

3. Acknowledge support of the need for new legislation to:
    a. Raise the age of sale for tobacco products effectively meaning that children aged 14 and younger this year will not ever be able to legally purchase tobacco products creating a smoke-free generation.
    b. Regulate the sale of vaping products to make them less affordable, visible and appealing to children.
    c. Strengthen existing enforcement to prevent underage and illicit sales of tobacco and vaping products.

"Creating a smokefree generation and tackling youth vaping: your views"

Question 1

Do you agree or disagree that the age of sale for tobacco products should be changed so that anyone born on or after 1 January 2009 will never be legally sold (and also in Scotland, never legally purchase) tobacco products?

Agree

Gloucestershire ICB welcomes the proposal to raise the age of sale for tobacco products. Smoking remains the leading cause of preventable ill health and early death in Gloucestershire, with 2,070 deaths every year being attributable to this addiction. Many more are living with tobacco related sickness. In Gloucestershire, 67,600 (11.5%) people smoke, with those living in our most underserved areas being more likely to smoke. Smoking significantly impacts on health inequalities, 26,000 smoking households in Gloucestershire live in poverty. In Gloucestershire, 38% of those with mental health conditions smoke with smoking being the leading cause of the 10–20-year reduction in life expectancy. People working in routine and manual jobs in the county are more likely to smoke with over 23% employed in these occupations being smokers. Smoking rates are also higher amongst people who are homeless, in prison, living in social housing, and living with drug and alcohol addictions. Smoking prevalence in our fifteen-year-olds is nearly 9%. Reducing the number of smokers would help to lift significant numbers of children out of poverty, reduce exposure to second-hand smoke and increase health and life chances.

4 in 5 people that smoke start before the age of 20. Among those who try smoking 70% will go on to be daily smokers. Raising the age of sale is likely to both delay smoking uptake and reduce the number of young people who start smoking in the first place. Raising the age of sale from 16 to 18 in 2007 in England and raising the age of sale from 18 to 21 in the US more recently both reduced rates of smoking in the relevant age group by around a third.

A comprehensive communication plan would be essential to promote compliance and Gloucestershire ICB would keenly provide local support to a national campaign.

Question 2

Do you think that proxy sales should also be prohibited?

Yes

Yes, it will be important for proxy sales laws to be in line with age of sale laws to ensure consistency, however enforcement is very difficult. Controls over proxy sales already exist for tobacco and electronic cigarettes. Proxy sales are often seen as the method for underage persons obtaining tobacco and other age restricted products due to compliance with age restrictions by many shops. If proxy sales weren't prohibited, it would leave a

loophole. It is essential that local authority trading standards teams are given sufficient funding to enable them to enforce any new legislation.

Question 3

Do you agree or disagree that all tobacco products, cigarette papers and herbal smoking products should be covered in the new legislation?

Agree

Gloucestershire ICB believe that all tobacco containing products as well as cigarette papers should be covered by the new legislation, mirroring current age of sale laws. The tobacco industry has been shown to find ways to subvert laws which are not comprehensive. If tobacco products are not all included it will make enforcement more challenging and create opportunities for the industry to find loopholes.

Question 4

Do you agree or disagree that warning notices in retail premises will need to be changed to read 'it is illegal to sell tobacco products to anyone born on or after 1 January 2009' when the law comes into effect?

Agree

It would make sense for the warning notices in retail premises to be changed to reflect the new legislation, promote the change, and ensure the proposal is simple and easily understood as well as serving as a reminder to both customers and staff. We would recommend that the new notices should be A3 in capitals as is currently required. We would also recommend this is discussed with retail groups that are not affiliated to tobacco manufacturers.

The currently required notice will obviously be irrelevant if this part of the proposal is enacted. Notices serve as a reminder to customers and staff.

We support the current law which states the notice should be "at the point of sale" I.e. at the checkout/till. A requirement to also a display a message in shop windows would further raise awareness in the general public about tobacco law.

We welcome the commitment from the Government to increase funding for tobacco enforcement, recognising the crucial role our regulatory partners have in working towards

creating a smokefree generation. We are pleased that there will be a refreshed national illicit tobacco strategy and as such, it will be vital that this funding for enforcement is sustained to support the implementation of regulations.

Question 5

Do you agree or disagree that the UK Government and devolved administrations should restrict vape flavours?

Agree

We recognise that having a variety of vape flavours available may make vaping a more appealing option to adults who are using vapes to help quit smoking. We are also concerned that there is a need to set clear limits to prevent loop holes. We therefore believe that vape flavours should be limited to tobacco, mint, menthol and fruits. We also support the view of ASH that regulations should restrict how vape products are named, described and portrayed to limiting the use of descriptors that might appeal to children.

(The following comment will not be included in the response. We would welcome comment from ICB members on their views on the suggested answer to this question: Please note this response deviates from the ASH response. ASH believe that the focus of the legislation should be to eliminate the descriptors of the flavours and other marketing tools which appeal to children and young people and those who do not currently smoke and that more research should be done before restricting flavours as there is a risk it will discourage adult smokers using vapes to quit. We are concerned however about the risk of loop holes and feel that a balanced approach would be to allow a number of flavour options to maintain their appeal but limit them to avoid flavours that might appeal more to children such as 'chocolate' and 'sweets')

Question 6

Which option or options do you think would be the most effective way for the UK Government and devolved administrations to implement restrictions on flavours? (You may select more than one answer)

Option 1: limiting how the vape is described
Option 2: limiting the ingredients in vapes
Option 3: limiting the characterising flavours (the taste and smell) of vapes

We support the view of ASH that as a priority the law needs to restrict how vape products are named, described and portrayed and limit descriptors that are shown to appeal to children. An acceptable example of improved restrictions would be a vape described as 'blueberry flavour' rather than 'berry blast'. We also believe that vape flavours and ingredients should be limited to a selection that provides a large enough range to appeal to adult smokers wanting to use vapes to help them quite, whilst not exposing loop holes

to enable the selling of vapes that might appeal more to children and those that do not currently smoke.

(The following comment will not be included in the response. We would welcome comment from ICB members on their views on the suggested answer to this question: Please note this response deviates from the ASH suggested response as described above)

Question 7

Which option do you think would be the most effective way for the UK Government and devolved administrations to restrict vape flavours to children and young people?

Option C: flavours limited to tobacco, mint, menthol and fruits only
We would support the option for fruit flavours to remain available as they are popular with adult smokers who using vapes to help them quit – ASH commissioned research found that 47% of current adult smokers are using fruit flavours compared to 12% who use tobacco flavours.

Consideration should also be given to ensuring that the new legislation allows flexibility to be extended in response to adaptations by the market which may continue to appeal to children and those that do not currently smoke, without needing to go through lengthy parliamentary processes.

(The following comment will not be included in the response. We would welcome comment from ICB members on their views on the suggested answer to this question: Please note this response deviates from the ASH response. ASH believe that the focus of the legislation should be to eliminate the descriptors of the flavours and other marketing tools which appeal to children and young people and those who do not currently smoke and that more research should be done before restricting flavours as there is a risk it will discourage adult smokers using vapes to quit. We are concerned however about the risk of loop holes and feel that a balanced approach would be to allow a number of flavour options to maintain their appeal but limit them to avoid flavours that might appeal more to children such as 'chocolate' and 'sweets')

Question 8

Do you think there are any alternative flavour options the UK Government and devolved administrations should consider?

Yes
As outlined above we support the view of ASH that flavour descriptors should be limited through regulations.

Question 9

Do you think non-nicotine e-liquid, for example shortfills, should also be included in restrictions on vape flavours?

Yes
Yes, if rules are in place to restrict flavours, how flavours are described and characterising flavours, these should be in place for all vaping products to avoid risk of companies finding loopholes in the law to continue to promote products inappropriately.

Question 10

Which option do you think would be the most effective way to restrict vapes to children and young people?

Option 2: vapes must be kept behind the counter but can be on display
We support the view of ASH. There are currently too many inappropriate examples of point of sale displays of vape products in shops leading to increasing awareness of vape promotion among children and young people. To address this, we believe that vapes should only be kept behind the counter but can still remain on limited display with no other instore or externally visible promotion and providing that regulations have been implemented to remove child-friendly packaging and labelling. This reflects the different levels of risk between tobacco products and vape products: if vape products are subject to all of the same regulations as tobacco (i.e. behind the counter and out of sight such as with point of sale display rules for tobacco products) then this could add to the existing misperceptions among the public that vapes are equally as, or more, harmful than tobacco. However, once implemented, if this measure is not found to be sufficient, then there should be powers in the primary legislation to allow the regulations to be strengthened to ensure vape products are both behind the counter and out of sight. It is also worth noting that placing vapes behind the counter, and the customer needing to ask to purchase one, provides the retailer with an additional opportunity to assess the customer's age supporting enforcement efforts. Restrictions around the ways in which vapes can be displayed may help to limit the number of outlets who sell vaping products. While it would not be desirable for vapes to be less available than tobacco, having fewer retailers selling products will also aid enforcement.

Question 11

Do you think exemptions should be made for specialist vape shops?

Agree
However, we support the ASH position that there should still be some regulations around vape displays in specialist vape shops, particularly those in shop fronts that are visible from

the street and also restrictions should be considered around any on street marketing boards etc. It may be appropriate to consider further age restrictions on specialists shops to ensure they are primarily accessed by adults.
Question 12 If you disagree with regulating point of sale displays, what alternative measures do you think the UK Government and devolved administrations should consider? N/A
Question 13 Which option do you think would be the most effective way for the UK Government and devolved administrations to restrict the way vapes can be packaged and presented to reduce youth vaping? **Option 2: prohibiting the use of all imagery and colouring on both the vape packaging and vape device but still allow branding such as logos and names** We support the view of ASH that restrictions should be introduced on how vapes are packaged, the imagary and branding to prevent it appealing to children whilst still being appealing to adults who want to quit smoking. Research from King's College London and ASH looked at how packaging affects the appeal of vaping to teenagers and adults. It found that those in the teenage group were more likely to report that their peers would have no interest in vapes when marketed in standardised packaging, in contrast to the adult group whose interest in using vapes was not reduced by the standardisation of packaging. We recommend that the Government commits in the first instance to restricting brand imagery – and to consider prescribing the size and type face of any branding which does remain, as per tobacco packaging regulations – and then to undertake more detailed research to inform the development of effective regulations. There is hesitancy to go down a fully standardised plain packaging route until more research is undertaken with smokers around perceptions of harms of vaping versus smoking.
Question 14 If you disagree with regulating vape packaging, what alternative measures do you think the UK Government and devolved administrations should consider? N/A
Question 15

Do you agree or disagree that there should be restrictions on the sale and supply of disposable vapes?

That is, those that are not rechargeable, not refillable or that are neither rechargeable nor refillable.

Agree
Please see response to next question.

Question 16

Do you agree or disagree that restrictions on disposable vapes should take the form of prohibiting their sale and supply?

(The following comment will not be included in the response. We would welcome comment from ICB members on their views on the suggested answer to this question: ***Please note there are two answer options*** *for consideration – we are seeking agreement on which we should submit. Alternatively if there is not a consensus view we can seek to submit "Don't Know" and present the pros and cons of agree/disagree options)*

Agree
Single-use (disposable) vapes are the usual means of children who vape and the cause of the epidemic rise we are seeing nationally. In Gloucestershire our 2022 Pupil Wellbeing Survey found that whilst cigarette smoking has continued to decline since 2018, vaping has sharply risen, with overall exposure to nicotine rising by 42% between 2020 to 2022 and national evidence indicating a continued rise. Single-use vapes are also incredibly damaging to the environment. From a trading standards perspective it would be much easier to respond to illegal single-use vape trade if there was an outright ban as it would be much easier to evidence.

Whilst we appreciate that single-use vapes may be more accessible to some population sub-groups of adult smokers wanting to vape to help them quit (for example older smokers with dexterity issues) we believe that this could be resolved either through market adaptations or through single-use vapes being approved and available on prescription only.

OR

Disagree
We need to monitor the evidence on disposable' vapes. However, ASH believe that a ban at this time would be unlikely to deliver a reduction in teen vaping which is the stated policy objective but could risk damaging quitting options for some groups of vulnerable smokers. A ban on disposable vapes may have unintended consequences as set out in the joint paper from ASH, Chartered Trading Standards Institute and Material Focus. With an existing significant uncontrolled issue with illicit products a ban would be unlikely to significantly reduce the supply of products to underage vapers who are more likely to access illicit products. This must be brought under control before a ban might be effective. However, a

ban would limit the use of products with vulnerable groups of smokers such as those in mental health and custodial settings and individuals with dexterity issues such as older smokers. It should be noted that many stop smoking services remain keen to have access to disposable vapes as part of the Government's swap to stop programme specifically because of the benefits to some groups of smokers. There is growing concern over the environmental impacts of disposable vapes and it is essential that action is taken to mitigate these as much as possible e.g. improving product design, increasing access to responsible disposal options.

Question 17

Are there any other types of product or descriptions of products that you think should be included in these restrictions?

Restrictions should consider predictions around emerging and novel products to foresee the actions of tobacco companies to circumnavigate restrictions.

We also support ASH's view that the Government may wish to consider regulating the shape and form of such devices and seek to standardise these. This could be beneficial from both an environmental and enforcement point of view, with the likely result that devices would not take the form of toys or gadgets that may be appealing to children. Careful consideration would need to be given to any policy development in this area to ensure that it doesn't result in unintended consequences.

Question 18

Do you agree or disagree that an implementation period for restrictions on disposable vapes should be no less than 6 months after the law is introduced?

Disagree
We believe the legislation should be implemented as quickly as possible. We also support ASH's view that the loophole which enables free distribution of any vape to anyone of any age (as opposed to the selling of in the current legislation) needs to be closed urgently.

Question 19

Are there other measures that would be required, alongside restrictions on supply and sale of disposable vapes, to ensure the policy is effective in improving environmental outcomes?

We support ASH's recommendations regarding the concerns about the environmental aspect of single use vapes that need to be addressed urgently. Vape companies are currently not complying with their environmental obligations and we support the recommendations of Material Focus who are calling for a revision of regulations. The full environmental costs of collecting and recycling vapes – including raising public awareness

– should be met by industry and not by public finances. We also need action to address the negative impact on the environment caused by discarded tobacco products and in particular cigarette butts which are the most littered item worldwide and which can't be recycled, do not biodegrade and which leach toxic chemicals into the environment. In 2021 DEFRA and DHSC announced they were regulatory extended producer responsibility scheme for cigarette butts in England under the Environment Bill to require the tobacco industry to pay the full disposal costs of tobacco waste products. This should be implemented to ensure the sector takes sufficient financial responsibility for the litter its products create.

Question 20

Do you have any evidence that the UK Government and devolved administrations should consider related to the harms or use of non-nicotine vapes?

Yes
We have received anecdotal reports from professionals that work with children that vapes are being adapted by young people to administer illicit drugs.

Question 21

Do you have any evidence that the UK Government and devolved administrations should consider on the harms or use of other consumer nicotine products such as nicotine pouches?

Yes
We support the view of ASH that non-nicotine vapes should be regulated in the same way as nicotine containing vapes. This will prevent industry from using them to promote vaping in ways that they aren't allowed to communicate with nicotine-containing vapes. The Tobacco and Related Product Regulations only cover e-cigarettes and novel tobacco products, not novel nicotine products like pouches. That means that for novel nicotine products there are:

- No age of sale regulations so they can be sold to anyone, as well as being handed out free.
- No standardised regulatory requirement for information on packaging to provide information to consumers
- No controls on their advertising, promotion and sponsorship – these products are being promoted online via influencers, free samples and competitions
- No limits on nicotine content – some of them are very high strength, much higher than allowed by the regulations for e-cigarettes.
- No regulation of contents or ingredients – other than that required for them to conform to general product safety rules

The regulations need to be revised to include not just nicotine pouches but any novel nicotine products, as this is a market which is likely to continue to evolve. We also believe that more independent research is needed to determine what, if any, role such products can play in tobacco control and for broader public health.

Question 22

Do you think the UK Government and devolved administrations should regulate other consumer nicotine products such as nicotine pouches under a similar regulatory framework as nicotine vapes?

Yes

Restrictions should include nicotine pouches and consider any other emerging and novel products to foresee the actions of tobacco companies. We support ASH's view that nicotine pouch use among those under 18 is undesirable but they may have a value for adult smokers looking to switch and should be regulated in a similar way to vaping products. The Government should not wait until a market has been established in those under 18.

Question 23

Do you think that an increase in the price of vapes would reduce the number of young people who vape?

Yes

Yes this would probably reduce the the number of young people accessing vapes, but there may be unintended consequences such as illegal vapes trade and affordability for adult quitters. Operation CeCe showed illegal tobacco is endemic in the UK and the sale of illegal tobacco defeats taxation objectives. Increasing the price could cause an increase in the illegal market. We also support ASH's view that regulations need to be consistently applied across all nicotine products.

Question 24

Do you think that fixed penalty notices should be issued for breaches of age of sale legislation for tobacco products and vapes?

Powers to issue fixed penalty notices would provide an alternative means for local authorities to enforce age of sale legislation for tobacco products and vapes in addition to existing penalties.

Yes

The use of fixed penalty notices would provide a rapid resolution to an underage sale offence. These should be applicable to the seller and the business (who employs the seller). The fixed penalty would at least permit "first time" offenders to be punished. Prosecutions

take too long; the penalty comes long after the offence due to the time to investigate and getting the matter to court. It is essential that local authority trading standards teams are given sufficient funding and longer-term funding commitment to enable them to train and recruit a workforce which will be able to enforce any new legislation.

Question 25

What level of fixed penalty notice should be given for an underage tobacco sale?

Other

Penalties have always been very low for age restricted offences such that it serves as no deterrent. The fine should be punitive. The fine for selling a non-compliant vape (not complaint with the Tobacco and Related Products Regulations) far exceeds the fine for selling a vape to a person under 18 which doesn't reflect the harm sought to be avoided. A child that buys a vape (or cigarettes for that matter) may go on to be hooked for life. There should be one fine limit for the business and one fine limit for the employee. The maximum fine for tobacco under age sale is £2500 so the FPN should be more reflective of this. If set too low, it will be no deterrent for a business that deliberately sell. It is essential that local authority trading standards teams are given sufficient funding and longer-term funding commitment to enable them to train and recruit a workforce which will be able to enforce any new legislation.

Question 26

What level of fixed penalty notice should be given for an underage vape sale?

Other

Penalties have always been very low for age restricted offences such that it serves as no deterrent. The fine should be punitive. The fine for selling a non-compliant vape (not complaint with the Tobacco and Related Products Regulations) far exceeds the fine for selling a vape to a person under 18 which doesn't reflect the harm sought to be avoided. A child that buy a vape (or cigarettes for that matter) may go on to be hooked for life. There should be one fine limit for the business and one fine limit for the employee. The maximum fine for vape underage sale is £2500 so the FPN should be more reflective of this. If set too low, it will be no deterrent for a business that deliberately sell. It is essential that local authority trading standards teams are given sufficient funding and longer-term funding commitment to enable them to train and recruit a workforce which will be able to enforce any new legislation.

Agenda Item 13

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**System Quality Terms of Reference Update**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
	NHS Gloucestershire System Quality Committee	19th October 2023					
Executive Summary	The ICB System Quality Committee (SQC) Terms of Reference (TOR) have been slightly updated following discussion held at a System Quality workshop in June 2023. The high-level fundamental changes have been to include an updated governance flowchart demonstrating the reporting structure into the SQC, page12, and the inclusion of Childrens Social Care.						
Key Issues to note	It is worth noting that the System Experience Group as shown within the governance chart has yet to be set up and plans are in place. There are no other issues to note.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without Committee ToRs which provide the framework in which the committee operates there would be no ICB committees providing an assurance and strategic function for the ICB. (4x3) 12 The development of ToRs has reduced this risk considerably to: (4x1) 4 (residual meaning accepted risk)						
Management of Conflicts of Interest	The TOR have been reviewed with the involvement and engagement of SQC which has full system partner representation, as well as governance staff. There are no conflicts of interests as this has been collaborative process following best practice.						
Resource Impact (X)	**Financial**		**Information Management & Technology**				
	Human Resource		**Buildings**				
Financial Impact	N/A						

Regulatory and Legal Issues (including NHS Constitution)	The Committee will continue to oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained,		
Impact on Health Inequalities	Committee ToRs are not directly about patients, but the committees will cover patient care and issues related to health inequalities.		
Impact on Equality and Diversity	The Quality Committee shall scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.		
Impact on Sustainable Development			
Patient and Public Involvement	N/A		
Recommendation	The Board is requested to approve the updated System Quality Committee Terms of Reference.		
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**
Sponsoring Director (if not author)	**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

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD

QUALITY COMMITTEE

TERMS OF REFERENCE

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

Contents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1. Introduction

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

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

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

2. Purpose of the Committee

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

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

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

3. Delegated Authority

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

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

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

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

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

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

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

4. Membership

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

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

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

One or more Local Authority representatives (Director of Public Health, Director for Adult Social Care, Childrens Social Care).

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

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

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

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

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

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

4.6 Attendees and other Participants

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

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

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

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

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

4.7 Attendance

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

5. Quoracy

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

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

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

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

6. Voting and decision-making

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

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

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

7. Frequency and notice of meetings

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

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

8. Committee secretariat

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

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

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

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

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

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

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

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

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

9. Remit and Responsibilities of the committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

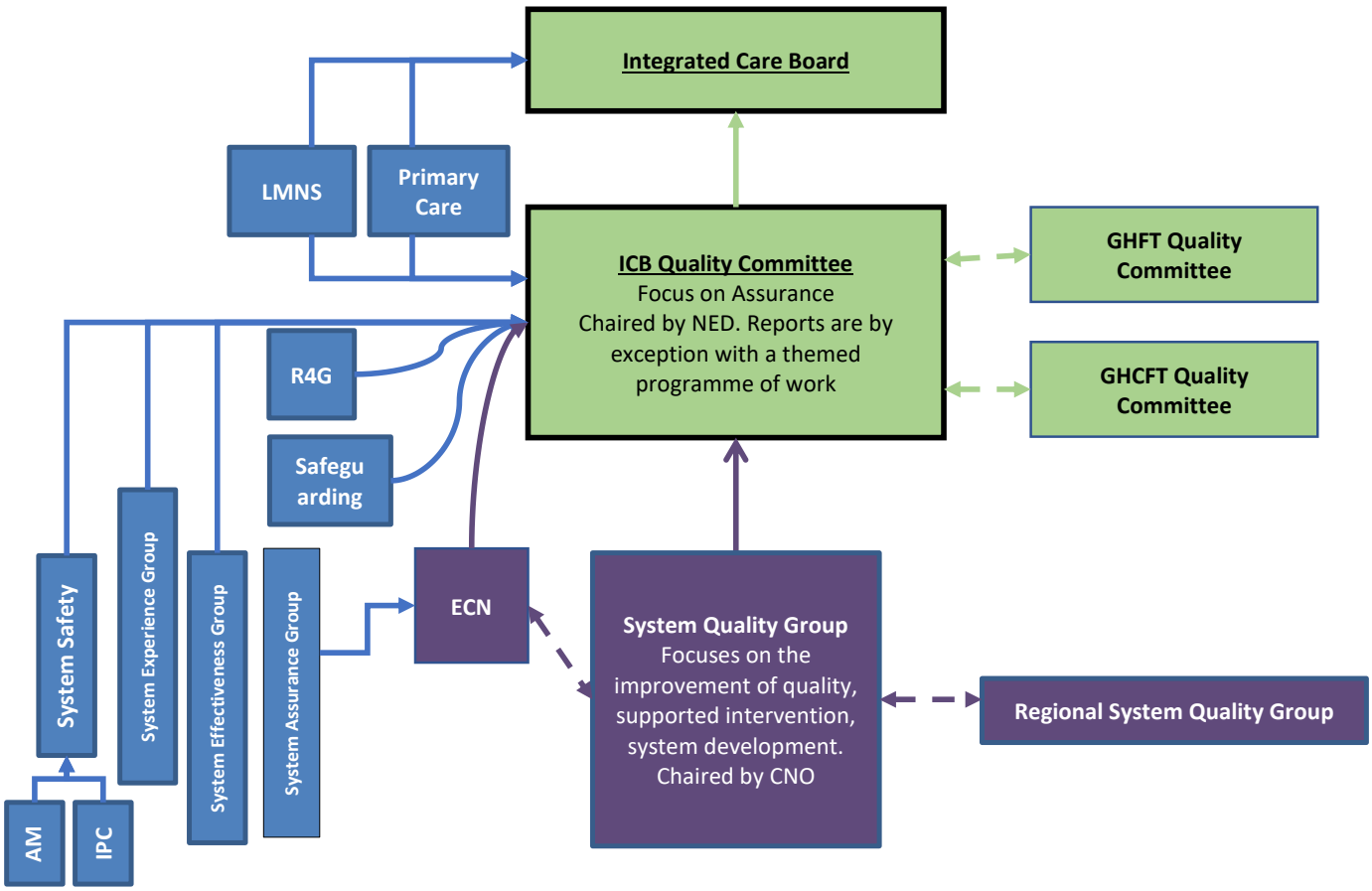
10.3 The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Infection Prevention and Control, Safeguarding Boards / Hubs etc).

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

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

10.6 The below governance chart demonstrates the reporting structure from sub-groups and other meetings that will provide assurance and updates into the System Quality Committee, including the System clinical Effectiveness Group, and Patient Experience.

10.7



11. Policy and best practice

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

12. Monitoring and Reporting

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

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

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

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

13. Conduct of the Committee

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

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

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

13.4 Conflicts of interests

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

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

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

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

14. Review of ToR

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

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

Agenda Item 14

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Delivery Plan for Recovering Access to Primary Care – System Plan**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X						
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:						
	ICB Internal	**Date**	**System Partner**	**Date**			
	PCN Development Group Primary Care Operational Group	2/11/2023 14/11/2023	Strategic Executive	16/11/2023			
Executive Summary	In May 2023 the Delivery Plan for Recovering Access to Primary Care (hereby referred to as the 'National Delivery Plan') was published by NHSE, outlining the requirement for ICBs to develop system-level access improvement plans ('System Delivery Plan'). There is a national requirement to submit an ICB report on progress by November 2023 and second report in April/May 2024. The report details Gloucestershire's key priorities for recovering access to Primary Care against the national published checklist, including supporting practices to improve their 2 and 4 week appointment data, appointment mapping, establishing self-referral routes in Gloucestershire for 7 services, supporting 15 critical practices to move from analogue to digital telephony, reduce bureaucracy within the system, support PCNs/practices with national support offers, coverage of Patient Participation Groups (PPGs), Support Level Framework (SLF) conversations, expansion of community pharmacy services and implementation of the local communication plan to support the national communication plan.						
Key Issues to note	There are several challenges faced by GP practices in the current climate which need to be considered alongside this programme of work, which include (but are not limited to), financial pressures, workforce pressures, patient demand and expectation. We are reviewing these and working with practices and PCNs to understand the issues.						

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	This report has identified that intensive resources in practices, PCNs and the ICB will be required to achieve the plan's ambition. The ICB are working with several practices to support their ongoing resilience and sustainability. There is a risk that public and patient expectations around access could be set unrealistically given the number of factors at play. There is a risk that there is not sufficient funding available in the System Development Funding (SDF) to support the System Delivery Plan, given the number of commitments against this budget.			
Management of Conflicts of Interest	Any conflict of interest on the Recovering Access in Primary Care Project Group and wider system colleagues has been raised prior/during the meetings.			
Resource Impact (X)	**Financial**	**X**	**Information Management & Technology**	**X**
	Human Resource	**X**	**Buildings**	**X**
Financial Impact	Small financial impact – funding is provided by NHSE. It should be noted that there is some pressure on the SDF to support this plan, given the number of commitments already against this budget. This is being worked through with the ICB Director of Finance.			
Regulatory and Legal Issues (including NHS Constitution)	N/A			
Impact on Health Inequalities	Health inequalities for recovering access in Primary Care are being addressed through various Primary Care workstreams including Core20plus5 areas.			
Impact on Equality and Diversity	PCN Capacity and Access Improvement Plans (CAIPs) consider the impact on equality and diversity on their patient population.			
Impact on Sustainable Development	The System Delivery Plan aims to support practices and PCNs to be sustainable and manage patient demand and capacity.			
Patient and Public Involvement	The ICB Patient Engagement Team have shared supportive information with practices/PCNs to help with the development of PPGs and local surveys.			
Recommendation	**The Board is requested to:** • **Note the information provided.**			
Author	**Jo White**	**Role Title**	**Deputy Director of Primary Care & Place**	
Sponsoring Director (if not author)	**Helen Goodey, Director of Primary Care & Place**			

Abbreviation	Explanation or clarification of abbreviations used in the paper
ARR	Additional Role Reimbursement
CAIP	Capacity and Access Improvement Plans
CPCF	Community Pharmacy Contractual Framework
CPD	Continuous Personal Development
DES	Direct Enhanced Service
DHSC	Department of Health and Social Care

DoS	Directory of Service
DPF	Digital Pathway Framework
EIA	Equality Impact Assessment
FFT	Friends and Family Test
FTE	Full Time Equivalent
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GPAD	GP Appointment Data
GPIP	GP Improvement Programme
GPPS	GP Patient Survey
HCA	Health Care Assistant
ICB	Integrated Care Board
ICES	Integrated Community Equipment Service
ICS	Integrated Care System
ICT	Integrated Community Team
IIF	Impact and Investment Fund
LMC	Local Medical Committee
MHP	Mental Health Practitioner
NHSE	NHS England
NWRS	National Workforce Reporting Service
PCARP	Primary Care Access Recovery Plan
PCN	Primary Care Network
PCTH	Primary Care Training Hub
POMI	Patient Online Management Information
PPG	Patient Participation Group
SDF	System Development Funding
SLF	Support Level Framework

Agenda Item 14

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

1. Introduction

1.1. In May 2023 the Delivery Plan for Recovering Access to Primary Care (hereby referred to as the 'National Delivery Plan') was published by NHSE, outlining the requirement for ICBs to develop system-level access improvement plans ('System Delivery Plan'), aligning with their leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

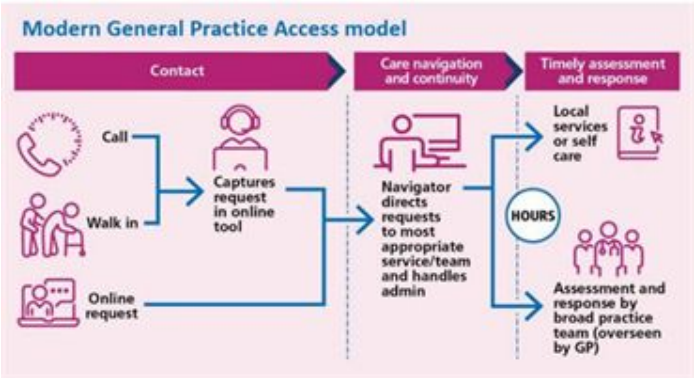
1.2. The National Delivery Plan for Practices and PCNs aims to support the increase in demand within Primary Care and focuses around four areas:

- Empower Patients
- Implement 'Modern General Practice Access'
- Build Capacity
- Cut Bureaucracy

1.3. The National Delivery Plan has two central ambitions:

- To tackle the 8am rush and reduce the number of people struggling to contact their practice.
- For patients to know on the day they contact their practice how their request will be managed.

1.4. The National Delivery Plan supports a way of working to manage demand in General Practice called the Modern General Practice Access Model, see image below.



1.5. The Modern General Practice Access model is designed to provide equitable access regardless of whether patients contact the practice by telephone, digitally or by walking in.

It does need digital tools to be embraced, but also recognising that some patients may struggle with digital access. Patients should have access to the right service and the right clinician, at the right time.

1.6. NHS England want ICBs to lead the change that is right for their system and will measure progress from ICB public board reporting.

1.7. ICBs are required to take system-level Delivery Plans to their public board in October/November 2023 and provide an update in February/March 2024. The areas noted in the Appendix B are intended to help support boards in the task of assuring plans.

2. Local Context

2.1. The requirement for ICBs to develop system delivery plans for recovering Access in Primary Care comes at a challenging time and while national GP contract negotiations are under way there is uncertainty for all GP practices and PCNs around future funding for 2024 onwards. Practices generally are experiencing financial challenges which when coupled with workforce issues means capacity is harder to manage with many practices now finding GP locums, for instance, unaffordable. Financial challenges, which as well as threatening the sustainability of practices, impact on the ability of practices to find the time to invest in making change.

2.2. Locally we recognise there is even greater impact on practices in areas of deprivation and accordingly there is a focus on supporting the Core20plus5 areas, in particular, with additional funding for practices in these areas to support recruitment, the Health Inequality GP role and the additional time and resource it takes to manage patients from the most deprived areas in our communities. However, reducing Health Inequalities is extremely challenging. We are working to understand from providers on the ground the specific day to day challenges and how we as a system can support solutions. We also recognise the financial gap that is experienced by some providers as a result of health inequalities.

2.3. GP practices in Gloucestershire are delivering approximately 27% more appointments post-covid than they were compared to pre-covid pandemic (September 2019 vs September 2023) with a 6 month rolling average of 24%. This is compared to the National position which has seen an increase of 21% for September with a 6 month rolling average of 15% compared to pre-covid activity levels. This increase in demand is having a significant impact on General Practice workload in Gloucestershire. Understanding the drivers of demand in Primary Care is essential and considering whether we are maximising other potential Primary Care pathways is key to help manage demand.

2.4. In Gloucestershire, GP practices are delivering considerably more urgent appointments; in September 2023 GP practices in Gloucestershire provided 23% more same-day appointments than in September 2019 (105013 same day appointments in September 2019 and 137330 in September 2023; GPAD). Nationally there has been a 13% increase in same day appointments over the same period.

2.5. Overall, 73% of appointments in Gloucestershire are in person (face to face) with a clinician; the remaining 27% are conducted by phone or virtually (GPAD, September 2023) which is back to pre-pandemic levels. Nationally 71% of appointments were face to face in September 2023.

2.6. Every practice in Gloucestershire will generally see patients on the same day or next day, for urgent appointments. General Practice prioritise babies and young children, to ensure they are seen in a timely way and according to clinical need. However, we are aware that Gloucestershire General Practice routine appointment wait times for 15 days and over are higher (worse) than the national average. This is seen as a partly inevitable outcome of the significant increase in total appointments provided by Gloucestershire practices.

2.7. According to patients, their experience of appointments in Gloucestershire is good, with the national GP Patient Survey data for Gloucestershire showing overall patient experience rates that are above the national average, 80% of patients reported good experience in Gloucestershire compared to 71% nationally. There are specific areas, such as Inner City Gloucester and areas of Cheltenham where results are lower than the average, which reflect areas of higher deprivation.

2.8. The National Delivery Plan for recovering access is welcomed, as it will help to address telephony/digital access discrepancies across the County and support practices to move towards the Modern General Practice Access model. There are also many local initiatives and work streams linked to the national agenda that compliment this work to support Primary Care access and workload.

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2.10. An example to support Primary Care pathways is work that is progressing to monitor 111 and MIIU activity, as part of the Urgent Care pathways review, to identify if there are any trends to help plan best use of in-hours Primary Care provision to support Primary Care access.

2.11. The System Delivery Plan is being undertaken in conjunction with recommendations from the Fuller report which sets out a vision and framework for Primary Care to integrate with the wider health and care system to improve access, experience and outcomes for communities. This work is being led through the Gloucestershire Neighbourhood Transformation Group.

2.12. Following system direction and support from members of the Gloucestershire Neighbourhood Transformation Group and the ICB Board Development session in October, we are progressing the development of Integrated Neighbourhood Teams in the county. Commencing in neighbourhoods in Cheltenham and Gloucester, the approach will initially focus around frailty and how partnership working can be unleashed to work differently with

people in their communities in a proactive way whilst at the same time reducing duplication and fragmentation. It is anticipated that the teams around each neighbourhood will utilise the Personalised Proactive Whiteboard tool in order to identify cohorts of people to be proactively supported, following established use of the tool with some Primary Care teams.

2.13. The System Delivery Plan also aligns to the current Primary Care Strategy (2019-2024) with access being a key theme and this is also reflected in the development and engagement process for the next five-year strategic plan for Primary Care.

2.14. The System Delivery Plan links to the Prevention Workstream of the Working as One Transformation programme which purpose is to proactively support people's independence to live and thrive in their community for as long as possible, reducing or delaying getting to the point of an urgent need. This programme of work will support Primary Care workload and subsequently relate to the Delivery plan.

2.15. The proposed trial/improvement cycle areas of the Working as One Transformation programme are:

- Admissions avoidance Pathways for GPs this winter - To improve navigation and therefore keep people at home/in communities where possible, positive impact on ED attendances and use of GP time.
- Falls Prevention - Increase referrals to prevention services including and link to Rapid Response and other primary/community services, MSK CPG, Falls Pathway, MECC.
- Integrated Proactive Neighbourhoods - Integrated teams around neighbourhood populations including and link into Personalised Proactive Whiteboard as an enabler to identifying at risk cohorts, PCN QI, Frailty.

2.16. In addition, health inequalities projects are taking place in Inner City Gloucester which has approximately two thirds of patients who meet Core20PLUS5 criteria and two thirds of patients who are in Level 1 deprivation (ICB average 7.8% and 9.7% respectively). This project looks to understand the challenges in delivering effective care to this population across the system and in particular to support the delivery of high-quality Primary Care in order to reduce health inequalities.

2.17. NHS Gloucestershire is, with the support of the respective Integrated Locality Partnership, delivering a number of Community Health and Wellbeing hubs in Core20 areas of the county which supports Primary Care. These hubs are intended to be locally appropriate and accessible community health and wellbeing assets to include health promotion such as health checks and vaccinations. Proposals are being designed alongside local stakeholders to plan for future sustainability.

2.18. An Integrated Locality Project in Cheltenham is targeting support for Health Inequality populations to support Primary Care demand and capacity. Cheltenham has a close to county average life expectancy but shows significant inequality in life expectancy between the most and least deprived residents. This translates to 10 years difference in life expectancy in West Cheltenham. To proactively tackle the root cause of health inequalities and improve health and wellbeing in West Cheltenham we have assembled a collective that

includes representatives from the community, VCS, council, health and social care. Nursing and Social Prescribing Link Worker representatives from Central PCN for instance, facilitated a recent Family Fun Day offering health checks, advice and support to families.

2.19. Within Gloucestershire PCNs have received local funding for Quality Improvement Projects. Five PCNs, have chosen to focus on projects related to frailty, to proactively support their population with the aim to help people to live and thrive in their community for as long as possible and reducing need for GP services.

3. The System Delivery Plan

3.1. A Gloucestershire System Delivery Plan has been developed (Appendix A). A working group to support the development of the System Delivery Plan for Gloucestershire has been established with progress reported through the Primary Care Operational Group and the Primary Care and Direct Commissioning Committee. Following analysis against the nationally published checklist the key Gloucestershire priorities for the System Delivery Plan have been identified as follows:

- Support practices to improve their 2-week and 4-week appointment wait data;
- GPAD appointment mapping for practices and PCNs;
- Establish and expand self-referral routes in Gloucestershire for falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services, are operational and successful, including ensuring the Digital Pathways for self-referrals support patient care;
- Support the 15 ‘critical’ practices to move from analogue to digital telephony
- Reduce bureaucracy within the system to establish local mechanisms to facilitate the primary-secondary care interface;
- Supporting PCNs/practice take up of the national GP Improvement Programme towards implementing the Modern General Practice Access model;
- Coverage of Patient Participation Groups (PPGs),
- Support Level Framework conversations
- Expansion of community pharmacy services and;
- Implementation of the local communication plan to support the national communication plan.

4. Challenges

4.1. There are several challenges with this programme of work in General Practice, which include (but not limited to), financial pressures, workforce pressures and patient demand and expectation. We are reviewing these and working with practices and PCNs. The key challenges, wider support needs and barriers to highlight are noted below.

4.2. The System Delivery Plan has identified that intensive resources in practices, PCNs and the ICB will be required to achieving the plans ambition. The success of implementing the System Delivery Plan is dependent on practices engaging with the support available. Yet, it

does not unilaterally address the significant issues facing Primary Care in terms of staffing, patient demand and financial issues. In parallel, the ICB are working with several practices to support their ongoing resilience and sustainability.

4.3. Some practices lack the stability to engage in this programme and patient expectations continue to increase through this national commitment.

4.4. There is not sufficient funding available in the SDF to support the System Delivery Plan, given the number of commitments against this budget.

4.5. We are aware that there are ongoing issues with GPAD mapping which the digital team are supporting practices with.

5. Next Steps

5.1. The ICB will continue to work with practices and PCNs to deliver the required actions for this programme of work.

5.2. Funding associated with the System Delivery Plan will continue to be shared with practices and PCNs where appropriate to support the implementation of the General Practice Access Model.

5.3. Support offers, both nationally and locally, will continue to be communicated and discussed with practices and PCNs to ensure the best possible engagement and implementation of the System Delivery Plan.

5.4. The Gloucestershire System Delivery Plan will be taken to the public board in November 2023.

5.5. Plans are in place to review PCN CAIPs and discuss progress in April 2024, with payments due to PCNs by 31 August 2024.

5.6. The digital aspects of the System Delivery Plan are interdependent and part of the wider Primary Care digital programme which is progressing. Timescales for delivery will vary, depending on the starting point for each practice and are dependent on contracts and supplier availability.

5.7. As summarised in Section 2.0 Gloucestershire has identified key priorities, these are detailed in the table below with further details including reasons/barriers that need to be considered and next steps. A system approach is required to address these.

6. Recommendations

6.1. The Board is asked to:

NOTE the contents of this report to Recovering Access in Primary Care including the national ambition and the local key priorities identified in the System Delivery Plan, challenges, wider support needs, barriers and next steps.

Table 1 Gloucestershire System Delivery Plan Priority Areas, Reasons/Barriers, and Next Steps

Priority Area	Reasons / Barriers	Next Steps/Action
Support practices to improve their 2-week and 4-week appointment data;	No PCNs are currently achieving the IIF lower or upper threshold for the ACC-08 indicator. In Gloucestershire, same-day and next day appointments are similar to the national average, reflecting that patients may be being prioritised based on need. PCNs have noted in their CAIP that they are reviewing appointments to ensure they are appropriately mapped, which could be an influencing factor on this data. There will be cases where due to patient preference, or clinical advice, the appointment wait is longer than 2 weeks. NHSE is working with IT system suppliers to implement exception categories reflecting this.	Further analysis is being undertaken to understand the rationale behind the higher appointment waits beyond 14 days.
GPAD appointment mapping for practices and PCNs	Practices/PCNs need to map appointments correctly to ensure data is accurate. As above, this may be an influencing factor for appointment wait times. It is also potentially an influencing factor for online appointment data which currently is very low in Gloucestershire. PCN data has been made available via GPAD. PCNs have advised that this is not correct, and does not match the clinical system, NHSE have advised there is a known problem with the data flow which they are working to resolve.	GPAD mapping guidance has been shared with PCNs/Practices and the ICB digital team are continuing to work with practices to ensure appointments are mapped correctly.
Establish and expand self-referral routes in Gloucestershire for falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services, are operational and successful, including ensuring the Digital Pathways for self-referrals support patient care	Self-referral to audiology is not currently in place. Whilst there is support for the principle of moving to self-referral for audiology this has to be considered alongside other priorities for the service including delivering the national paediatric quality improvement programme requirements and supporting recovery of the ENT service.	Due to these competing priorities the move to self-referral for audiology is currently on hold with a view to reviewing the position at the end of quarter 4.
Support the 15 ‘critical’ practices to move from analogue to digital telephony	Practices remained on analogue telephony for several reasons, including: a lack of previous guidance, awareness and cost pressures.	The ICB are continuing to work with these practices and the NHS Procurement Hub to support practices to move from analogue to digital telephony and

Priority Area	Reasons / Barriers	Next Steps/Action
		national funding has been allocated to these 'critical' practices to support this change.
Reduce bureaucracy within the system to establish local mechanisms to facilitate the primary-secondary care interface;	Approval within the system to have a Primary Care liaison officer has yet to be agreed.	Progress with approval for Primary Care liaison officer and finalise Job Description. Interface document to be circulated in Q4 of 23/24
Supporting PCNs/practice take up of the national GP Improvement Programme towards implementing the Modern General Practice Access model	All Gloucestershire practices and PCNs have been offered and encouraged to participate in the GP Improvement Programme. PCNs/practices most in need of support were initially given priority for Gloucestershire system allocation of these support offers, this was then widened to all practices and PCNs. Locally uptake has been slow, which likely is related to many reasons, such as workforce pressures, and limited capacity within General Practice.	ICB Primary Care Team to continue to encourage PCNs/practices participate in the GP Improvement Programme (GPIP), advising of the benefits of taking part in the programme.
Coverage of PPGs	Eight practices do not currently have an established PPG. In Gloucestershire practices without a PPG tend to be inner city and rural practices. This could be due to the patient population engagement and other factors such as language barriers and rurality of practice.	The ICB Patient Engagement Team have shared supportive information with practices/PCNs to help with the development of PPGs and local surveys
SLF conversations	There is limited capacity within both the practices and ICB which has delayed progress with the SLF conversations. There are many conflicting priorities within General Practice, who are already stretched and may also have other support available to them, through ICB resilience conversations and NHSE support offers.	ICB communication is being sent to practices offering Practice conversations (lasting approx. 1-2 hours) to Practices who have not signed up to the national offer to help Practices to identify areas for improvement to move to the modern general practice access model.
Expansion of community pharmacy services	Insufficient links with community pharmacy and General Practice Teams. Existing workload and community pharmacy contractual framework 2019-2024 currently being negotiated restricting progress with the expansion of community pharmacy services.	Working with community pharmacy leads to build communication and relationships across the pharmacy network and member practices within each PCN. Preparing pharmacy teams to create clinical capacity (i.e. teach and treat programme and

Priority Area	Reasons / Barriers	Next Steps/Action
		community pharmacy independent prescribing pathfinder programme).
Implementation of the local communication plan to support the national communication plan.	NHS England have launched a major communications campaign to explain the evolving nature of Primary Care to the public and how they can best use the NHS. This will help patients understand how practices function and how their requests for an appointment will be handled, based on clinical need. Also helping patients to understand that they may not always need to see a GP and other healthcare professionals may be best placed to deal with their concern. Local communications will support the national comms in a more localised and targeted way.	Plans to engage with communities in ways that work best for them.

Appendix A: The Gloucestershire System Delivery Plan

Gloucestershire System Delivery Plan for Recovering Access to Primary Care

2023/24

Contents

Glossary of Terms

Abbreviation	Explanation or clarification of abbreviations used in the paper
ARR	Additional Role Reimbursement
CAIP	Capacity and Access Improvement Plans
CPCF	Community Pharmacy Contractual Framework
CPD	Continuous Personal Development
DES	Direct Enhanced Service
DHSC	Department of Health and Social Care
DoS	Directory of Service
DPF	Digital Pathway Framework
EIA	Equality Impact Assessment
FFT	Friends and Family Test
FTE	Full Time Equivalent
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GPAD	GP Appointment Data
GPIP	GP Improvement Programme
GPPS	GP Patient Survey
HCA	Health Care Assistant
ICB	Integrated Care Board
ICES	Integrated Community Equipment Service
ICS	Integrated Care System
ICT	Integrated Community Team
IIF	Impact and Investment Fund
LMC	Local Medical Committee
MHP	Mental Health Practitioner
NHSE	NHS England
NWRS	National Workforce Reporting Service
PCARP	Primary Care Access Recovery Plan
PCN	Primary Care Network
PCTH	Primary Care Training Hub
POMI	Patient Online Management Information
PPG	Patient Participation Group
SDF	System Development Funding
SLF	Support Level Framework

Gloucestershire System Delivery Plan for Recovering Access to Primary Care

2023/24

1. Background

1.1. In May 2023 the **Delivery Plan for Recovering Access to Primary Care** (hereby referred to as the 'National Delivery Plan') was published by NHSE, outlining the requirement for ICBs to develop system-level access improvement plans ('System Delivery Plan'), aligning with their leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

1.2. The System Delivery Plan for practices and Primary Care Networks (PCNs) aims to support the increase in demand within Primary Care and focuses around four areas:

i. Empower Patients
ii. Implement 'Modern General Practice Access'
iii. Build Capacity
iv. Cut Bureaucracy

1.3. The NHSE Delivery Plan has two central ambitions:

- To tackle the 8am rush and reduce the number of people struggling to contact their practice.
- For patients to know on the day they contact their practice how their request will be managed.

1.4. ICBs were asked to work with system partners to develop system delivery plans to meet the national objectives for recovering access to Primary Care and the local priorities set by systems. Our local System Delivery Plan follows the same four key areas noted above.

2. Gloucestershire's Priorities for 2023/24

2.1. This report outlines the Gloucestershire System Delivery Plan. Following analysis against the nationally published checklist the key Gloucestershire priorities for the System Delivery Plan have been identified as follows:

- Support practices to improve their 2-week and 4-week appointment wait data;
- GPAD appointment mapping for practices and PCNs;
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3. Local Context

3.1. The requirement for ICBs to develop system delivery plans for recovering Access in Primary Care comes at a challenging time and while national GP contract negotiations are under way there is uncertainty for all GP practices and PCNs around future funding for 2024 onwards. Practices generally are experiencing financial challenges which when coupled with workforce issues means capacity is harder to manage with many practices now finding GP locums, for instance, unaffordable. Financial challenges, which as well as threatening the sustainability of practices, impact on the ability of practices to find the time to invest in making change.

3.2. Locally we recognise there is even greater impact on practices in areas of deprivation and accordingly there is a focus on supporting the Core20plus5 areas, in particular, with additional funding for practices in these areas to support recruitment, the Health Inequality GP role and the additional time and resource it takes to manage patients from the most deprived areas in our communities. However, reducing Health Inequalities is extremely challenging. We are working to understand from providers on the ground the specific day to day challenges and how we as a system can support solutions. We also recognise the financial gap that is experienced by some providers as a result of health inequalities.

3.3. GP practices in Gloucestershire are delivering approximately 27% more appointments post-covid than they were compared to pre-covid pandemic (September 2019 vs September 2023) with a 6 month rolling average of 24%. This is compared to the National position which has seen an increase of 21% for September with a 6 month rolling average of 15% compared to pre-covid activity levels. This increase in demand is having a significant impact on General Practice workload in Gloucestershire. Understanding the drivers of demand in Primary Care is essential and considering whether we are maximising other potential Primary Care pathways is key to help manage demand.

3.4. In Gloucestershire, GP practices are delivering considerably more urgent appointments; in September 2023 GP practices in Gloucestershire provided 23% more same-day appointments than in September 2019 (105013 same day appointments in September 2019 and 137330 in September 2023; GPAD). Nationally there has been a 13% increase in same day appointments over the same period.

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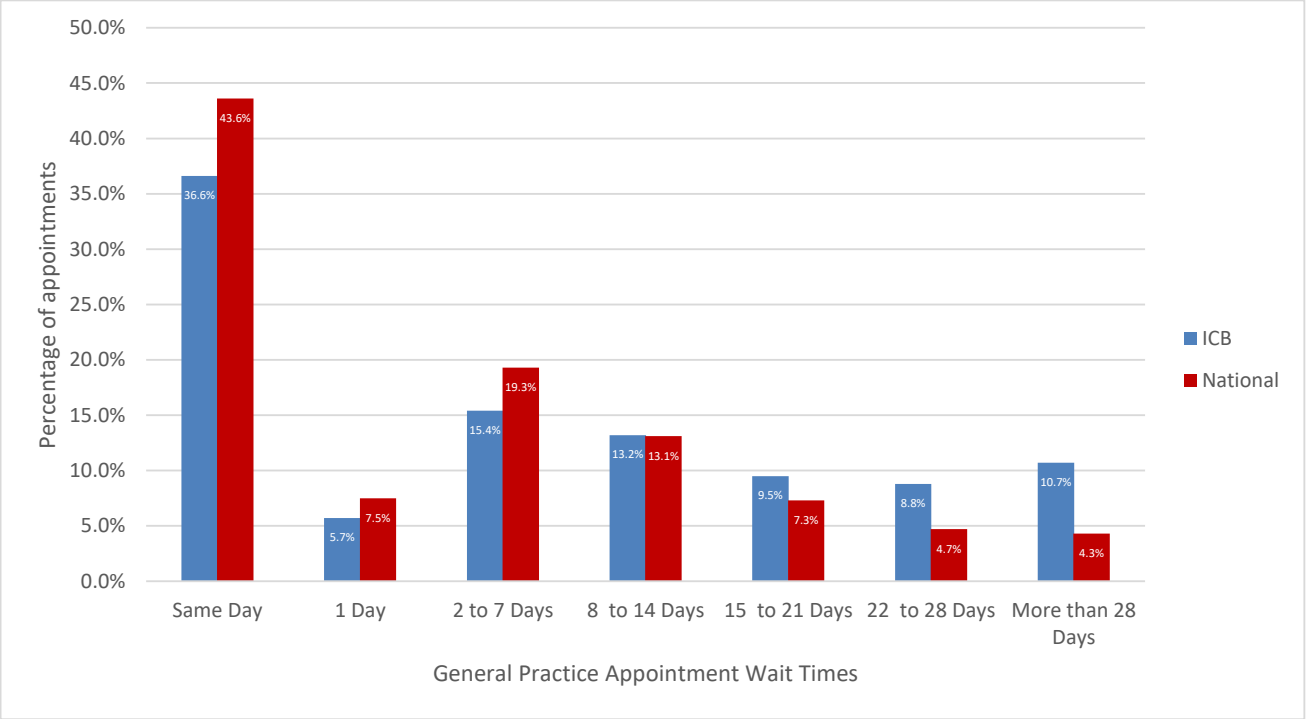
3.7. According to patients, their experience of appointments in Gloucestershire is good with the national GP Patient Survey data for Gloucestershire showing overall patient experience rates that are above the national average, 80% of patients reported good experience in Gloucestershire compared to 71% nationally. There are specific areas, such as Inner City Gloucester and areas of Cheltenham where results are lower than the average, which reflect areas of higher deprivation. Health inequalities are being addressed through various workstreams across Gloucestershire.

3.8. General Practice workforce recruitment and retention is still challenging for Gloucestershire, despite some improvement in GP recruitment over Summer 2023 recruiting to other roles remains difficult. Recruitment and retention is being addressed through local and national initiatives.

Figure 1 General Practice Appointment wait times, Gloucestershire ICB and National



Source: GPAD data (September, 2023)

3.9. There are considerable financial challenges in many of our GP practices in Gloucestershire, which as well as threatening the sustainability of practices, impacts on the ability of practices to find the time to invest in making change.

3.10. The National Delivery Plan for recovering access plan is welcomed, as it will help to address telephony/digital access discrepancies across the County and support practices to move towards the Modern General Practice Access model. There are many local initiatives and work streams linked to the national agenda that compliment this work to support Primary Care access and workload.

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3.13. This programme is being undertaken in conjunction with recommendations from the Fuller report which sets out a vision and framework for Primary Care to integrate with the wider health and care system to improve access, experience and outcomes for communities. This work is being led through the Gloucestershire Neighbourhood Transformation Group. Following system direction and support from members of the Gloucestershire Neighbourhood Transformation Group and the ICB Board Development session in October, we are progressing the development of Integrated Neighbourhood Teams in the county. Commencing in neighbourhoods in Cheltenham and Gloucester, the approach will initially focus around frailty and how partnership working can be unleashed to work differently with people in their communities in a proactive way whilst at the same time reducing duplication and fragmentation. It is anticipated that the teams around each neighbourhood will utilise the Personalised Proactive Whiteboard tool in order to identify cohorts of people to be proactively supported, following established use of the tool with some Primary Care teams.

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3.20. Within Gloucestershire, PCNs have received local funding for Quality Improvement Projects. Five PCNs, have chosen to focus on projects related to frailty, to proactively support their population with the aim to help people to live and thrive in their community for as long as possible and reducing need for GP services.

4. Process

4.1. Summaries of the actions for PCNs/practices and ICB to implement the System Delivery Plan are noted below including status, next steps and any issues.

4.2. By 30 June 2023, PCNs were required to submit local Capacity and Access Improvement Plans (CAIPs) to the ICB which outlined their plan to improve across 3 key areas; patient experience of contact; ease of access and demand management; and accuracy of recording in appointment books. All 15 PCNs in Gloucestershire submitted a plan. These plans reflect the differing starting points for some PCNs/practices, and PCNs and individual practices are now working to implementing these plans during 2023/24 to make a difference to their patient population.

5. Empowering Patients

5.1. The national ambition is to empower patients by rolling out tools they can use to manage their own health, and expand services offered by community pharmacy.

5.2. The national ambition is to help the public do more for themselves, making information and easy-to-use tools available by:

A. improving information and NHS App functionality
B. increasing self-directed care where clinically appropriate
C. expanding community pharmacy services.

5.3. Improving information and NHS App functionality

5.3.1. The national ambition is to enable patients in over 90% of practices to see their prospective records, receive messages, book appointments and order repeat prescriptions using the NHS App by March 2024. Locally the ICB have been working with practices on these requirements, however there are issues including the additional workload initially for practices to implement, the availability of data to

review bookable appointments and repeat medications, and practices data sharing concerns relating to prospective record access.

5.3.2. All Gloucestershire practices have Accurx messaging software in place to support practices to communicate with patients via SMS messaging and NHS App notifications. The Digital Team are liaising with NHSE to understand NHS App functionality releases to support practices to improve messaging capabilities.

5.4. **Increasing self-directed care where clinically appropriate**

5.4.1. As set out in the 2023/24 Operational Planning Guidance, ICBs are required to expand Self-referral pathways, where clinically appropriate. The ICB have achieved this for 6 out of the 7 areas, however, Audiology services are not currently in place.

5.4.2. Self-referral to audiology is not currently in place as whilst there is support for the principle of moving to self-referral for audiology this has to be considered alongside other priorities for the service including delivering the national paediatric quality improvement programme requirements and supporting recovery of the ENT service. Due to these competing priorities the move to self-referral for audiology is currently on hold with a view to reviewing the position at the end of quarter 4.

5.4.3. Community equipment services: Service users in Gloucestershire can self-refer to the adult help desk (Gloucestershire County Council) and staff will determine the most appropriate team/service that they can be signposted to. This could include the following:

- We Care and Repair for minor adaptations.
- Where there is a need for an intervention by Social Care and Health, information is shared with the Social Care Team for MDT
- For OT/ Therapy intervention only, information is shared with the Integrated Community Teams who will in turn get in touch with services as needed.
- As part of the conversations at the Helpdesk, we adapt a person-centred approach, if someone rings for example for a low-level piece of equipment such as replacement Ferrule for a walking stick they would be signposted to self-serve options.
- For self-serve option we signpost to our Your Circle directory

Integrated community equipment service (ICES): Run by Gloucestershire Health & Care NHS Foundation Trust (GHC) and is not a patient facing service and hence don't take any referrals. It provides advice, guidance and catalogue updating and clinical governance to the equipment issuing process.

Gloucestershire Industrial Services (GIS) Community equipment: This service manages the operational aspects of equipment provision and therefore do not currently receive any referrals from service users.

5.4.4. Digital pathways for self-referrals are being considered by each of the self-referral routes and processes are in place with the ICB Digital Team to ensure practice websites and digital platforms are up to date with the relevant self-referral links for patients to access.

5.5. **Expanding community pharmacy services**

5.5.1. System work to expand community pharmacy services (including the oral contraception and blood pressure services) and coordinate local communications is ongoing. A Community Pharmacy

Strategy Group has been established with wide stakeholder involvement, and a focus on utilising the skill-mix of community pharmacy teams to best effect as part of access recovery in Primary Care.

5.5.2. The launch of the Pharmacy Contraception Service for which 48% Community Pharmacies in Gloucestershire have registered interest. National Community Pharmacy Contractual Framework (CPCF) negotiations continue and when concluded will enable us to build local service activity.

5.5.3. Local communications are coordinated by ICB comms team, and the team are in regular contact with community pharmacy partners around contributions to patient care and system resilience with messages such as Click or Call First and ensuring community pharmacy features in our local winter campaign.

5.5.4. There are some gaps such as workforce vacancies, as outlined earlier in this report, but mitigations are in place such as the local pharmacy workforce delivery plan which includes a pipeline for encouraging young people to stay and work in county.

5.5.5. There will be better utilisation of staff skill mix through understanding existing workforce and opportunities within digital transformations.

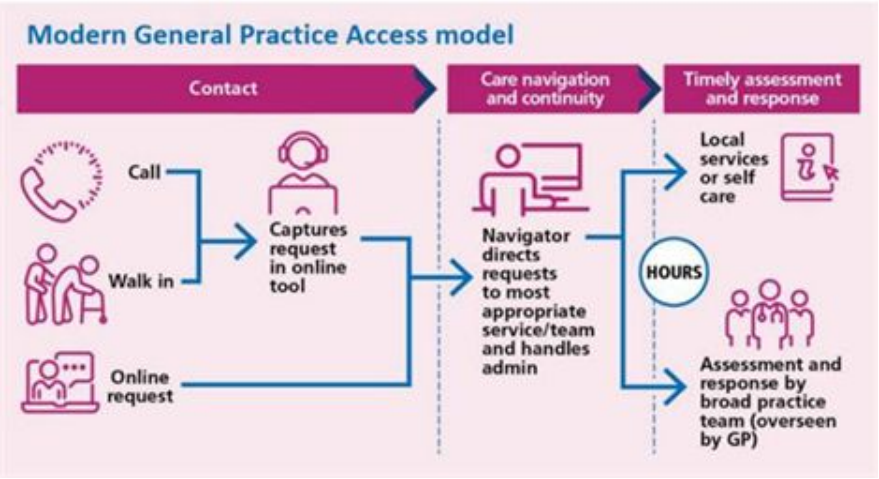
6. Modern General Practice Access

6.1. As noted previously, one of the main ambitions of the National Delivery Plan is to reduce the 8am rush. The approach, which NHSE are calling Modern General Practice Access (see Figure 2), has three components:

A. better digital telephony
B. simpler online requests
C. faster navigation, assessment, and response.

6.2. The Modern General Practice Access model means providing equitable access regardless of whether patients contact the practice by telephone, digitally or by walking in. It does need digital tools to be embraced, but also recognising that some patients may struggle with digital access. Patients should have access to the right service and the right clinician, at the right time.

Figure 2 Modern General Practice Access Model



6.3. **Better digital telephony**

6.3.1. All Gloucestershire practices telephony has been assessed and 15 practices were identified as 'critical', needing to move from analogue to digital telephony. The ICB is working with these practices and the NHS Procurement Hub to support practices to move from analogue to digital telephony and national funding has been allocated to these 'critical' practices to support this change.

6.3.2. Where practices are already on digital telephony, there is a need to ensure call-back and queuing functionality is enabled, where included in the current contract costs. The ICB have gathered data to understand the call back and queuing functionality practices are currently using. The ICB Primary Care Team have shared with all practices the NHSE Better Purchasing Framework and directed practices to the Procurement Hub to ensure that any contract renewal includes the functionality required.

6.4. **Simpler online requests**

6.4.1. As of October 2023, the Digital Pathway Framework (DPF), which includes new digital solutions to support implementing the Modern General Practice Access model, is partially live. NHSE have advised this is planned to be fully live by December 2023. Both Accurx and footfall, which are already in place for Gloucestershire practices, are on the DPF. Locally, Footfall websites are partially funded and Accurx fully funded by the ICB, however when the contract is up for renewal (Footfall in 2024-26, Accurx in 2025) a procurement process using the DPF will take place and awarded to the successful supplier.

6.4.2. Work is in progress to ensure practice websites meet the NHS standard. In Gloucestershire, 42 practices have moved to Version 6 of Footfall, the remaining Practices using are being contacted to discuss ensuring that their websites meet the NHS standard. Rosebank PCN have volunteered to pilot the new Footfall Foundation website, which will determine, the minimum standard required and define the roll out plan to other practices. There are 11 practices which have expressed an interest in the Foundation Website. We anticipate the roll out will commence in Q4 of 2023/24.

6.4.3. The ICB have been reviewing Practice websites to determine availability of booking online appointments and how this relates to POMI Data, which only advises if practices have this functionality enabled which 100% of practices have done. Practices plan to be contacted in Q4 of 2023/24 to discuss adding online booking to their website and support promotion of the NHS App.

6.4.4. Reviewing online consultation mapping is a particular focus for many PCNs, as baseline GPAD data from February shows that in Gloucestershire 2 per 1,000 registered patients received an online consultation. PCNs have noted in their CAIP they are planning reviews of GPAD mapping to ensure that appointments are mapped appropriately (supported by discussions at PCN/practice away days). This is an area that requires improvement in Gloucestershire. Practices/PCNs have advised that this is not a true reflection of their online consultations, therefore believe it is a mapping issue. The ICB Digital Team are supporting practices with GPAD mapping and contacting practices where data issues have been identified.

6.5. **Faster navigation, assessment, and response**

6.5.1. The data on two-week and four week waits for GPs appointments shows Gloucestershire practices generally as an outlier compared to nationally, with no PCNs currently achieving the IIF lower or upper threshold for the ACC-08 indicator. As above, PCNs have noted in their CAIP that they are reviewing appointments to ensure mapped appropriately, however, further work is being undertaken to understand the rationale behind this.

6.5.2. While appointment levels in Gloucestershire are clearly much higher than in other areas a survey has been developed for a sample of GPs to complete to identify where this pressure is coming from to be able to support all practices to understand what is driving the demand in Primary Care and maximise other potential Primary Care pathways.

6.5.3. All Gloucestershire practices and PCNs have been offered and encouraged to participate in the GP Improvement Programme hands-on support, including the Universal offer of webinars, drops in and online resources, Intermediate (practice) consisting of 13 weeks of hands-on support, Intermediate (PCN) consisting of 12 half-days in person facilitated sessions and Intensive (practice) consisting of 26 weeks of hands-on support. PCNs/practices most in need of support were initially given priority for Gloucestershire system allocation of these support offers, this was then widened to all practices and PCNs. Table 2 shows the Gloucestershire uptake of the support offers. However, locally uptake has been slow, this is recognised as a priority to encourage more practices/PCNs to take up these support offers.

Table 2 Gloucestershire Uptake of the NHSE GP Improvement Programme Support Offers

NHSE GPIP Support Offer	Number of Practices / PCNs
Intermediate (practice)	2
Intensive (practice)	4
Intermediate (PCN)	2

6.6. All practices and PCNs have received information on the available national Care Navigation training, as well as the local training offer for implementing the Gloucestershire Directory of Services (DoS). To date, 20 practices have engaged with the national care navigation programme and 19 practices have received the full local DoS system, 11 practices are in progress of receiving this and a further 6 practices have demos/training scheduled in the coming weeks.

6.7. Currently no Gloucestershire PCNs have been able to sign up to the NHSE Digital and Transformation PCN leads training due to lack of places and access. Further cohorts are being released and the ICB will continue to promote these to PCNs.

6.8. Following the national guidance, locally we will be offering practice conversations (lasting approx. 1-2 hours, using the Support Level Framework) to practices who have not signed up to the national offer to help practices to identify areas for improvement to move to the Modern General Practice Access model including workforce, demand and capacity planning, quality, leadership etc. These practice conversations, which are targeted to be completed by end of March 2024, will help to identify wider System priorities and areas for support and improvement. This is alongside regular conversations with PCNs and practices to identify any support needs.

6.9. The Transition and Transformation funding (Avg. £13.5k per practice over 2 years) to support practices to implement the Modern General Practice Access model is in the process of being distributed to practices.

6.10. Many PCNs are looking to implement local patient surveys in collaboration with Patient Participation Groups (PPGs) to understand the needs of their populations. Practices/PCNs are engaging their PPGs to improve the uptake of Friends and Family Tests and ensure they are compliant with submitting their data, as well as local surveys. The ICB Patient Engagement Team have shared supportive information with practices/PCNs to help with the development of PPGs and local surveys and are working with the 8 practices who do not currently have a PPG in place.

6.11. Processes are in place for practices to inform of diversion to 111 and monitor exceptional use when overcapacity. The ICB Primary Care Team work regularly with the practices where there are demand and capacity challenges and practices have been reminded that they must inform the ICB Primary Care team prior to diverting to 111 to ensure this is being used appropriately. This process has been working well with practices.

7. Building Capacity

7.1. PCNs are actively supported by the ICB to utilise their full ARRS budget and support is available for PCNs with their recruitment and retention of workforce through the Primary Care Training Hub (PCTH). Conversations which were held with all PCNs over the summer and in advance of August workforce plan submissions, where discussions were held on proposed roles including opportunities and challenges.

7.2. The national PCN ARR workforce plans completed by Gloucestershire PCNs shows that majority of Gloucestershire PCNs are planning to utilise their full budget in 2023/24. Table 3 outlines ARRS roles in post as of August 2023, and planned recruitment by March 2024, which shows a 24% growth of FTE between August and March 2024.

7.3. However, we note that there are several challenges with ARRS recruitment. ARRS issues for PCNs are noted as a lack of physical space in practices to accommodate ARRS staff and being unable to recruit specific roles due to there not being enough trained healthcare professionals in the system.

Table 3 ARRS Roles, Actual FTE as at August 23 and Planned FTE as at March 24

Job Role	Actual FTE Aug 23	Planned FTE March 24	Variance
Pharmacy Technicians	37.53	46.93	9.40
Clinical Pharmacists	69.15	75.17	6.02
Clinical Pharmacist (Advanced Practitioner)	0.00	0.00	0.00
Dietitians	1.00	1.00	0.00
Dietitian (Advanced Practitioner)	0.00	0.00	0.00
First Contact Physiotherapists	12.65	15.75	3.10
First Contact Physiotherapist (Advanced Practitioner)	0.00	0.00	0.00
Occupational Therapists	0.00	0.00	0.00
Occupational Therapist (Advanced Practitioner)	0.00	0.00	0.00

Paramedics	16.70	17.37	0.67
Paramedic (Advanced Practitioner)	1.00	1.00	0.00
Podiatrists	0.00	0.00	0.00
Podiatrist (Advanced Practitioner)	0.00	0.00	0.00
Clinical Practitioner Nurses (Advanced Practitioner)	4.92	7.28	2.36
Physician Associates	6.21	8.71	2.50
Apprentice Physician Associates	0.00	0.00	0.00
Care Co-ordinators	71.81	91.49	19.68
Health and Wellbeing Coaches	5.91	12.96	7.05
Social Prescribing Link Workers	43.19	48.08	4.89
Nursing Associates	2.75	4.46	1.71
Trainee Nursing Associates	9.91	10.77	0.86
GP Assistants	8.74	15.44	6.70
Digital & Transformation Lead	8.97	10.82	1.85
Adult Mental Health Practitioner (Band 4)	0.00	0.00	0.00
Adult Mental Health Practitioner (Band 5)	0.00	0.00	0.00
Adult Mental Health Practitioner (Band 6)	0.00	2.00	2.00
Adult Mental Health Practitioner (Band 7)	13.05	14.15	1.10
Adult Mental Health Practitioner (Band 8a)	0.00	3.40	3.40
Children and Young Persons Mental Health Practitioner (Band 4)	0.00	0.00	0.00
Children and Young Persons Mental Health Practitioner (Band 5)	0.00	0.00	0.00
Children and Young Persons Mental Health Practitioner (Band 6)	0.00	0.00	0.00
Children and Young Persons Mental Health Practitioner (Band 7)	0.00	1.00	1.00
Children and Young Persons Mental Health Practitioner (Band 8)	0.00	0.00	0.00
Totals	**313.48**	**387.78**	**74.30**

7.4. The PCTH prepared an ARRS reference document outlining key ‘need to knows’ about each ARRS role including training, role support etc. The PCTH have also sent bespoke emails to each PCN with reference document, offering additional conversation to discuss workforce plans.

7.5. There is a key focus on 3 ARR roles

- Care Co-ordinators – offering PCN’s opportunity to send CC’s recruited post May 23 on fully-funded HCA course to support development of Personalised Care skills
- General Practice Assistants
- Pharmacy Technicians – working with Pharmacy team to promote apprenticeships, but longer-term objective.

7.6. A Mental Health Practitioner (MHP) Evaluation has been undertaken and a business case is being submitted for system funding (50% PCN & 50% system) for further recruitment of MHPs.

7.7. Gloucestershire are delivering several GP retention schemes which include:

- GP Support Lead role in place providing confidential support offer, career guidance, mentoring and coaching for GPs who may need additional Support.
- Local Retainer scheme with additional facilitated peer support group for retainer GPs.

- Mid-late career GP mini-fellowship offer with CPD and project work support offered for priorities aligned to PCN and ICB priorities.
- Partnership support offer in development to replace the NHSE New to Partnership offer, whilst offering a local bespoke partnership fellowship offer, peer support, mentoring and training. The offer will also extend to prospective and current partners, to aid retention.
- Funded GP fellowship offers (outside of the General Practice Fellowship scheme) offering Health Inequalities and Specialism fellowships, targeted at practices within CORE20PLUS5 areas. This scheme has supported the recruitment and retention of 11 GPs to date, with more in progress, in practices where recruitment and retention has been more challenging.
- Partnership exit survey and exit interviews offered to try and understand local reasons for leaving partnership.
- General Practice Fellowship scheme for newly qualified nurses and GPs (and nurses new to Primary Care). This is reported via the PCMS, but Gloucestershire has excellent uptake of this scheme.
- Legacy mentoring scheme for nurses.
- Preceptorship scheme for nurses which is now accredited.
- Communities of Practices established for the majority of role types in General Practice

8. Reducing bureaucracy

8.1. Work is progressing with the Chief Medical Officer (CMO) to build on existing local mechanisms to improve the primary-secondary care interface including the established Gloucestershire Medical Council being in place, regular meetings with the LMC between the ICB and other provider organisations, secondary care consultants responding to Advice & Guidance and Cinapsis requests for many conditions. The system has good mechanisms to support clinicians to manage patients across the interface including local guidance via G-care, and a well utilised Advice and Guidance system through eRS and/or Cinapsis for both planned and urgent care.

8.2. PCNs/practices to move towards a system wide approach for primary-secondary care interface, utilising Advice & Guidance and Cinapsis where appropriate.

8.3. A primary-secondary care interface principles document has been drafted, which is due to be circulated for wider engagement (LMC, Medical Council), and anticipated that this will be published in Q4 of 2023/24. This will detail processes for the four areas ICBs are required to address; onward referrals, complete care (fit notes and discharge letters), call and recall and clear points of contact.

8.4. The position on onward referrals by consultants is set out in the GHFT access policy and is consistent with national guidance. This will also be detailed in the primary-secondary care interface principles document to further reinforce the position.

8.5. Whilst fit notes can be issued from outpatients there is further work to do to do to ensure that this becomes standard practice. The expectation that fit notes will be issued from outpatients in line with the guidance is included within the interface principles document and work is underway to develop the capability to issue electronic fit notes within GHFT.

8.6. Call and recall processes are already in place, but it is recognised that communication with patients can be improved to avoid patients contacting their GP unnecessarily. The draft interface principles document includes expectations around communication with patients to ensure the patient is always

clear on next steps and who to contact with queries. A Primary Care liaison officer, if in place, is anticipated to support with this area too.

8.7. The system is exploring the idea of recruiting a Primary Care Liaison Officer (as recommended in the AoMRC report) to support relationships with secondary care colleagues and help address the four areas noted above. Whilst this has been shown to be effective in other areas further work is required to understand how such a role would work within the Gloucestershire system.

8.8. Support and awareness have been provided to practices to sign up to the Register with a GP surgery service including sharing the NHSE webinars.

8.9. The ICB Communications Team have developed a Communications Plan outlining the coordinated system communications to support patient understanding of the new ways of working in general practice including digital access, the ARR and multidisciplinary roles, and wider care that is available to the public. It will be important that patient expectations are managed carefully given the level of demand in Primary Care, alongside workforce and financial challenges.

8.10. To support the above, the DoS team are working closely with practices to continue to promote the use of the local DoS, to offer training where appropriate, and ensure the information is relevant and up to date to promote a wider care service and ensure the patient sees the right healthcare professional.

9. Finance

9.1. A Finance Plan has been produced and includes a clear outline of various national funding streams associated with this plan.

9.2. It should be noted that there is some pressure on the SDF funding to support this plan, given the number of commitments already against this budget. This is being worked through with the ICB Director of Finance.

10. Challenges

10.1. There are several challenges with this programme of work in General Practice, which include (but not limited to), financial pressures, workforce pressures and patient demand and expectation. We are reviewing these and working with practices and PCNs. The key challenges, wider support needs and barriers to highlight are noted below.

10.1.1. The System Delivery Plan has identified that intensive resources in practices, PCNs and the ICB will be required to achieving the plans ambition. The success of implementing the System Delivery Plan is dependent on practices engaging with the support available. Yet, it does not unilaterally address the significant issues facing Primary Care in terms of staffing, patient demand and financial issues. In parallel, the ICB are working with several practices to support their ongoing resilience and sustainability.

10.1.2. Some practices lack the stability to engage in this programme and patient expectations continue to increase through this national commitment.

10.1.3. There is not sufficient funding available in the SDF to support the System Delivery Plan, given the number of commitments against this budget.

10.1.4. We are aware that there are ongoing issues with GPAD mapping, which the digital team are supporting practices with.

11. Next Steps

11.1. The ICB will continue to work with practices and PCNs to deliver the required actions for this programme of work.

11.2. Funding associated with the System Delivery Plan will continue to be shared with practices and PCNs where appropriate to support the implementation of the General Practice Access Model.

11.3. Support offers, both nationally and locally, will continue to be communicated and discussed with practices and PCNs to ensure the best possible engagement and implementation of the System Delivery Plan.

11.4. The Gloucestershire System Delivery Plan will be taken to the public board in November 2023.

11.5. Plans are in place to review PCN CAIPs and discuss progress in April 2024, with payments due to PCNs by 31 August 2024.

11.6. The digital aspects of the System Delivery Plan are interdependent and part of the wider Primary Care digital programme which are progressing. Timescales for delivery will vary, depending on the starting point for each practice and are dependent on contracts and supplier availability.

11.7. As summarised in Section 2.0 Gloucestershire has identified key priorities, these are detailed in Table 1 with further details including reasons/barriers that need to be consider and next steps. A system approach is required to address these.

Table 4 Gloucestershire System Delivery Plan Priority Areas, Reasons/Barriers and Next Steps

Priority Area	Reasons / Barriers	Next Steps/Action
Support practices to improve their 2-week and 4-week appointment wait data;	No PCNs are currently achieving the IIF lower or upper threshold for the ACC-08 indicator. In Gloucestershire, same-day and next day appointments are similar to the national average, reflecting that patients may be being prioritised based on need. PCNs have noted in their CAIP that they are reviewing appointments to ensure they are appropriately mapped, which could be an influencing factor on this data. There will be cases where due to patient preference, or clinical advice, the appointment wait is longer than 2 weeks. NHSE is working with IT system suppliers to implement exception categories reflecting this.	Further analysis is being undertaken to understand the rationale behind the higher appointment waits beyond 14 days.
GPAD appointment mapping for practices and PCNs	Practices/PCNs need to map appointments correctly to ensure data is accurate. As above, this may be an influencing factor for appointment wait times. It is also potentially an influencing factor for online appointment data which currently is very low in Gloucestershire. PCN data has been made available via GPAD. PCNs have advised that this is not correct, and does not match the clinical system, NHSE have advised there is a known problem with the data flow which they are working to resolve.	GPAD mapping guidance has been shared with PCNs/Practices and the ICB digital team are continuing to work with practices to ensure appointments are mapped correctly.
Establish and expand self-referral routes in Gloucestershire for falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services, are operational and successful, including ensuring the Digital Pathways for self-referrals support patient care	Self-referral to audiology is not currently in place. Whilst there is support for the principle of moving to self-referral for audiology this has to be considered alongside other priorities for the service including delivering the national paediatric quality improvement programme requirements, and supporting recovery of the ENT service.	Due to these competing priorities the move to self-referral for audiology is currently on hold with a view to reviewing the position at the end of quarter 4.
Support the 15 ‘critical’ practices to move from analogue to digital telephony	Practices remained on analogue telephony for several reasons, including: a lack of previous guidance, awareness and cost pressures.	The ICB are continuing to work with these practices and the NHS Procurement Hub to support practices

Priority Area	Reasons / Barriers	Next Steps/Action
		to move from analogue to digital telephony and national funding has been allocated to these 'critical' practices to support this change.
Reduce bureaucracy within the system to establish local mechanisms to facilitate the primary-secondary care interface;	Approval within the system to have a Primary Care liaison officer has yet to be agreed.	Progress with approval for Primary Care liaison officer and finalise Job Description. Interface document to be circulated in Q4 of 23/24
Supporting PCNs/practice take up of the national GP Improvement Programme towards implementing the Modern General Practice Access model	All Gloucestershire practices and PCNs have been offered and encouraged to participate in the GP Improvement Programme. PCNs/practices most in need of support were initially given priority for Gloucestershire system allocation of these support offers, this was then widened to all practices and PCNs. Locally uptake has been slow, which likely is related to many reasons, such as workforce pressures, and limited capacity within General Practice.	ICB Primary Care Team to continue to encourage PCNs/practices participate in the GP Improvement Programme (GPIP), advising of the benefits of taking part in the programme.
Coverage of PPGs	Eight practices do not currently have an established PPG. In Gloucestershire practices without a PPG tend to be inner city and rural practices. This could be due to the patient population engagement and other factors such as language barriers and rurality of practice.	The ICB Patient Engagement Team have shared supportive information with practices/PCNs to help with the development of PPGs and local surveys
SLF conversations	There is limited capacity within both the practices and ICB which has delayed progress with the SLF conversations. There are many conflicting priorities within General Practice, who are already stretched and may also have other support available to them, through ICB resilience conversations and NHSE support offers.	ICB communication is being sent to practices offering Practice conversations (lasting approx. 1-2 hours) to Practices who have not signed up to the national offer to help Practices to identify areas for improvement to move to the modern general practice access model.
Expansion of community pharmacy services	Insufficient links with community pharmacy and General Practice Teams. Existing workload and community pharmacy contractual framework 2019-2024 currently being negotiated restricting progress with the expansion of community pharmacy services.	Working with community pharmacy leads to build communication and relationships across the pharmacy network and member practices within each PCN.

Priority Area	Reasons / Barriers	Next Steps/Action
		Preparing pharmacy teams to create clinical capacity (i.e. teach and treat programme and community pharmacy independent prescribing pathfinder programme).
Implementation of the local communication plan to support the national communication plan.	NHS England have launched a major communications campaign to explain the evolving nature of Primary Care to the public and how they can best use the NHS. Helping patients understand how practices function and how their requests for an appointment will be handled, based on clinical need. Also helping patients to understand that they may not always need to see a GP and other healthcare professionals may be best placed to deal with their concern. Local communications will support the national comms in a more localised and targeted way.	Plans to engage with communities in ways that work best for them.

Appendix B: The System Delivery Plan Assurance

The below areas, suggested by NHSE in their briefing note, have helped to ensure that the System Delivery Plan includes the required actions and considerations. NHSE acknowledge that plans may need to iterate over time, particularly as take-up of support offers and digital tools are confirmed.

The System Delivery Plan assumes a key role for the ICS in the delivery of recovering access in Primary Care, aligning with the Medium-Term Financial Plan and inputting into the Systemwide Planning Group to ensure alignment with the 23/24 Operational Plan and inform the alignment for the upcoming development of the 24/25 Operational Plan.

The *Vision and improvement approach* of the Delivery Plan aligns to the current Primary Care strategy (2019-2024) with access being a key theme and this is reflected in the development and engagement process for the next five-year strategic plan for Primary Care.

The System Delivery Plan supports *health inequalities* including equality and inclusion by identifying areas of most support including the critical digital practices and ensuring the correct support and investment is provided. It also ensures that practices and PCNs in areas of deprivation are locally identified for additional support.

The System Delivery Plan clearly outlines the *PCN/practice actions* in detail, outlining:

- the status of the actions;
- any gaps or mitigations, the most challenging being but not limited to financial pressures, workforce pressures and patient demand and expectations;
- and next steps including continuing to implement their Capacity and Access Plans as well as take-up offers of support and training.

The System Delivery Plan clearly outlines the *ICB actions* in detail, outlining*:*

- the status of the actions;
- any gaps or mitigations, the most challenging being but not limited to, improving the primary-secondary care interface, support and build the Primary Care workforce, and national details for the Pharmacy services (Common Conditions Service and Pharmacy First service);
- and next steps including continuing to offer digital support to practices, and continuing to encourage practices/PCNs to engage with the support offers including practice engagements conversations.

The delivery of the System Delivery Plan will be *assured* by addressing the improvements required to meet the national delivery milestones. Regular ICB meetings take place to discuss collecting, analysing and sharing of data, such as appointment data, GPAD appointment mapping data and POMI data. Assurance will also be sort by ensuring that all patients are seen by need, prioritising safely and equitably, as well as ensuring that there is clear communication of the change to patients.

This will help improve patient education and subsequently behaviour change i.e., reducing the 8am morning rush.

A detailed *Finance* Plan has been produced and includes a clear outline of national funding associated with the Delivery Plan, how this will be used and maximised, how the funding is being reviewed by the ICB to ensure there is timely funding support to practices/PCNs to move to a Modern General Practice Model. Other funding has been considered via PCNs, include the ARR digital and transformation lead roles could be aligned to the programme of work and utilise the national training on offer.

A detailed *Communications* Plan has been produced by the ICB that focuses on promoting key messages from the Delivery Plan at place level and to local communities. NHS England has recently launched a new campaign to highlight the different health professionals in general practice teams who are helping patients get the right care, more easily, first time.

The Communications Plan that sits behind the Delivery Plan outlines the patient and public involvement and engagement. Alongside this *Co-production and patient voice*, the PCN CAIP plans have utilised patient feedback to support their development, utilising GP Patient Survey (GPPS) and local survey data collected via Patient Participation Groups (PPGs). The CAIP detail how PCNs plan to continue to engage with PPGs for implementation of the plan and ensure they are kept up to date with feedback.

Agenda Item 15

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th November 2023

Report Title	**Urgent and Emergency Care (UEC) and System Flow: Board Update**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	*Describe the prior engagement pathways this paper has been through, including outcomes/decisions:*					
	ICB Internal	**Date**	**System Partner**	**Date**		
	Strategic Escalation Group (SEG)	8/11/23	Strategic Executive	16/11/23		
Executive Summary	The purpose of this paper is to: • Present Public Facing Winter Plan engagement document (attached as Appendix A). Our plan has been designed by working collaboratively with system partners across the ICS, including Adult Social Care, Gloucestershire Hospital NHS Foundation Trust, Primary Care, Voluntary Care Sector providers, Gloucestershire Health and Care NHS Foundation Trust (community physical and mental health), South West Ambulance Service, and Private Sector Providers; with the key objective of delivering high quality consistent urgent and emergency care delivery throughout the winter period. • To present the core narrative for the Working as One Programme (Attached as Appendix B). Working as One is our system wide transformation programme for Urgent and Emergency care. Our core narrative has been developed to set out the need for change, principles and expected impact of the Working as One programme; with our vision to deliver quality, integrated care for the people of Gloucestershire to support the best possible physical and mental health outcomes, enabling them to lead the most happy and healthy lifestyles. The core narrative will be disseminated across the system via communication and engagement channels and UEC meeting structures.					

Key Issues to note	Our Winter Assurance for 2023/24 has been developed against a challenging landscape, recognising the 'usual' anticipated winter challenges, as well as planning for seasonal flu, ongoing impact of Covid-19 and continued industrial action and workforce challenges across Health and Social Care. UEC continues to experience significant performance challenges, with increased regional and national focus on our improvement trajectories. The ability to realise financial benefits is inherently linked with performance delivery.			
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Key Risks to delivery of plan relate to the ongoing impact of cross system bed capacity fluctuations during the winter period, in line with strategic programmes of work, which will ultimately improve patient experience. Considerable mitigation planning has taken place to mitigate the associated risk and these plans are subject to weekly review by Tactical Escalation Group (TEG) and Strategic Escalation Group (SEG). In addition, the unknown impact of ongoing periods of industrial action (IA) and seasonal illness including Covid, have the potential to also further impact delivery if demand becomes excessively high. Risk that there is insufficient capacity for change at pace alongside operational pressures. Additional change leadership and resource brought into system to enable delivery, through Newton Europe as a dedicated delivery partner and additional roles agreed in the system. Integrated system governance structures including visibility at Tactical Escalation Group, UEC CPG and Flow Friday.			
Management of Conflicts of Interest	No conflicts of interest declared.			
Resource Impact (X)	**Financial**	x	**Information Management & Technology**	
	Human Resource	X	**Buildings**	
Financial Impact	Any failure to deliver against the 23/24 operational plan in terms of the urgent care performance targets agreed may pose a risk to financial plan delivery.			
Regulatory and Legal Issues (including NHS Constitution)	Risk to delivery of improved performance as set out in the appropriate NHS Constitution targets.			
Impact on Health Inequalities	Failure to deliver the proposed winter plan and public offer outlined in the winter public facing engagement document or aspiration of the Working as One programme, may result in the inability to provide consistent urgent care delivery to all residents, at all times, county wide, during periods of increased demand.			
Impact on Equality and Diversity	NA			
Impact on Sustainable Development	No impact anticipated			
Patient and Public Involvement	The production of a public facing winter planning document has the primary function of engaging the population with the plans, approach and offer to Gloucestershire residents this winter. Further input has been received into operational planning and service delivery through the input of the People and Communities Reference Group (PCRG) via the UEC Clinical Programme Group.			

Recommendation	**The Committee/Board is requested to:** **Note the contents of both the public facing winter plan and Working as One core narrative.**		
Author	**Eve Olivant**	**Role Title**	**Director of System Flow**
Sponsoring Director (if not author)	**Ellen Rule, Deputy CEO / Director of Strategy and Transformation**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
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
SDEC	Same Day Emergency Care
iUEC	integrated Urgent and Emergency Care
CATU	Community Assessment and Treatment Unit
EPRR	Emergency Preparedness, Resilience and Response
IVT	Intra-venous Therapy Team
RSV	Respiratory syncytial virus
DES	Directed Enhanced Service
ARI	Acute Respiratory Infection
MiiU	Minor Injury and Illness Unit
OPEL	Operational Pressures Escalation Levels
SCC	System Coordination Centre
KLOE	Key Lines Of Enquiry
TTO	(To Take Out) Medication
SHREWD	Single Healthcare Resilience Early Warning Dashboard
CYP	Children and Young People
MDT	Multi-Disciplinary Team
ToCB	Transfer Of Care Bureau
NcTR	No criteria to reside
UKHSA	UK Health Security Agency
EPR	Electronic Patient Records
HIU	High Intensity User
LLOS	Long length of stay
IA	Industrial Action

One Gloucestershire
Transforming Care, Transforming Communities

Working as One
Prevention | Support | Redesign

One Gloucestershire
Winter Pledge

One Gloucestershire
Integrated Care System (ICS)

Working with you through winter

2023/24

Contents

Forewords

Albert Weager
Chair of the Urgent and Emergency Care Patient and Public Involvement Network

It is my privilege, as your long serving community representative, to pen this introduction to One Gloucestershire's Winter Plan 2023/24.

Born out of the principles underpinning 'Your Health, Your Care', it has been designed and co-produced by the organisations across Gloucestershire's Integrated Care System (ICS). It offers concise information about accessing and using our health and care services over the winter months and makes pledges to us, the residents of the county, over this period. You can find information about these organisations near the end of this plan.

These pledges and the partnership working of the ICS organisations offer a framework for the provision of our care in a timely, effective and appropriate way, from wherever people need to interact with health and care services to the best available point and place of delivery.

This plan is very much about what 'the system' will do for us, the people of Gloucestershire. What can we do, as a thoughtful population, to give it every chance of success? Can we make our own pledges, in supportive communities, to best care for ourselves, our families and neighbours, to prevent or reduce a need for health and care services?

A significant challenge to all of us! Can we rise to it?

Faye Noble
Urgent and Emergency Care Clinical Lead for One Gloucestershire ICS

As a consultant doctor in Gloucestershire's Accident and Emergency (A&E) department, I know first-hand that winter is a time that represents great challenge for the NHS and social care, and particularly for Urgent and Emergency Care services.

More recently, seasonal variation has become far less pronounced, with most services working at capacity throughout the year, not just peaking in the winter months.

Our plan to deliver the best care we can through winter aims to be responsive to you, the people and communities of Gloucestershire. It aims to be realistic for our staff who work in our busy health and social care services, who have already worked so tirelessly throughout this year.

We have real opportunities through working together as health and care organisations – and with your help – to create a plan for winter that truly represents our shared priorities.

In this regard the sum is far greater than the parts, and we pledge to do our very best to rise to the challenge that Albert describes above, with you and for you.

Our 2023/24 Winter Plan is clear and simple. We will work together to deliver joined up urgent and emergency services, focussing on our goals of ensuring care is safe, timely and centred on you and the people in your life. I am confident that this plan offers us a real opportunity to address the challenges that face Urgent and Emergency Care as we go into next year and lays the foundation for our exciting 'Working As One' improvement programme.

This winter in context

Our plan to handle the pressures we know come at this time of year is more important than ever, and reflect the priorities faced by the whole country. The last couple of years have seen some unprecedented levels of need for health and care services, especially during the 'winter period' which extends from October through to spring.

The NHS faces recognised challenges in staffing numbers that the pandemic and its subsequent impact on waiting times added to, and we have had a year of various industrial action periods. Last winter we faced the challenges of the Strep A outbreak and saw an expected rise in COVID-19 illness - as we face this coming winter, we know that COVID-19 infections are on the rise, and waiting lists for routine and planned care are increasing.

Our main priorities will be to:

- Prepare for the kind of seasonal respiratory challenges we know come around this time of year; for example by providing vaccination for a range of common illnesses.
- Improve the resilience of NHS 111 and 999 services.
- Improve the speed in which 999 Category 2 (i.e. urgent, but not emergency) responses happen, and keep reducing how long it takes for ambulance crews to transfer people into hospital care. This is better for patients and ensures ambulances can get to the next priority call.
- Improve peoples' experience by using a range of alternatives to A&E which means more people who need urgent (but not emergency) care will be able to be seen without going to one of the main hospitals. This will also improve the experience of people who do need emergency care in our A&E departments by reducing crowding and waiting times.
- Reduce how busy our hospitals are including through 'virtual wards' where patients receive excellent care in their own home, and by making sure moving through our services is as smooth and timely as possible.
- Ensure people can be discharged safely and quickly from all our health settings, working ever more closely with social care and implementing nationally recognised improvement actions.
- Provide better support for people at home, giving support to those who have complex care needs or access our hospital services frequently.

Most importantly, our communities and you, the residents of Gloucestershire, are key to how well we manage this winter. We present this plan and our pledges to you and ask for your help and support to use the right services at the right time for your needs.

Working as One

Prevention | Support | Redesign

In the autumn we launched **Working as One**, a programme to transform how we carry out our Urgent and Emergency Care services. The COVID-19 pandemic showed us that, on a day-to-day basis, the health and care organisations in Gloucestershire are stronger and better when we work more closely together.

We have a shared commitment and determination that people are cared for in the right place at the right time, to ensure that they can achieve the best health outcomes.

This exciting programme starts this winter with putting into place improvements to how we work across all parts of the health and care system. That will provide a strong foundation for further transformation work in the medium and long term as we build ever-improving urgent care services for the people of Gloucestershire.

What is in this winter plan?

This winter plan is focused on concisely informing you, the people and communities of Gloucestershire, of our pledges about how each part of our health and care 'system' will rise to the challenge of the winter period.

It provides the key contact and access information you might need for each area, and also sets out how you can make a difference to keeping these services working best for people that need them, and to care for your own health and wellbeing.

One Gloucestershire Winter Pledge

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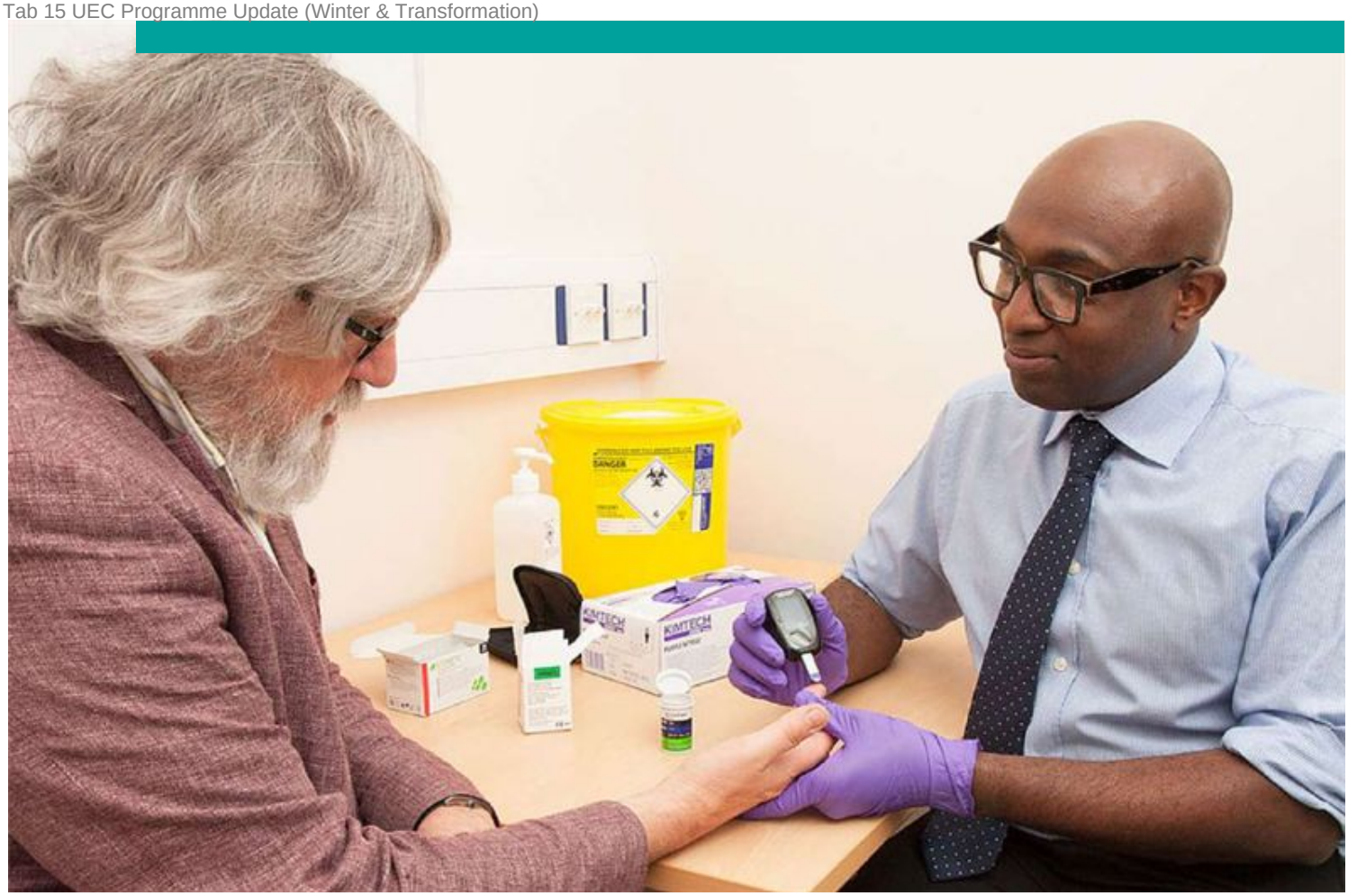


Primary Care

Community Pharmacies

Local pharmacies support and underpin many other parts of healthcare in Gloucestershire. We are introducing the national *Community Pharmacist Consultation Service* approach with NHS 111, GP Surgeries, and our Urgent and Emergency Care (UEC) services[1].

These services will be able to refer patients to community pharmacies for minor illnesses, emergency prescriptions, contraception services, discharge medicines, and hypertension.

COMMUNITY PHARMACY GLOUCESTERSHIRE

[1] https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacist-consultation-service/

GP Surgeries

Our GP Surgeries, with community pharmacies, are the foundation of local healthcare services in Gloucestershire. In recent years we have seen more and more surgeries move into new premises, improving access and the experience of patients whilst keeping them at the heart of our communities.

Primary Care teams work incredibly closely with every other part of the health and social care system and have the most detailed up to date information about your health and care.

If you don't have your GP Surgery details to hand, use the Gloucestershire ASAP website (www.asapglos.nhs.uk/) with your postcode to find their contact details and opening times.

Dental Services

We are aware that access to NHS dentistry in Gloucestershire is challenging. We are actively working with dentists in Gloucestershire, with help from patient representatives, to secure more appointments for patients with urgent needs, and we have written to all 77 NHS dental practices in the county inviting them to take on more NHS work.

If you have a dental emergency, there are arrangements in place to ensure that anyone who does not have a dentist and has an urgent dental need can access an urgent appointment by contacting NHS 111.

Primary Care Pledges

One Gloucestershire Winter Pledge

- We will provide as much pharmacy-based care as possible appropriate to people's needs, including using the *Community Pharmacist Consultation Service* for a number of common conditions. We can also take your blood pressure, and if it is too high (hypertension) and needs treatment, we can refer you to your GP.
- We will provide vaccinations at the heart of our local communities to those who are eligible, such as people with 'at risk' clinical conditions, and people in areas of known health inequalities.
- We will further support people where possible with their medicines when they are discharged from hospital. We will do this by increasing direct referrals from hospitals to a patient's Community Pharmacy on discharge to at least 500 per month for appropriate situations.
- GP surgeries will work together to offer additional appointments on weekday evenings and Saturdays, matching your needs to the relevant healthcare professional.
- We will refer people as appropriate to our Acute Respiratory Infection (ARI) Hubs. Through to March we will provide over 10,000 appointments to help avoid hospital attendance and care for people closer to home.

First Response Services

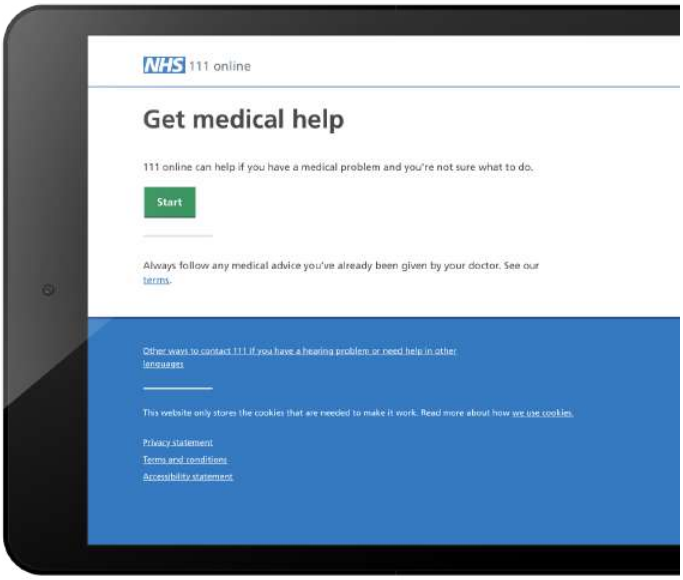
NHS 111

NHS 111 helps people get the right advice and treatment when they urgently need it, be that for their physical or mental health, 24 hours a day, 7 days a week.

Nearly half of all calls to NHS 111 are resolved by the initial call handler who can help people with self-care advice or to find the service they need.

To get help from NHS 111, you can:

- **Go online to 111.nhs.uk if the person is 5 years or older.**
- **Call 111 for free from a landline or mobile phone for people of any age.**



Out-of-hours (OOH)

Our Out Of Hours service provides primary care outside normal GP surgery hours (18:30 to 08:00 Monday to Friday, and all day Saturday, Sunday and Bank Holidays).

When you contact Out Of Hours, you will be advised by them how to use the service – that may include having your needs dealt with over the phone, being directed to one of our Out Of Hours locations around the county or having a visit at home.

To get help from Out Of Hours:

- **Call 111 for free from a landline or mobile phone.**

South West Ambulance Service NHS Foundation Trust (SWASFT)

The ambulance service provides paramedics and vehicles to accidents and emergencies, and much more besides. As well as taking people to hospital Accident and Emergency (A&E) departments if needed, the ambulance service carries out 'hear and treat' responses over the phone and provide 'see and treat' paramedic services in people's homes, avoiding taking people to hospital when it's not needed.

In our hospital A&E we have a Hospital Ambulance Liaison Officer (HALO) available every day from midday to midnight, who assists with quicker flow into hospital to reduce ambulance handover delays and improve patient experience, for example by identifying which patients could be cared for by Same Day Emergency Care (SDEC) alternatives once at A&E.

Please – only call 999 if you have an emergency or life-threatening situation, and use the ASAP app or website (www.asapglos.nhs.uk/) or call your GP Surgery, NHS **111**, or our Minor Injury and illness Units (**0300 421 7777**).

What is a medical emergency?
A critical or life-threatening situation, such as:

- Loss of consciousness
- Fits that are not stopping
- Severe chest pain or signs of stroke
- Breathing difficulties
- Severe bleeding that cannot be stopped
- Severe allergic reactions
- Severe burns or scalds
- Major trauma such as a road traffic accident.

Community and mental health services and hospitals

Gloucestershire Health and Care NHS Foundation Trust (GHC) provides mental health, physical health, and learning disability services to people of all ages. We do this in community hospitals and other buildings and, primarily, in people's own homes.

Physical health care

Our six Minor Injuries and Illness Units (MIIUs), based in our community hospitals, are for walk-in patients and appointments booked through the NHS 111 service or GPs, or by calling **0300 421 7777** directly.

MIIUs are open every day 8.00am to 8.00pm
(final appointment and walk-in at 7.30pm)

- Cirencester Hospital
- Lydney and District Hospital
- North Cotswolds Hospital (Moreton in Marsh)
- Stroud General Hospital
- Tewkesbury Community Hospital
- Vale Community Hospital (Dursley)

What our MIIUs can treat:	What our community hospitals cannot treat:
Sprains	Head injuries with loss of consciousness
Simple fractures needing x-rays and plasters	Persistent, severe chest pains
Simple wounds that may need suturing (stitches)	Pain that is not relieved by simple pain killers
Minor burns	Sudden confused state of mind
Emergency contraception	Breathing difficulties
Minor head injuries with no loss of consciousness	Stroke or suspected stroke
Minor illness, earache, sore throat, etc	Alcohol-related problems
Skin problems such as rashes, bites, stings and infections	Overdoses
Eye conditions including foreign bodies and conjunctivitis	Complicated or serious injuries
	Major or long-standing illnesses

We do other important work to support people to remain independent at home, including:

- Providing a 'falls response' service across the county to people falling in their own homes, including care homes, reducing ambulance calls and hospital attendances.
- Identifying 999 calls that can be dealt with by our community Rapid Response Team, instead of an ambulance.
- Providing assessment and treatment beds at community hospitals that GPs can refer patients to rather than sending them to Cheltenham General or Gloucestershire Royal Hospitals; similarly we provide a range of services that prevent people deteriorating and help them to recover and become able to care for themselves.
- Our 'Home First' service that can get people out of hospital and back into their own home with appropriate care as soon as possible.

There are also Minor Injury Units provided by other organisations:

- **Tetbury Hospital**
  - 8.30am to 6pm, last walk-in at 5.30pm
  - Monday to Friday, not open on public holidays)
  - Or call **01666 502336** and ask for the Minor Injuries and Illness Unit
- **Winchcombe Medical Centre**
  - 8.15am to 6.30pm
  - Monday to Friday, not open on public holidays
  - Call **01242 602 307**

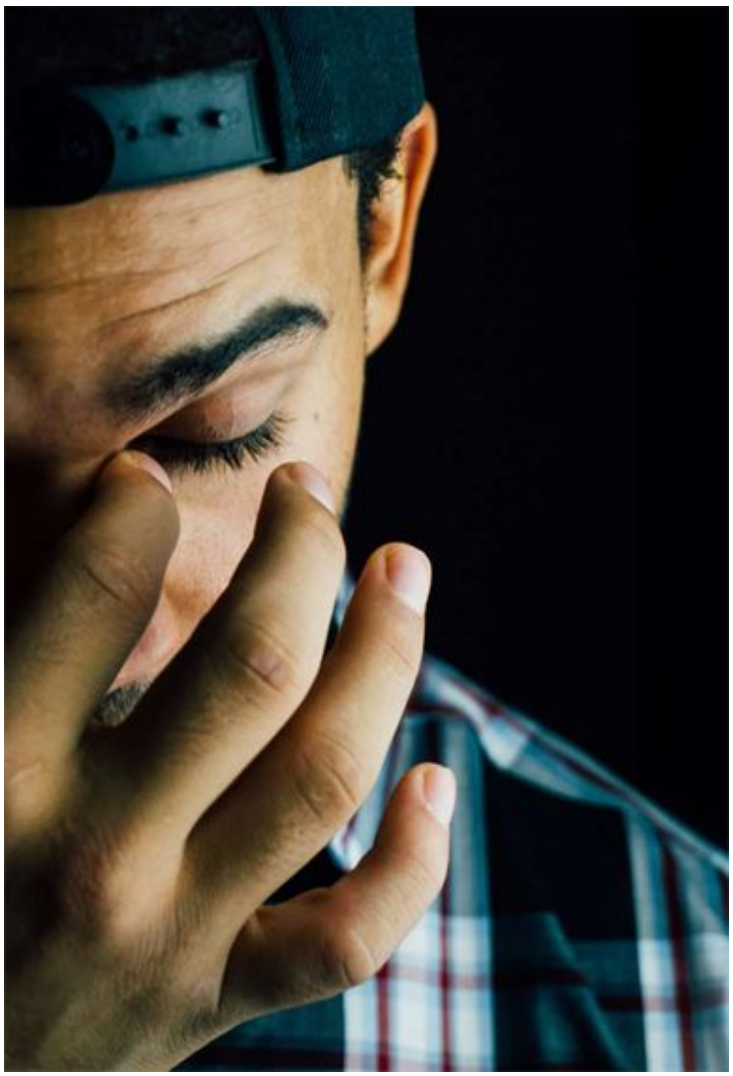
Community Health services winter pledges

One Gloucestershire Winter Pledge

- We will work with the ambulance service to guide people into community services, to provide care closer to home to avoid A&E visits when appropriate and safe to do so.
- We will build on the success of our Frailty Team working on 'Virtual Wards', to care for people at home that would otherwise have been admitted to hospital – we plan to increase Frailty Virtual Ward spaces from 10 last year to 45 over this winter.
- We will focus on prevention of both ill-health and the need for hospital attendance.

Mental Health care

Winter can be a hard time for people's mental health too. There are many ways the NHS, and the voluntary sector, work together to care for people with mental health concerns and crises:



Where to go for help:

- www.bewellglos.org.uk
- Mental Health Crisis team - **0800 169 0398** available 24 hours a day, 7 days a week. Use the following options:
  - Option 1 for Stroud and Cotswolds
  - Option 2 for Gloucester and Forest
  - Option 3 for Cheltenham, Tewkesbury and North Cotswolds
  - If you are hearing impaired, please TEXT:

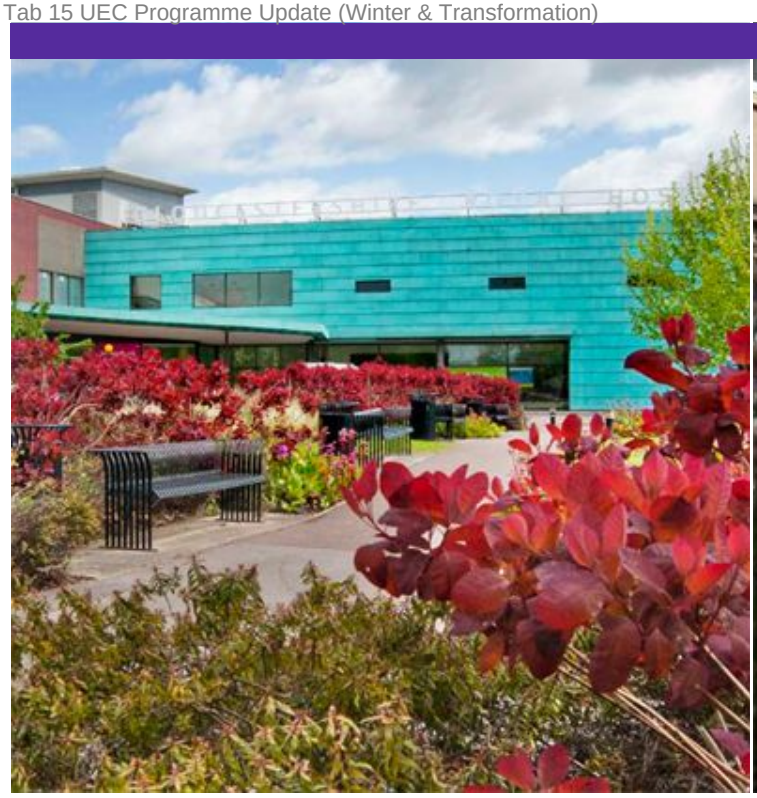
    07775 510 693 – 7am – 9.30pm

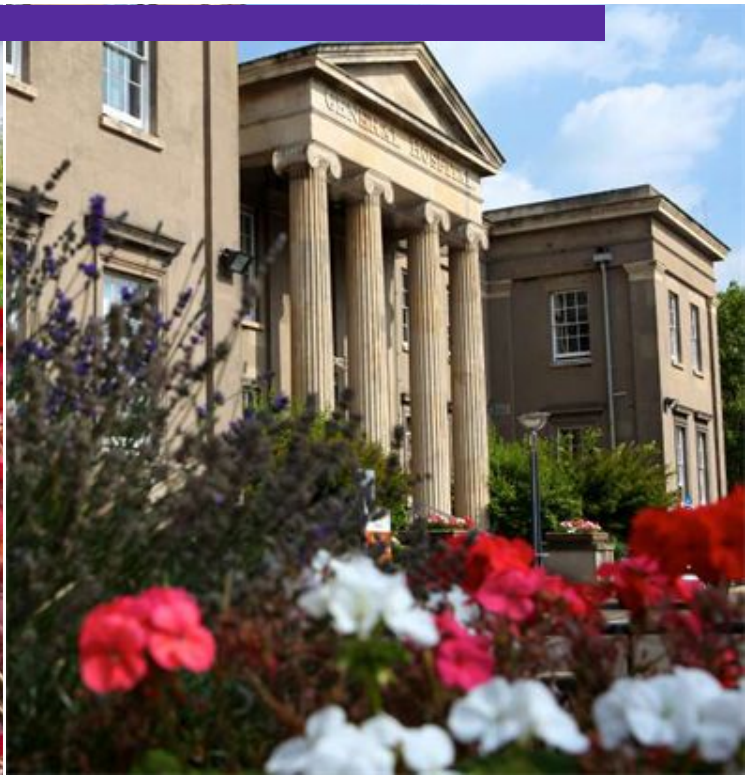
    07768 776 863 – 9.30pm – 7am
- Samaritans, if someone is experiencing feelings of distress or despair – **116 123** (free)
- The *Stay Alive App* (www.stayalive.app), packed full of useful information and tools to help you stay safe in crisis
- Gloucestershire Self Harm helpline - **0808 801 0606** or text **07537 410 022**
- Shout – 24/7 text service for anyone in crisis – **text 85258** (free on all major mobile networks)
- Childline – **0800 11 11** (free)
- The Silver Line (supporting older people – **0800 470 8990** (free)
- GP surgeries work with dedicated primary care Mental Health workers.

Mental Health services winter pledges

One Gloucestershire Winter Pledge

- We will provide or support mental health care in as many points of contact with the NHS as possible, including through GP surgeries, in hospitals, and through our own wide range of services.
- We will provide a mental health crisis line 24/7 (0800 169 0398) so that there is always someone to reach out to; support is also available through NHS 111.
- We will work with charities and other local organisations to support care for peoples' mental health in their own communities.





Cheltenham General Hospital and Gloucestershire Royal Hospital

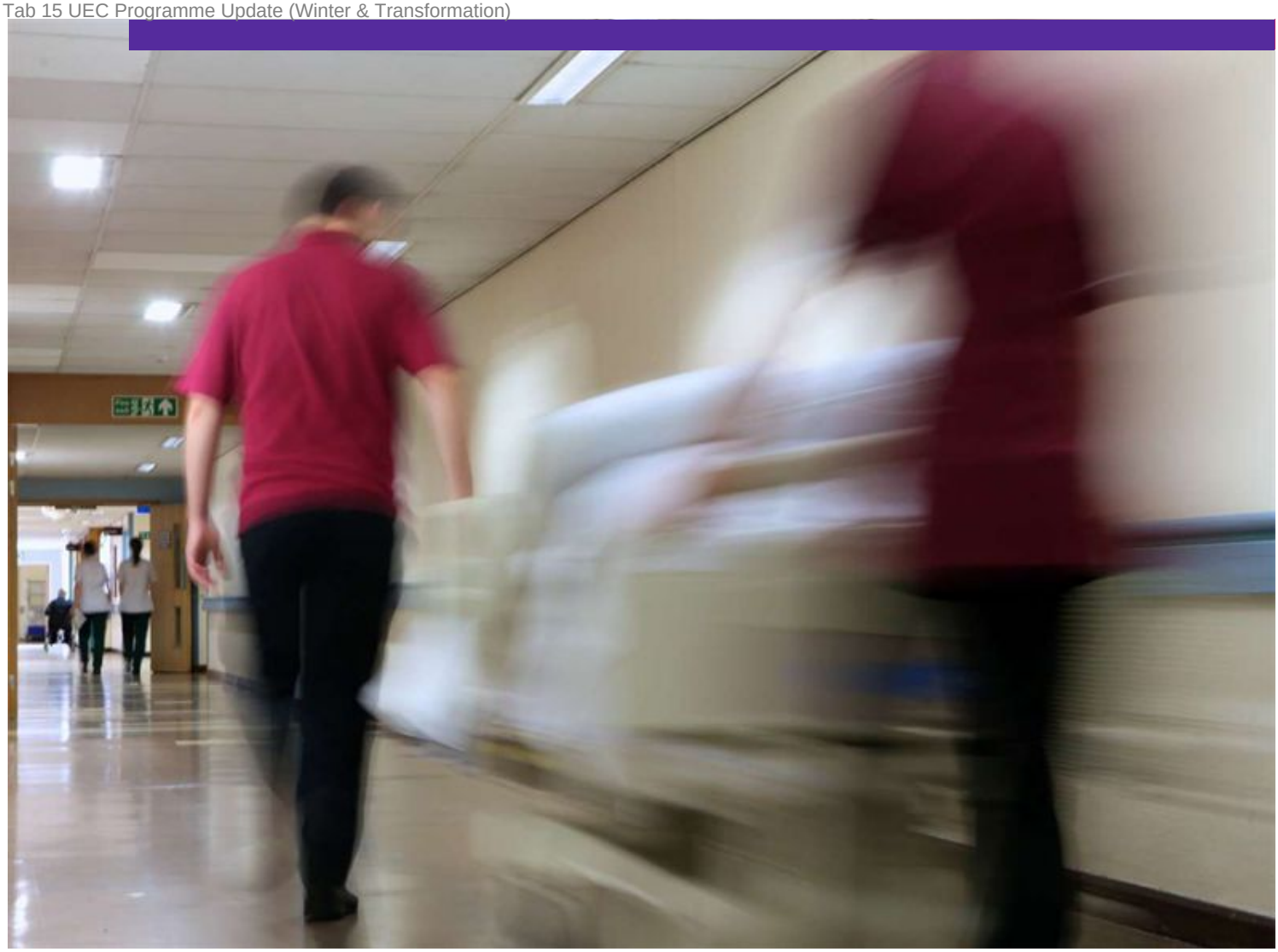
In our two main hospitals this winter we will do all we can to ensure only the people who really need Accident and Emergency (A&E) services are in the department. We will do everything possible to keep the length of time people spend waiting in A&E as short as possible and will also reduce the chance that someone will be admitted for an overnight stay when they don't need to.

To take pressure off A&E we will make as much use as possible of surgical, trauma, frailty and paediatric assessment areas, guiding people to the best place in the hospital for their care.

We want as many people as possible to be treated and sent home safely on the same day. Where people do need to stay one or more nights, we do all we can to ensure safe and timely decisions about what each patient needs, and where, to keep A&E running smoothly for the next person.

Care in our hospitals

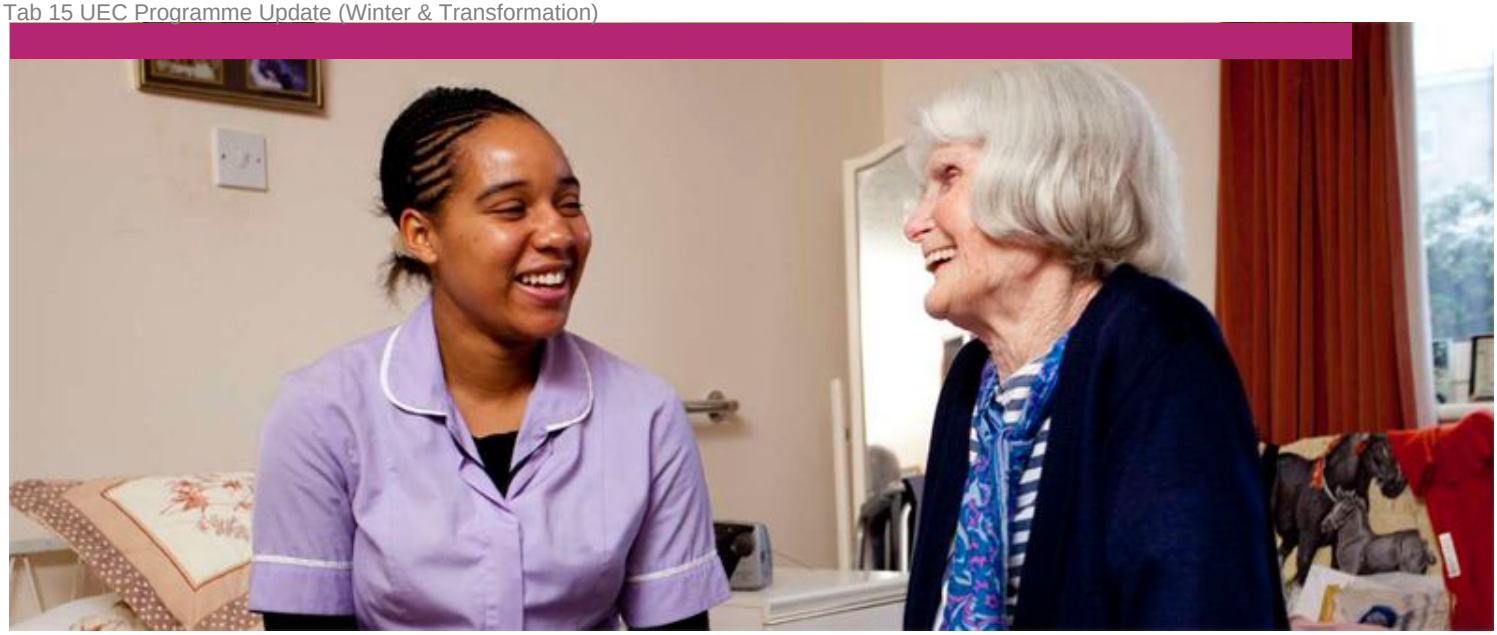
- Patients will have their conditions and care reviewed by the most appropriate experts, including doctors, nurses and therapists, every day of the week. We will ensure as much diagnostic testing is requested earlier in the day, to make timely decisions about the best place for people's ongoing care or whether they are ready to go home.
- If unavoidable, we will restrict visits to wards if there are risks of infection, notably from flu, norovirus (vomiting bug) or other seasonal illnesses including COVID-19. These illnesses can make patients more ill, and also impact the health and availability of our staff.
- We will work hand-in-hand with our colleagues in the community and social care to ensure people can go home or to a more appropriate place to finish their recovery.



Hospital winter pledges

- We will use our range of *Same Day Emergency Care (SDEC)* services as much as possible every day of the week to reduce pressure on A&E. This will also help how quickly we transfer people from ambulances into A&E to ensure they get the most appropriate care as soon as possible, and to help ambulances get to the next person that needs them.
- We will ensure people with specific conditions are cared for by the right people as quickly as possible. For example, by guiding people to facilities such as:
  - Anyone attending A&E with mental health concerns (regardless of physical health issues) will be able to access a specialist assessment within 45 minutes on average. This service, one of only three of its kind in England, is available 07.00 – 19.00 every day; during the winter we have an ambition to increase this towards a full 24/7 service.
  - 'Virtual Wards' (increased from 50 spaces last year to 223 by December), notably for people affected by frailty and respiratory conditions, and people who have had a stroke.

  Similarly we will ensure children and pregnant people are directed to the most appropriate area if not A&E.
- We will focus on increasing our discharges across all seven days of the week and will prepare discharge information and medication as early as possible in the day.



Social Care

The Hospital Discharge and Assessment Team (HDAT) work in various locations in the county, notably in our hospitals, Charlton Lane Mental Health Hospital, and assessment bed units across the county. Our innovative 'Care Navigators' provide support and information when people are admitted to hospitals and work alongside the *Complex Care at Home teams*, the North Cotswold Frailty Team, and Community Hospitals across Gloucestershire.

From late November, HDAT will operate an Admission Avoidance advice telephone line seven days a week, offering support to the Accident and Emergency departments by advising health colleagues about appropriate alternatives to hospital admissions.

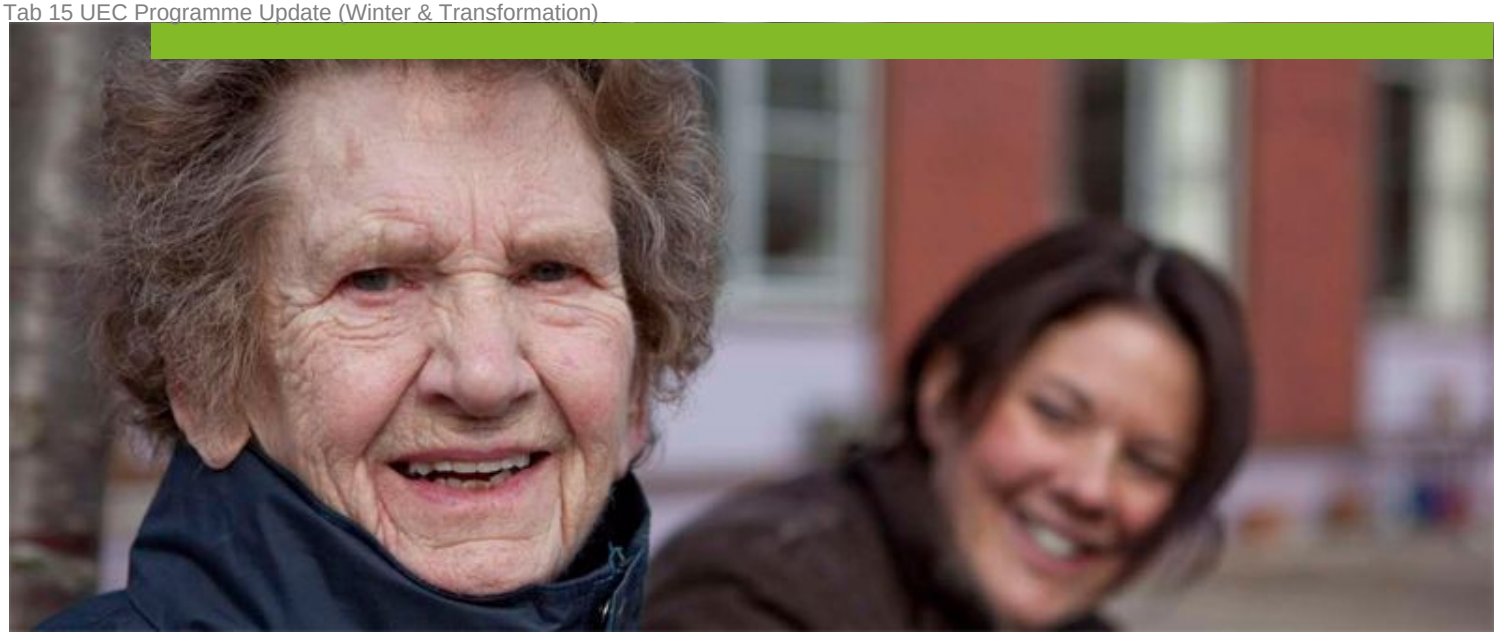
Our key priorities this winter are:

- To provide informed, quality advice and guidance to prevent avoidable admissions and to support timely hospital discharges every day.
- To support and advise decision-making in the hospitals and sharing our Social Care knowledge around complex situations.
- To support the needs of those entering short-term assessment beds to aid safe and timely discharges.
- To support health partners in our 'Home First' principles and reduce how much bed-based care people need after leaving hospital.
- To champion prevention of ill-health and connect people with services in their communities.
- Support, information and care for Carers.

Full information about social care services and support can be found at www.gloucestershire.gov.uk/health-and-social-care/adults-and-older-people/finding-the-right-information-and-support/

Social Care winter pledges

- We will support the flow of people through all of Gloucestershire's health and care services and ensuring speedy access to the most appropriate next stage of care, by prioritising assessments and ensuring home and bed-based care is provided based on people's needs. We support and assess people in up to 200 beds at any one time on leaving hospital, and assess peoples' needs (where required) within their own home.
- We will work closely with broad range of private, independent and voluntary sector providers from around the county and beyond to support our overall response to the challenges of winter.
- Social Workers will be working in the two large hospitals to help avoid unnecessary hospital stays and to support planning for post-hospital care. This is provided through our Social Care Hub Monday to Friday 9.00 to 17.00, in A&E and on hospital wards. We also support at the weekends via telephone referral.



Support in your community

The cumulative impact of health inequalities, the impact of COVID-19 on health and livelihoods, and the risks to health and wellbeing arising from the cost-of-living crisis have focussed our attention on the strength of communities and the nature of our partnership with the Voluntary, Community and Social Enterprise (VCSE) sector.

Health inequalities have a significant bearing on whether a person needs to access urgent of emergency care. With the cost-of-living crisis anticipated to affect a greater number of households this winter - including some of the people who make up our workforce - we expect to see these needs increase.

Our shared focus this winter is to work alongside communities to reduce peoples' need for health and social services. Our VCSE partners are the real front line in supporting carers, people's other needs beyond healthcare, as well as the response to the cost-of-living crisis as they were during the COVID-19 pandemic. We will continue to work with them this winter to identify and handle risks to safe and secure communities that help keep people well, and at home where it is possible to do so.

You can access lots of information about these services and support at www.youcircle.org.uk, an online directory provided by Gloucestershire County Council.

Many people in Gloucestershire also care for someone else in their life. We recognise the amazing care they provide every day, which is supported by a wide range of resources, training and offers from Gloucestershire Carers, who can be contacted on 0300 111 9000, or via their website at (www.gloucestershirecarershub.co.uk)

Community support winter pledges

- Voluntary and community sector partners provide some follow-up services to ensure people are supported to remain at home after leaving hospital.
- We will offer our *Warmth on Prescription* service, helping those in need with long-term cardiovascular and respiratory conditions to pay their energy bills and stay healthier; we will also promote how to *Stay Well This Winter* at all times, supporting people to eat well, stay active, access vaccinations and care for their mental health.
- We will ensure our *Click or Call First* and *ASAP* services are kept up to date with the latest information people need to care for themselves and access the right services when they need them.

One Gloucestershire Winter Pledge

What can you do to help?

Unless it's a genuine accident or emergency we recommend that you access the Gloucestershire ASAP website (www.asapglos.nhs.uk/, smartphone apps also available for download). ASAP helps you to search by both adult and child conditions, or by service.

Keep yourself as well as possible

Please ensure you, any children in your care, your older loved ones and carers have all vaccinations up to date (www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/vaccination/), including flu and COVID-19. Keep warm and hydrated and try to avoid travelling in bad weather.

Community Pharmacies

Before contacting your GP ask your local pharmacy for help. They can offer confidential consultations for many common ailments and advise you about the best non-prescription medicines they can provide, especially to reduce our reliance on antibiotics. Your pharmacy will also be able to advise you what the best service to contact is if not them.

GP Surgeries

Try to use other services than GP surgeries as much as possible, especially first thing in the morning when people with urgent needs may be calling in. Most of all see if your local pharmacy can help or signpost you to another service. Don't assume that you need antibiotics for minor ailments such as coughs and colds; pharmacists will advise if you need to get a GP prescription.

NHS 111

Visit your local pharmacy for help with minor ailments; they will advise who else could help, which may include directing you to NHS 111. Use NHS 111 for as much as possible instead of calling 999, which should be used only for real emergencies that could be life-threatening.

Ambulance service

Only call 999 if you really need to. There are lots of alternatives to a 999 call for situations that, while urgent and important, can be helped appropriately and quickly by one of our other services. Please help us prioritise our ambulances for real emergencies and accidents that need them.

Minor Injuries and Illness Units (MIIUs)

Use the community hospitals' MIIUs wherever possible for problems that are not genuine emergencies; NHS 111 and GPs can book you directly into appointments at the MIIUs, and you can call them directly on 0300 421 7777.

Mental Health services

If you or someone you know needs help in a mental health crisis, call our 24/7 crisis teams on 0800 169 0398. If you are hearing impaired, please text 07775 510 693 (7.00am to 9.30pm) or 07768776863 (9.30pm to 7.00am)

Accident and Emergency departments

Use other services as much as possible before considering visiting one of the A&E departments, for example local pharmacies, GP surgeries, NHS 111, and Minor Injury and Illness Units (MIIU's). This helps prioritise the most unwell patients for the kind of specialist and emergency care that hospital A&E's provide. Please also support your family and friends who may be in our hospitals to return home or their usual place of residence as soon as possible so that we can care for more people sooner.

Glossary

The organisations that provide your health and social care and support:

Organisation	What they provide	Where they provide it
GP surgeries	Broad diagnosis, treatment and care of non-urgent illness. Support and decisions to refer patients to specialist services in other organisations. Long-Term Care and supporting self-care	Through GP surgery premises across the county, and their branch sites Via the Out of Hours service More help available at: www.asapglos.nhs.uk
Gloucestershire Health and Care Foundation NHS Foundation Trust (GHC) www.ghc.nhs.uk	District nursing Health services, clinics and therapies Inpatient care, rehabilitation and Minor Injury and Illness Units Mental Health assessment, treatment and care services	In people's homes. At NHS clinic sites around the county At community hospitals At mental health specialist centres and hospitals
Gloucestershire Hospitals NHS Foundation Trust (GHT) www.gloshospitals.nhs.uk	Specialist medical treatment and care, and diagnostics A&E departments for the most urgent and serious accidents and illness	At Cheltenham General Hospital and Gloucestershire Royal Hospital
Gloucestershire County Council (GCC) www.gloucestershire.gov.uk/health-and-social-care/	Social care services Domiciliary care visits Carer assessments	In people's homes At social care units around the county Via independent sector units
South West Ambulance NHS Foundation Trust (SWAST) www.swast.nhs.uk	999 call handling Ambulance and paramedic prioritisation and despatch Transfer of patient care appropriate for other services	Ambulance main hub, local ambulance stations, a range of ambulance vehicles and in people's homes
Voluntary, Community and Social Enterprise (VCSE) organisations www.glosvcsalliance.org.uk/	Ranges from small community-based groups/schemes through to larger registered Charities that operate locally, regionally & nationally	Within communities and peoples' homes and health and social care facilities
E-zec e-zec.co.uk/our-services/	Non-emergency patient transport services	Non-emergency ambulance vehicles
Gloucestershire Integrated Care Board (ICB) www.glosnhs.nhs.uk	Oversight and commissioning (purchasing) of all health and care services for Gloucestershire. Gloucestershire Integrated Brokerage	

Terms and acronyms

Not all of these terms appear in this document; however you may see or hear them referenced if you use our Urgent and Emergency Care services this winter:

A&E	Accident & Emergency, operated from our acute hospital Emergency Department
ARRS	Additional Roles Reimbursement Scheme, expanding types of roles in primary care
ASC	Adult Social Care, a function of Gloucestershire County Council
CATU	Community Assessment & Treatment Unit (Older Person)
CGH	Cheltenham General Hospital, one of our two acute hospitals
CPG	Clinical Programme Group
CYP	Children & Young People
D2A	Discharge to Assess
DTA	Decision To Admit (to hospital)
DoS	Directory of Services
EAC-I	Enabling Active Communities and Individuals – promoting healthy lifestyles
ED	Emergency Department, dealing with the most serious injuries and illness
EPR	Electronic Patient Record
FAU	Frailty Assessment Unit – a dedicated unit to assess underlying frailty
G-care	Online point of clinical reference for Gloucestershire clinicians
GP	General Practitioner
GRH	Gloucestershire Royal Hospital, one of our two acute hospitals
HALO	Hospital Ambulance Liaison Officer – a dedicated function to enable flow
HAT	Homeward Assessment Team
HIU	High Intensity User – patients who have complex and frequent health issues
HOSC	Health Overview & Scrutiny Committee (GCC) holding organisations to account
IAPT	Adult Improving Access to Psychological Therapies, a key mental health service
ICS	Integrated Care System, now enshrined in law
IPC	Infection Prevention and Control
LA	Local Authority (Gloucestershire County Council)
LoS	Length of Stay, a key measure in hospital-based care
MDT	Multi-Disciplinary Team, an approach to care that looks after all a patient's needs
MH	Mental Health
MiDOS	My Directory of Service; electronic signposting to the most appropriate care
MIIU	Minor Injury & Illness Unit, based on community hospitals
NEPTS	NHS funded Non-Emergency Patient Transport Service
NHS 111	Free telephone and online service for patients to access urgent health care advice
NHSE	National Health Service England, the national body that oversees delivery of services
OOH	Out Of Hours (usually in reference to primary care services at night and weekends
OPEL	Operational Pressures Escalation Levels (1, 2, 3, 4)
POC	Package of Care
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SDEC	Same Day Emergency Care
SHREWD	Single Health Resilience Early Warning Database
ToCB	Transfer of Care Bureau
UEC	Urgent & Emergency Care
VCSE	Voluntary, Community and Social Enterprise

One Gloucestershire
Transforming Care, Transforming Communities

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To discuss receiving this information in other formats please contact:

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FREEPOST RTEY-EBEG-EZAT
One Gloucestershire Integrated Care System (ICS),
Shire Hall, Westgate Street, Gloucester,
Gloucestershire, GL1 2TG

@One_Glos
www.onegloucestershire.net

November 2023

Working As One
Programme Narrative

Table of Contents

Working as One
Prevention | Integration | Redesign

Why does this Programme matter?

1 Why change? | 2 What's the vision? | 3 How will we get there? | 4 What might look different?

Sarah Scott
Senior Programme Leadership
Gloucestershire County Council

Ellen Rule
Senior Programme Leadership
NHS Gloucestershire ICB

Andy Seymour
Senior Programme Leadership
NHS Gloucestershire ICB

Gloucestershire can be rightly proud of its skilled and dedicated health and care professionals that make sure quality care and support is there when people need it most.

Together, we have made great strides to improve how we provide this care, but in the face of unprecedented growth in levels of need, the time is right to look at how we evolve and target our efforts to meet these challenges for the people we serve.

Given our strong track record in joint working, One Gloucestershire is in a unique position to both innovate and integrate - supporting our citizens to lead healthier lives and get the care they need at the right time. We're clear from the outset that prevention is as important as treatment and cure.

This programme will build on what works well and bring teams and services together in a positive way to make the improvements and changes necessary for current and future generations.

Working as One
Prevention | Integration | Redesign

Why do we need to change?

We deliver great care every day but we don't always have the right resources in the right place and we're not as joined up as we could be:

1 Why change? 2 What's the vision? 3 How will we get there? 4 What might look different?

An ageing population means there's a growing demand and pressure on the system to remain sustainable

While life expectancy continues to improve for the most affluent 10%, it has either stalled or fallen for the most deprived 10%

We don't direct people to our community services as well as we could and so our hospitals are under pressure – for example, at times an ambulance handover has taken 3 hours, and we have 70 people in the Emergency Department waiting for an acute bed

Many of our community staff don't know what some of our preventative services do, how to access them or if they deliver effective outcomes

People are staying longer in our hospitals - length of stay has risen from 6 to 9 days in the last few years

We find it hard at times to support people's discharge home - 1 in 4 people in our acute beds do not have a medical reason to be there

1 in 2 people being discharged into a bed in a medical setting in Gloucestershire could have returned to their own home instead

The length of stay in these beds is still 2x longer than national targets

Sometimes we find it hard to get the right support for people to leave hospital when they are ready- this limits the number of available beds for those who need it.

3 in 5 people ready to be discharged from hospital do not need to be there and are awaiting onward care

People leave our reablement service with inconsistent levels of care and our homecare is being overused rather than promoting independence

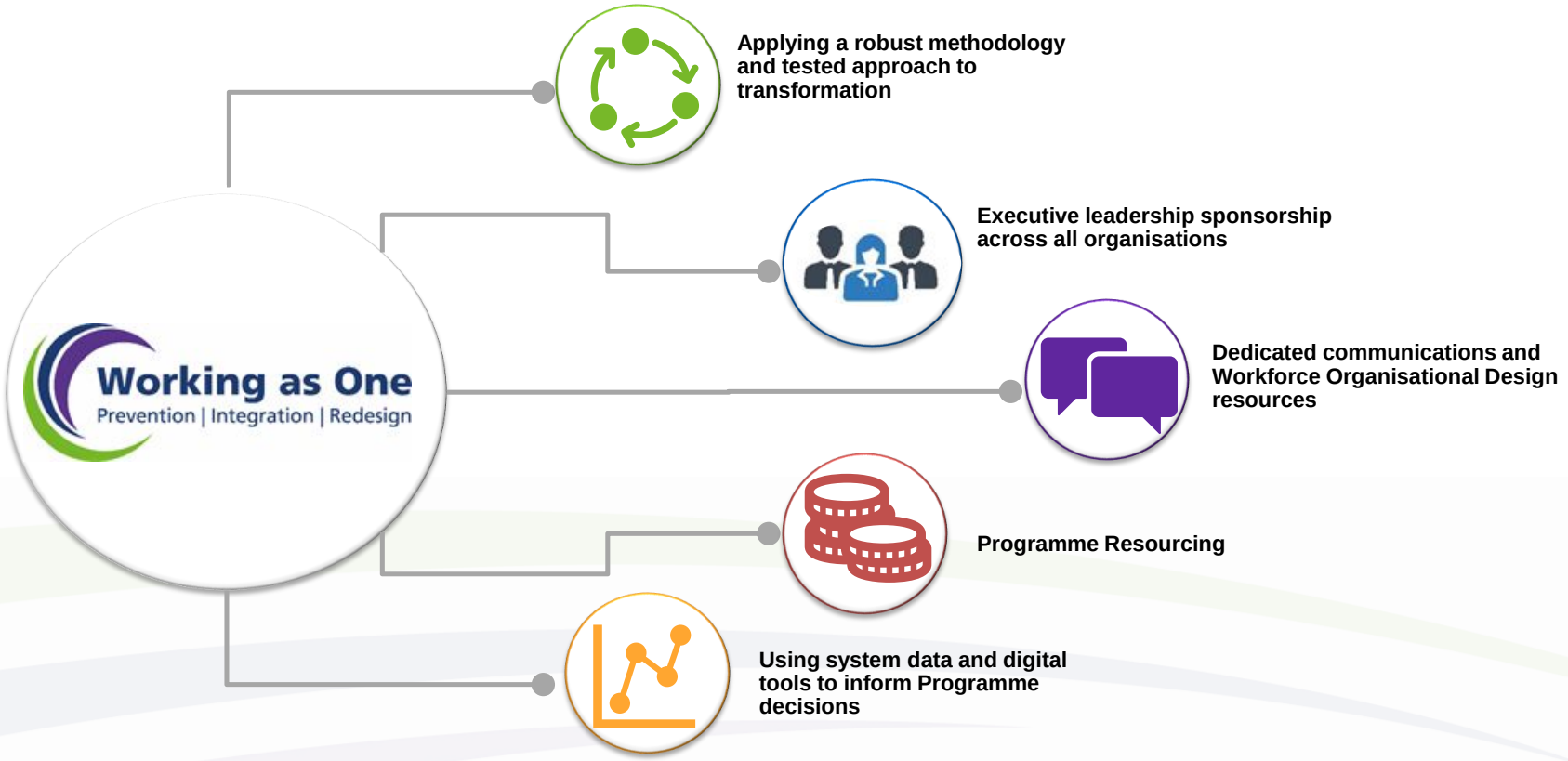
PREVENTION | COMMUNITY & HOSPITAL FRONT DOOR | ACUTE STAY | ON-WARD DISCHARGE | DISCHARGE TO LONG TERM SETTING

Working as One
Prevention | Integration | Redesign

Why is this Programme different from what we've done before?

1 Why change? | 2 What's the vision? | 3 How will we get there? | 4 What might look different?

We have invested heavily in Working As One across all our organisations in several areas



Our Programme Vision

To deliver quality, integrated care for the people of Gloucestershire to support the best possible physical and mental health outcomes, enabling them to lead the most happy and healthy lifestyles.

1 Why change? 2 What's the vision? 3 How will we get there? 4 What might look different?

We'll do this by…

Redesigning the way care is provided in the One Gloucestershire system by all partners working together to deliver the right care, in the right place, at the right time.

- Services in your area working together so people only need to tell their story once when needing care
- Making the right information available to staff to enable them to provide quality care and support to the people of Gloucestershire
- Building a culture of continuously improving together

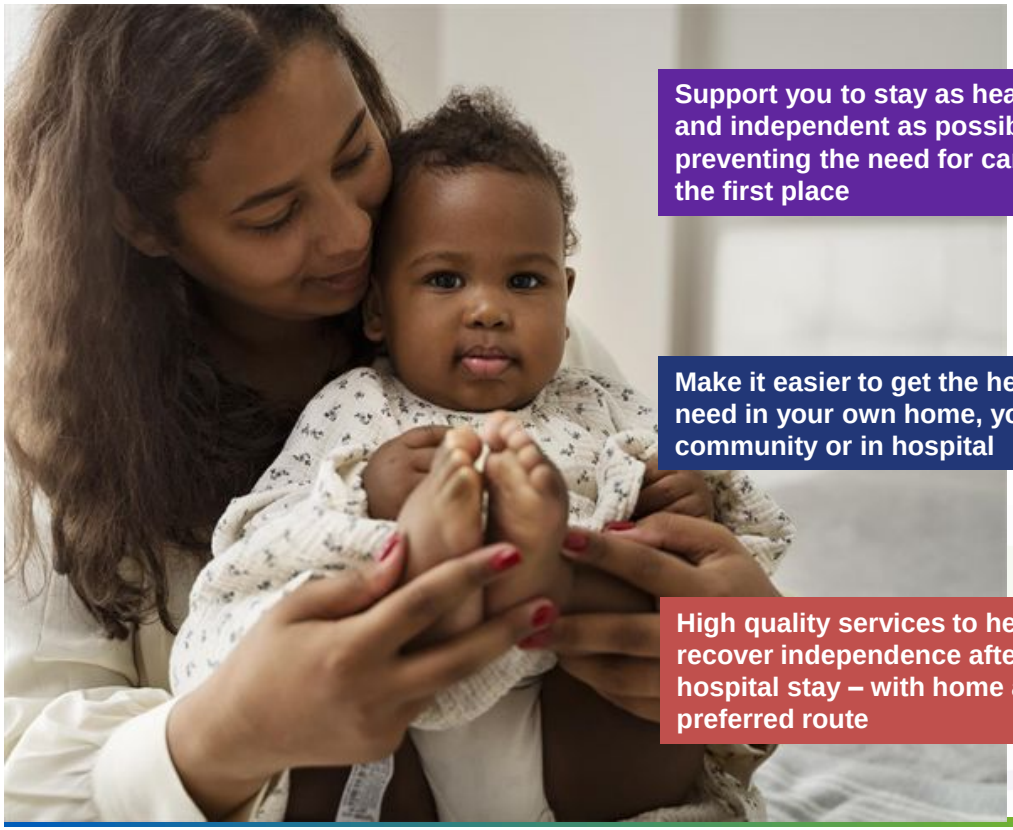
- Working in an integrated way to provide care to the people of Gloucestershire
- Empower staff to make decisions and provide an environment to be innovative in how to deliver better care
- A better-connected system that helps us be flexible and deliver the right support around people

- Support you to stay as healthy and independent as possible, preventing the need for care in the first place
- Make it easier to get the help you need in the community and your own home
- High quality services to help you recover independence after a hospital stay – with home as the preferred route

Working as One
Prevention | Integration | Redesign

What does it mean for the people of Gloucestershire?

1 Why change? | 2 What's the vision? | 3 How will we get there? | 4 What might look different?



Support you to stay as healthy and independent as possible, preventing the need for care in the first place

- Working closely with services in your local community to ensure we are proactively supporting people who are most at risk
- Not just treating the issue you seek care for but identifying how else we can support to prevent any future health or wellbeing issues

Make it easier to get the help you need in your own home, your community or in hospital

- You'll be connected to the service best placed to support you quickly and without frustrating handovers and repeating your story
- You'll receive the right support that will reflect your changing needs

High quality services to help you recover independence after a hospital stay – with home as the preferred route

- You'll have the right services to make sure that if you are able to recover your independence that you have the opportunity and support to be able to do so
- The aim is to get you home safely first and then provide you with the most appropriate support from there

Working as One
Prevention | Integration | Redesign

What does it mean for our staff?

1 Why change?
2 What's the vision?
3 How will we get there?
4 What might look different?

Working in an integrated way to provide care

- Improving the connections between primary, community, and hospital services, making it much easier to support people to get the right care at the right time
- Making it easy to do the things that are ideal for each person – having the right services and support available and easily accessible
- Availability of the best community rehabilitation services to avoid hospital stays altogether, not just once a person has spent time in hospital

Empower staff to make decisions and provide an environment to be innovative and provide quality care

- You will be supported, and have the power, to ensure that people get the right care and to adjust their level of care when required
- Be a part of testing the solutions that will enable integrated working and really improve outcomes, and then continuously improve our services from this point forwards

A more connected system that helps us flex and wrap the right support around people

- We will improve the visibility and awareness of services and the help they provide, and build strong trusted referral and navigation routes between services
- You'll be empowered with the right information at your fingertips to make the best decisions for the person you are caring for

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Prevention | Integration | Redesign

What are our transformation principles?

1 Why change?
2 What's the vision?
3 How will we get there?
4 What might look different?

- Put the person at the centre of the change
- Build on and supports existing system work and relationships
- Designed by staff. Enabled by leaders
- Use data & evidence-based decisions in all we do
- Work in an integrated way to ensure true system and people benefit
- Sustainable change, and a platform for further improvement

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What might look different?

An integrated system that is more proactive in keeping people healthy, but if care is needed it supports people to stay and return home as much as possible

1 Why change? 2 What's the vision? 3 How will we get there? 4 What might look different?

SYSTEM DESIGN

Proactive support for the community to reduce or delay them requiring urgent care. Improved co-ordination and navigation through out-of-hospital services that help people stay and return home when their needs escalate.

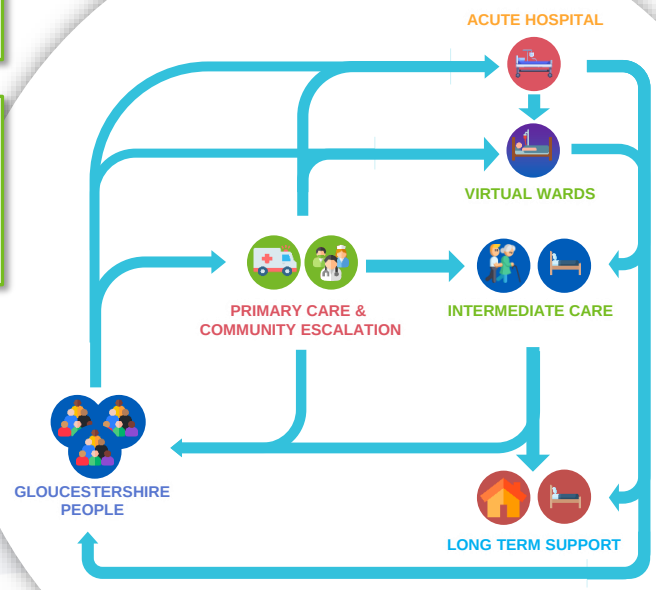
Improved ways of working at the front door of the hospital that help more people return home that day

Better use of services in the community – making sure we have effective referral routes to support the right people to stay in their own home

Co-ordinated proactive care that identifies at risk individuals and consistently puts the most effective interventions in place to prevent future escalations

Reduced time for people in hospital through better co-ordination of teams in the healthcare system

A collaborative discharge hub supporting our most complex patients quickly to their ideal next step



More people returning home with support that helps them recover their long-term independence

Working better together to improve patient flow through hospital and their outcomes

Reducing demand by maximising people's independence, and therefore services are available to quickly support those who need them

SYSTEM DESIGN

Which types of bed-based services we need in the community, and how they are best organised to be cost-effective while delivering great outcomes

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Prevention | Integration | Redesign

Programme Contacts

If I have questions or want to get involved – who do I contact?

Kelly Matthews
Programme Director
kelly.matthews1@nhs.net

Micky Griffith
Programme Director
micky.griffith@nhs.net

Stuart Appleby
Programme Director
Stuart.Appleby@newtoneurope.com

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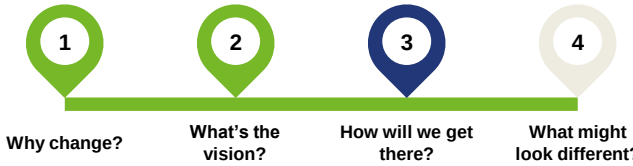
We will follow a structured approach to the transformation



Set up & Launch

The transformation project is across all of Gloucestershire which involves all system organisations in shaping and driving the change. and to be aware of the changes.

Validate

During this phase, we will validate the results from the initial assessment.

We want to ensure that our trials are targeted at areas where we can evidence there is value.

Trial Planning

After we validate the results, we start to plan our trials which can prove that our proposed design works.

We keep these small so we can quickly move into testing and iterate.

Running Trials

We will be running trials, measuring the results live and iterating the design until we surpass the opportunity identified in the diagnostic – this is where we gain confidence that our design works

Scale

After we're confident that the trials have been a success, we begin to scale up the size of the design. This could be, for example, expanding it from one community team or ward to 5 over a time period to confirm that the design can be rolled out to the wider system.

Rollout

During this phase we will scale up the new ways of working to their full rollout area and support the workforce with training and coaching to embed the key practices so we can maintain the level of care we provide to people.

Sustain

After the new ways of working are rolled out to the workforce and we're confident that performance is being maintained without programme support, we will monitor operational performance and confirm that the new ways of working are embedded.

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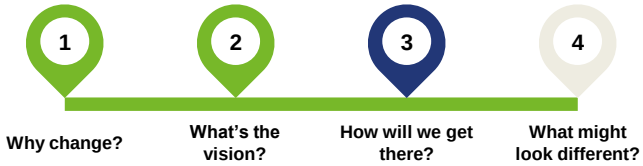
How are we going to do it

We're organising ourselves into 5 workstreams for the next 18 months:



Prevention

To proactively support people in the community to reduce or delay getting to the point of an urgent need, to support people's independence and enable them to live and thrive in their community for as long as possible.

Community Urgent Response & Front Door

Reducing avoidable acute hospital attendances and admissions (stays) by ensuring that the people of Gloucestershire receive the right support, from the right service, at the right time, using alternatives to hospital where possible. When they do arrive at the hospital, improved processes will support effective treatment and links to appropriate ongoing support.

Hospital Flow and Decision Making

Ensuring people benefit from timely referrals, tests, treatment and decision making when in hospital so their length of stay (LoS) is appropriate enabling them to be medically fit for discharge (MFD). Once MFD, patients are discharged to an appropriate setting for their needs in the minimum number of days.

Intermediate Care/Reablement*

To improve the availability, flow and outcomes of rehabilitative care in the community. To build the capacity required to allow prompt discharge from hospital (or step-up from community) into care in the most suitable location – with a Home First mentality.

*Intermediate care = intensive support from a range of professionals

Access To Care Packages

To ensure availability of long-term care packages for those who require them and supporting options for family or friends providing unpaid care to the person in need. This work will look at whether improved intermediate care is a solution, or where the improvement of intermediate care is fundamentally blocked by availability.

Digital

People-focused approach

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System's vision for Gloucestershire healthcare

NHS Gloucestershire

Alongside our communities, we want to improve health, improve access to high quality care and support when needed and make Gloucestershire a better place for the future.

We will do this by:

1.Making Gloucestershire a better place for the future
2. Transforming what we do
3. Improving Health & Care Services today

Gloucestershire County Council

To make the most of all that Gloucestershire has to offer, help improve the quality of life for every community, support businesses to be successful and make sure the county is a place where people want to live, work and visit.

NHS Gloucestershire Health and Care NHS Foundation Trust

Working together to provide outstanding care

NHS Gloucestershire Hospitals NHS Foundation Trust

Best care for everyone

NHS South Western Ambulance Service NHS Foundation Trust

Together, we will deliver the best care when you need us most

Working as One
Prevention | Integration | Redesign

NHS Gloucestershire Audit Committee Part I Meeting

Held at 2.00pm on Tuesday 27th June 2023

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

Members Present:		
Julie Soutter	JS	NED, Chair
Colin Greaves	CG	NED, Deputy Chair
Dr Jo Bayley	JB	Member
Participants Present:		
Adam Spires	AS	Partner, BDO LLP
Christina Gradowski	CGi	Associate Director of Corporate Affairs
Cath Leech	CL	Chief Finance Officer
Dan Povey	DPy	Public Sector Audit Manager, Grant Thornton LLP
Julie Masci	JM	Director, Grant Thornton LLP
Justin Turner	JT	Audit Manager, BDO LLP
Paul Kerrod	PK	Deputy Head of Local Counter Fraud Service, LCFS
Ryan Brunsdon	RB	Board Secretary
Shofiqur Rahman	SR	Deputy Chief Finance Officer
David Porter *(Agenda Items 15,16, 17)*	DP	Head of Procurement
In Attendance:		
Chinenye Nwaeze	CN	Intern
Ellen Rule	ER	Deputy Chief Executive Officer
Gerald Nyamhondoro	GN	Corporate Governance Officer (taking minutes)

1. Introduction and Welcome

1.2 The Chair welcomed members and participants present.

2. Apologies for Absence

2.1 Apologies were received from Marcia Gallagher.

2.2 The meeting was confirmed to be quorate.

3. Declarations of Interests

3.1 The Chair presented the Register of Interests of Committee members. The Chair stated that the declared interests were also in the Main Register published on the web for the benefit of the public.

3.2 JB declared a general interest of GPs in Primary HealthCare services. The committee considered the declaration and concluded that the participation of JB with full rights of

members was not prejudicial to the proceedings, or to the Gloucestershire Integrated Care Board (thereafter "the ICB"), or in any other conceivable way.

4. Minutes of the Last Meetings

4.1 Minutes of the meeting held on Thursday 16th March 2023 were approved as an accurate record of the meeting.

4.2 Minutes of the meeting held on Thursday 9th May 2023 were approved as an accurate record of the meeting.

5. Matters Arising & Action Log

5.1 **16th March 2023 Minutes, paragraph 8.5 -** Members discussed contents of the Corporate Risk Register (CRR) and observed that many risks needed updating. They requested that the CRR be updated in a timely manner for submission to the members. **Action: Closed.**

5.2 **16th March 2023 Minutes, paragraph 10.1 -** Members requested that a meeting be arranged for the Conflict-of-Interest Guardian to meet ICB staff. **Action: Closed.**

5.3 **16th March 2023 Minutes, paragraph 18.1 -** The Primary Care Team was working on mitigating POD transition risk. Members requested that an update or outcome of the transition be brought before the Audit Committee. **Action: Remained Open.**

5.4 **16th March 2023, Minutes, paragraph 19.1 -** The Chair directed that arrangements be made for members who were NEDs to meet separately with external auditors and internal auditors on bi-annual basis for periods not exceeding 30 minutes. **Action: Closed.**

5.5 **09th May 2023, Minutes, paragraph 4.4 -** JS directed that more information on IFRS16 and associated literature be circulated to members or alternatively be incorporated in a report to act as an aiding tool to members' oversight role. **Action: Closed.**

5.6 **09th May 2023, Minutes, paragraph 6.1 -** Members discussed the draft 2022-23 Annual Report and requested that the report be made available to them prior to the 27thJune 2023 meeting. **Action: Closed.**

6. Annual Reports

6.1 CGi presented the CCG report which covered the period 1st April 2022 to 30th June 2022. CGi also presented the ICB report which covered the period 1st July 2022 to 31st March 2023.

6.2 CGi highlighted that the reports had previously been brought before the members and subsequently gone through several amendments. CGi added that some housekeeping work relating to the reports was being carried out by the Communications Team ahead of submission to the Board and NHS England.

6.3 CG observed that Jo Davies and Peter Marriner were incorrectly shown as Non-Executive Directors instead of Governing Body Lay Members. JS enquired as to whether all matters of compliance relating to the formation of the ICB had been met. CL responded that the Operational Executive Committee reasonably believed that all compliance requirements had been met. JS further enquired as to whether there was a requirement to secure governance certification from NHSE and if so, were such measures taken (or being taken) to obtain the certification. **Action: CL was asked to make the changes identified.** **CL**

6.4 CG queried the date associated with the signature appended by the Accountable Officer on the 3-month CCG final report. **Action: CL to have the date corrected.** CG also stated that there were inconsistences in the way Mary Hutton (MH)'s and Dr Marion Andrews-Evans (MAE)'s pensions were reported in the 9-month ICB final report. **Action: CL to have the identified inconsistences adjusted.** **CL**
Members rated Assurance Amber and management action Green.

6.5 RESOLUTION: The Audit Committee recommended approval of the CCG and the ICB Annual reports subject to making minor adjustments as directed by the Committee.

7. Statutory Accounts

7.1 Months 1-3

7.1.1 CL and SR presented the CCG final Accounts which covered the period 1st April 2022 to 30th June 2022. SR explained that the CCG received a resource limit which equalled the net expenditure for the 3-month period thus resulting in breakeven financial position with the balance of the allocation shown against the ICB.

7.1.2 CL outlined key changes in the accounting policies and the adoption of IFRS16 which covered the changes to lease accounting. CL clarified that the changes removed the distinction between operating and finance leases. CL highlighted that the auditors identified a small number of insignificant over-accruals, but these reversed over the course of the financial year.

7.1.3 SR stated that external audit for the CCG was complete and summarised the key financial performance targets informing members that they had been met for the period.

7.2 Months 4-12

7.2.1 CL and SR presented the ICB final Accounts which covered the period 1st July 2022 to 31st March 2023. SR explained that the unaudited Accounts position as at 31st March 2023 was a small surplus of £19,000 and the final Accounts for the period showed a surplus of £6.866,000. The accounting treatment of some of the S256 agreements totalling £8,100,000 had been challenged by external auditors and as a result these were adjusted and would subsequently be shown as expenditure in year 2023/24.

7.2.2 SR highlighted that performance targets relating to revenue limit, net & running costs, cash balance and Better Payment Practice Code (BPPC) had been met. SR explained that the external audit of the Accounts was largely complete. SR added that the Annual Accounts were consistent with in-year performance reports presented to the Board.

7.2.3 CL stated that a full audited and signed report together with a full copy of the final Head of Internal Audit Opinion statement issued by BDO LLP would be submitted to the Department of Health by 09:00am on 30th June 2023. CL added that the ICB would publish the Annual Report and Accounts in full on the ICB public website by 28th July 2023. Members rated Assurance Green and management action Green.

7.3 RESOLUTION: The Audit Committee:

1. **Recommended approval of the CCG 1st April 2022 – 30th June 2022 Statutory Accounts and Annual Report subject to minor adjustments.**
2. **Recommended approval of the ICB 1st July 2022 – 31st March 2023 Statutory Accounts and Annual Report subject to minor adjustments.**

8. Service Auditors Reports

8.1 Electronic Staff Record (ESR) Report

8.1.1 CL presented and explained that the ICB relied on a third party to run its payroll and that PWC LLP had been commissioned nationally to carry out a Service Auditors report to test the design and operating effectiveness of the controls put in place.

8.1.2 CL emphasised that the ICB that the ICB had its own controls in place around these services. CL highlighted that PWC LLP issued a qualified report relating to controls relating to security. Members requested that CL investigate the risk identified within the report. **Action: CL to investigate risk any actions being undertaken nationally and report back to members.** **CL**

8.2 Primary Care Support Services

8.2.1 CL explained that Capita Business Services Ltd provided third party Primary Care support services to the ICB and its partners and Mazars LLP was commissioned nationally to audit the services and test the controls in place. CL explained that out of the 15 control objectives tested, the auditors issued a qualified opinion based on two controls

8.3 Commissioning Support Unit (CSU) Report on Internal Controls

8.3.1 CL stated that CSU provided reporting and payments calculation system for General Practitioner (GP) practices, and Deloittes LLP was commissioned nationally to carry out a Service Auditors Report and test the design and operating effectiveness of the controls in place. CL highlighted that Deloittes LLP issued some recommendations. CL reassured that the ICB had developed its own controls relating to the payments being made.

8.4 Control Systems for Extraction and Processing of General Practitioner Data Services

8.4.1 CL explained that PWC LLP had been commissioned nationally to carry out a Service Auditors Report which covered tests on design and operating effectiveness of the controls in place. PWC LLP issued a qualified opinion relating to controls applying to user access and segregation of duties. CL reassured that this was being addressed.

8.5 Report on NHS Share Business Services Ltd Finance and Accounting Services

8.5.1 CL stated that NHS Shared Business Services provided finance and accounting services to the ICB and PWC LLP was commissioned nationally to conduct a Service Auditors Report on the design and operating effectiveness of the controls in place for the service. CL highlighted that the auditors established that in all material respects controls were operating effectively.

8.6 NHS Business Services Authority Prescription Payments Process.

8.6.1 CL stated that the Business Services Authority provided prescription payments processes for the NHS, and PWC LLP were commissioned nationally to report on the design and effectiveness of controls in place. CL reiterated that the ICB developed extra controls for all third-party services.

8.6.2 The service auditors' reports were collectively rated Green for Assurance and Green for management action.

8.7 RESOLUTION: The Audit Committee noted contents of the Service Auditors reports.

9. External Audit

9.1 Months 1-3

9.1.1 JM stated that Grant Thornton conducted the audit of the CCG Accounts in accordance with the law, the International Standards on Auditing (ISA) and the Code of Audit Practice. JM described how the process of transitioning from the CCG to the ICB and the two sets of Accounts arising from the transition. The two sets of Accounts posed a challenge to capacity for both the auditors and the ICB Finance Team.

9.1.2 JM explained that no significant weaknesses or risks were found regarding matters of governance, financial sustainability, or any other conduct which could compromise Value for Money (VFM). JM added that the adjustments recommended by the auditors were minor.

9.2 Months 4-12

9.2.1 JM stated that Grant Thornton evaluated the appropriateness of the ICB's accounting policies, accounting estimates and financial disclosures. JM noted the adjustment to the accounts relating to the s256 arrangements.

9.2.2 DPy stated that tests carried to gauge the ICB's VFM position established that the arrangements in place were secure and adequate. DPy outlined extra steps recommended by auditors to further improve the VFM regime. DPy highlighted that evidence demonstrated that the ICB was already progressing the recommendations. CL added that the final version incorporating the recommendations would be presented to the ICB Board.

9.2.3 JB commended the recommendations and management response. JB also suggested that data quality arrangements and policy in place should be subject to further review by internal auditors. **Action: UR, JT and AS.** Members rated Assurance Green and management action Amber.

9.3 RESOLUTION: The Audit Committee:

1. **Noted Grant Thornton's audit report on the CCG's Statutory Accounts for the period 1st April 2022 to 30th June 2022.**
2. **Noted by the Board, of Grant Thornton's audit report on the ICB's Statutory Accounts for the period 1st July 2022 to 31st March 2023.**

10. Internal Audit

10.1 Head of Internal Audit Opinion, 1st April 2022 – 30th June 2022 (CCG)

10.1.1 AS presented the report and stated that BDO LLP assessed the design and operational effectiveness of controls, including the supporting processes, and found controls to be applied consistently. AS further highlighted that the CCG displayed strong controls in relation to key financial systems, conflicts of interest and primary care commissioning processes. Significant assurance opinion on the design and operational effectiveness of the processes was provided for these audits.

10.1.2 AS stated that there was evidence that the ICB continued to develop and enhance mechanisms that promoted Assurance and oversight functions. AS commended that there was demonstrable evidence that the ICB followed up on recommendations from auditors.

10.2 Head of Internal Audit Opinion, 1st July 2022 – 31st March 2023 (ICB)

10.2.1 AS reiterated that the ICB processes and controls demonstrated consistency. AS highlighted several areas of good practice and that the ICB displayed strong controls in relation to key financial systems, conflicts of interest and primary care commissioning processes. Significant assurance opinion on the design and operational effectiveness of the processes was provided for these audits.

10.3 Progress Report

10.3.1 AS described the Internal Audit Plan for year 2023-24 and outlined various developments in the health sector. AS highlighted the growing emphasis on environmental sustainability and promotion of zero carbon.

10.4 ICB Governance

10.4.1 JT summarised the ICB Board structure, and the tools and process employed by auditors to assess Board effectiveness. JT explained that such exercise incorporated active engagement with a sample of members drawn from the Board. JT described the assessment outcome and explained that the Board scored 7.7/10 on effectiveness. JT reiterated that there was recognition that ICS Strategy required joint ownership. It was expected that Board effectiveness would continue to improve. JT explained that BDO LLP would continue to review capability, processes and structure of the Board as part of internal audit reviews.

10.5 Primary Care Commissioning Report

10.5.1 JT explained that all aspects and areas of the commissioning cycle had over the past four years been audited and the latest audit focused on the Workforce Training Hub. JT highlighted that the Gloucestershire Primary Care Workforce Centre, which was led and managed by Gloucestershire Primary Care Training Hub, was created to establish a central and easily accessible resource for Primary Care staff. The Hub was established in collaboration with the ICB and Health Education England (HEE). JT stated that the Workforce Training Hub scored highly on both design and implementation.

10.6 Data Security & Protection Toolkit

10.6.1 AS presented the Data Security and Protection Toolkit (DSPT) and explained that all organisations that had access to NHS patient information were required to provide Assurance that they practised good information governance and they should employ the DSPT to evidence good practice. AS clarified that the DSPT supported the implementation of the key security standards recommended by the National Data Guardian.

10.6.2 CL explained that the ICB worked with ICS health partners on cyber security as ICS health partners were largely on the same network and therefore policies across the system needed to be consistent. CL reassured that the ICB was working with partners to ensure that it fully complied with data governance requirements. Members discussed the structural pressures and concluded that cyber security Assurance should be flagged as Amber.

10.7 Internal Audit Follow-Up Report

10.7.1 JT presented the outstanding recommendations and highlighted that BDO LLP had recommended that the Personal Health Budget (PHB) procedure should be updated to

accurately reflect the process required to be undertaken when setting up a PHB. JT emphasised that feedback should be collated from stakeholders to inform changes to the draft and the update would be ratified by the ICB Board's System Quality Committee.

10.7.2 JT also highlighted that BDO LLP recommended that Emergency Preparedness, Resilience and Response/Business Continuity Plan (EPRR/BCP) champions be identified and provided with adequate training to fulfil the role. JT recommended that a work stream be established to develop a system wide EPRR/BCP approach. JT stated that a report relating to recommendations associated with the EPRR/BCP plan should be submitted. **Action: Report to be prepared and presented to the System Quality Committee Andy Ewens (AE) and CGi.** Members overall, rated Assurance Green and management action Green. **CGi**

10.8 RESOLUTION: The Audit Committee noted contents of the Internal Audit reports.

11. Risk Management Report

11.1 RB stated that the Governance Team had revised its communication with directorates and Risk Leads to improve efficacy in risk management. RB added that directorates would be assigned dedicated facilitators who would support risk management processes. RB highlighted those technical issues affecting the risk management platform had been addressed.

11.2 RB presented the ICB Corporate Risk Register (CRR), the Board Assurance Framework and the Corporate Risk Closure Request before the Committee. RB added that there was a total of 32 risks highlighted across the directorates. JS suggested that it could be beneficial to explore how risk reporting could further be remodelled to simplify interpretation.

11.3 CG commented that the reports should be remodelled to show age of the risk as this would enable the analysis of risks where mitigations were not progressing. **Action: RB to discuss with 4Risk consultants and explore options.** CG further suggested that arranging a workshop to further explore risk strategy options would improve outcomes. **Action: CGi and RB to plan a workshop.** **RB**

11.4 RB requested closure of Risk 1106 owned by Ellen Rule who heads the Strategy & Transformation directorate. Such risk referred to the terminated Cinapsis Advice and Guidance system associated with the case of *Consultant Connect -v- BNSSG, BSW and Gloucestershire ICBs.* CG acknowledged the Governance Team's hard work but stated that the CRR required further housekeeping because there were a few risks whose scores were below threshold. **Action: RB to remove from the Register risks below threshold.** Members rated Assurance Green and management action Amber. **RB**

11.5 RESOLUTION: The Audit Committee:

1. **Noted contents of the CRR.**
2. **Noted contents of the BAF.**
3. **Approved closure of Risk 1106.**

12. Primary Care Prescribing Rebate Policy Update

12.1 CGi presented the draft policy update and explained that the update was in response to the changing environment which demanded a joined-up system wide approach to health delivery services. CGi requested approval of the policy. Members discussed contents of the draft policy.

12.2 RESOLUTION: The Audit Committee approved the updated Primary Care Prescribing Rebate policy.

13. Self-Assessment Template

13.1 CGi stated that the Audit Committee appraised its own performance every year. CGi highlighted that this helped to clarify individual roles and the collective responsibilities of members. CGi emphasised that self-assessment improved knowledge of what was expected of members, and this helped members to become more effective in discharging their duties. CGi explained that there was a constitutional requirement for the Board and its committees to self-assess their effectiveness. CGi stated that the self-assessment tool previously employed appeared to have its limitations therefore there was a need to upgrade or replace the tool.

13.2 CGi presented and recommended a template deemed fit for purpose for all committees of the Board. Settling for this new tool was done in consultation with BDO LLP. CGi requested approval of the new template and if approved, the new template would form the cornerstone of an online self-assessment platform to be developed inhouse by the Communications Team. Members discussed and suggested a few changes to the template. The new platform would be available to the Board and all its committees, online.

13.3 RESOLUTION: The Audit Committee approved the Self-Assessment template for use by the Board and its committees.

14. Counter Fraud Report

14.1 PK presented and stated that the Local Counter Fraud Service (thereafter "Counter Fraud") had submitted a standard annual return to the Counter Fraud Authority (CFA). PK explained that the return rated organisations against 12 standards and that a compliant return was submitted. PK described how Counter Fraud was working with the Governance Team to work and improve on the risks associated with fraud.

14.2 PK added that such risks had, through collaborative effort, been reduced from Red to Amber. JS suggested that the risks in question should be brought before members and members should explore available options to support the mitigation of risks. **Action: PK to** **PK**

present a report before members, the fraud, bribery and corruption risks with a view on how to support the ICB move from Amber to Green rating.

14.3 PK outlined CFA's 2023-26 strategy and stated that any changes required to the ICB policy would be brought to the Audit Committee. PK summarised the investigations carried out by Counter Fraud. PK stated that Counter Fraud enjoyed a close working relationship with local police.

14.4 PK added that Counter Fraud's relationship with Gloucestershire's Multi-Agency Approach to Fraud (MAAF) Group was already producing good outcomes. PK presented the year 2022-23 Counter Fraud, Bribery and Corruption Annual Report which detailed the work completed in relation to governance, counter fraud, bribery and corruption. PK also presented the year 2023-24 Counter Fraud, Bribery and Corruption Workplan. Members gave an overall rating of Green for Assurance and Green for management action.

14.5 RESOLUTION: The Audit Committee noted contents of the Counter Fraud report.

15. Report on Procurement Decisions

15.1 DP outlined the procurement scheme relating to the provision of NHS111 Telephony and Primary Care Out of Hours services. DP added that the Commissioning Support Unit (CSU) had been appointed to support the procurement process. DP described the procurement scheme relating to the provision of Alternative Provider Medical Services (APMS) contract for Drybrook Surgery. DP clarified that a 6-month contract for Drybrook Surgery had been secured and a long-term contract was being pursued. Members rated Assurance Green and management action Green.

15.2 RESOLUTION: The Audit Committee noted contents of the report on Procurement Decisions and supported the implementation of the recommendations.

16. Register of Waiver of Standing Orders

16.1 DP presented 22 Waivers of Standing Orders and explained that approval had been sought and granted by the Operational Executive Committee. Members discussed contents of the report, and rated Assurance Green and management action Green.

16.2 RESOLUTION: The Audit Committee noted contents of the Waivers of Standing Orders.

17. Conflicts of Interest Procurement Training Programme

17.1 DP presented and stated that the case of *Consultant Connect Limited -v- BNSSG, BSW and Gloucestershire ICBs* had informed the need to improve conflict of interest training where procurement were being undertaken. DP explained that the training would be

designed not only for use by ICB staff but also for other staff involved with the ICB in procurement activities. DP explained that the ICB was working with the CSU to develop training material and modules covering procurement principles and approaches to managing conflicts. Members rated Assurance Green and management action Green.

17.2 RESOLUTION: The Audit Committee noted contents of the report on Conflicts of Interest Procurement Training Programme.

18. 2022-23 Losses, Special & Fruitless Payment Report

18.1 SR presented and stated that two Special payments totalling £3,250 were made during the period 1st April 2022 – 30thJune 2022. The payments related to a complaint brought before the Parliamentary and Health Service Ombudsman who upheld the complaint. SR highlighted that the most significant payment was subsequently made in the period 1stJuly 2022- 31stMarch 2023 under a Court Order, and the payment totalled £640,000. SR stated that lessons were learnt, a review was undertaken, and changes were being introduced. Members rated Assurance Green and management action Green.

18.2 RESOLUTION: The Audit Committee noted contents of the Losses, Special & Fruitless Payment report.

19. Debt Write-offs

19.1 SR presented and stated that an invoice was raised to a former member of staff relating to a salary overpayment. SR explained that the invoice became overdue, and it was escalated to a debt recovery company, but the debt recovery company could not trace the former member of staff. The debt was therefore written off.

19.2 RESOLUTION: The Audit Committee noted contents of the Debts Write-Off report

20. Aged Debtor Report

20.1 CL presented the outstanding debt as of 20thJune 2023. CL explained that the outstanding debt as per the Sales Ledger was £190,559 of which £42,003 was NHS and £148,556 was non-NHS. Members expressed satisfaction with management action and the low level of risk. Both management action and level of Assurance were therefore rated Green.

20.2 RESOLUTION: The Audit Committee noted contents of the Aged Debtor report

21. Any Other Business

21.1 There was a request that agenda items for future committee meetings were forward planned and scheduled and presented to the members. **GN**

The meeting ended at 4:25pm.

Date and Time of Next Meeting: 7th September 2023 at 09:30am (Hybrid).

Minutes Approved by the Audit Committee:
Signed (Chair):_____ Date:_____

AUDIT COMMITTEE 4th October 2023

ASSURANCE REPORT

Part I

Area	Assurance	Actions	Notes
Internal Audit	G	G	Audit work progressing well with 3 key reports underway to report to next meeting. Report on Data Security and Protection Toolkit awarded medium for risk and moderate for assurance. Discussion on environmental sustainability work and links with GCC and others to make most effective use of resources. Focus on 2 overdue recommendations, specifically completion of Personal Health Budget policy and implementation.
External Audit	G	G	Verbal update only. Mental Health Investment Standard work progressing – due for completion and reporting Feb 24 deadline. Planning for 23/24 audit underway. Confirmed improved capacity in audit team and potential impact of recent recruitment of specialist VFM auditor.
Risk Management	A	A	Discussion of current work underway to refresh BAF to reflect new strategic priorities; how risk management can reflect good practice from guidance and other ICBs approaches; review of risk system and spreadsheets for reporting and how to identify and reflect system and high-level corporate risks across the ICS. Further risk workshop to be held in November. Development of risk reports and BAF to commence with areas covered by People and Resources Committees. Further report on progress to come to Dec meeting.
Counter Fraud	G	G	Approved revised counter fraud policy. Noted collaborative work with Internal Audit on Personal Health Budgets report and ongoing work to improve risk management rating from amber to green for next years submission. Also noted continuing development of local links with other agencies including Police.
Conflicts of interest	G	G	Noted achievement of targets for numbers of staff of all grades completing declarations of interest. Commended the good work in ensuring targets met.
Procurement	G	G	Noted procurement decisions and waivers (low value)
Financial Management	G	G	Noted debtor reports. No write offs or special payments proposed.
AOB	N/A	N/A	Committee effectiveness questionnaire to be made available to members to complete.

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Public Session

Thursday 3rd August 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 (Chair)	CG	Non-Executive Director, NHS Gloucestershire
Ayesha Janjua	AJ	Associate Non-Executive Director, NHS Gloucestershire
Dr Andy Seymour	AS	Chief Medical Officer, NHS Gloucestershire
Cath Leech	CL	Chief Finance Office, NHS Gloucestershire
Prof Jane Cummings	JC	Non-Executive Director, NHS Gloucestershire
Marion Andrews-Evans	MAE	Chief Nursing Officer, NHS Gloucestershire
Mary Hutton	MH	Chief Executive, NHS Gloucestershire
Participants Present:		
Becky Parish *(part-meeting)*	BP	Associate Director of Patient Engagement, NHS Gloucestershire
Carole Alloway-Martin	CAM	Councillor, Gloucestershire County Council
Christina Gradowski	CGi	Associate Director of Corporate Governance, NHS Gloucestershire
Dr Olesya Atkinson	OA	GP and Clinical Director of Cheltenham PCN
Declan McLaughlin	DM	Head of Primary Care Contracting, NHS Gloucestershire
Helen Edwards	HE	Associate Director of Primary Care & Place, NHS Gloucestershire
Jeanette Giles	JG	Head of Primary Care Contracting, NHS Gloucestershire
Julie Symonds	JS	Deputy Chief Nursing Officer, NHS Gloucestershire
Jo White	JW	Associate Director of Primary Care & Place, NHS Gloucestershire
Nigel Burton	NB	Healthwatch Representative, Healthwatch Gloucestershire
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
In attendance:		
Dawn Collinson	DC	Governance Support Officer
Andrew Hughes	AH	Associate Director, NHS Gloucestershire

1. Introduction & Welcome

1.1 CG welcomed members and attendees to the meeting and noted that this would be the last meeting conducted from Sanger House.

1.2 There was one member of the public in attendance.

2. Apologies for Absence

2.2 Apologies were received from Helen Goodey (HG).

2.3 The meeting was confirmed to be quorate.

3. Declarations of Interest

3.1 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.

4. Minutes of the Previous Meeting

4.1 The minutes of the previous meeting held on 1st June 2023 were approved by the Committee as an accurate record of the meeting. The Chair noted that he would like these turned around in a more timely fashion.

5. Matters Arising and Action Log

5.1 **17/04/23, Item 9.2 - Risk Report.**
The Chair was content that this had been actioned. **Item Closed.**

17/04/23, Item 14.1 – TWNS PCN Evaluation.
To be brought back to the October 2023 meeting. **Item to remain Open.**

01/06/23, Item 8.12 – Differences in Local & National Reporting.
Work ongoing on data inconsistencies. Possibly revisit in the October 2023 meeting. HG had written to the ICB Board in relation to data discrepancies where NHSE use national definitions in relation to GP numbers which had given a different perspective at a meeting where members of the Primary Care team had presented. This paper was in draft and awaiting final sign off. **Item to remain Open.**

01/06/23, Item 11.7 – Patient Survey Results.
To be discussed at today's meeting. **Item Closed.**

01/06/23, Item 11.8 – Data for Pharmacy, Optometry & Dentistry.
To be discussed at today's meeting. **Item Closed.**

6. Questions from the Public

6.1 There were no questions from members of the public.

7. Application from Yorkley and Bream Surgery to change the Practice Area

7.1 CG welcomed JG who gave a verbal overview of the application from Yorkley and Bream Surgery who wished to change their practice area.

7.2 JG informed the Committee that Yorkley and Bream Surgery had a list size of 8,524 and the practice was part of the Forest of Dean PCN. They had two sites, the main one being at Yorkley with a branch surgery in Bream. They had five partners and three salaried GPs and they were a well-established, stable partnership with a reputation for retaining GP trainees. There were 900 patients in the area to be removed and the practice's intention was to retain those patients and not to deregister them in either the short or long term, recognising that continuity of patient care was very important.

7.3 Babies born to those currently residing in the red area of the map would be registered, but students returning from university would not be registered. Patients new to the red area will no longer be able to register at the Practice, but there are five other practices available to register with. No nursing or residential homes would be affected by the proposed change.

7.4 Engagement and consultation had been as per the ICB's Standard Operating Procedure (SOP) and the Practice had worked closely with Becky Parish and her team in the

development of the survey. Responses from 600 people had been received and the Consultation Report was shown in Appendix 2. Additional surveys had been sent to local groups such as Yorkley Community Centre, Bream Rugby Club and others. A Patient Participation Group (PPG) was not in situ at the time of the survey but this was now in the process of being established and as a result, there were around 160 patients expressing an interest in joining. Despite not having a PPG in place, it was felt that the views from a wide range of patients had been captured.

7.5 Proposals were sent out to all neighbouring Practices, Healthwatch, the County Council and other areas. Feedback had been received from Blakeney Surgery, Severnbank Surgery, Healthwatch, the Local Medical Committee (LMC) and Hereford and Worcestershire ICB. The responses had been shared with the Practice and they had returned their comments. After receiving the practice's comments, the Local Medical Committee (LMC) had no concerns regarding the closure of the branch Surgery.

7.6 The Practice had stated that they had no intention to promote the boundary change actively or aggressively; it was difficult to quantify the number of patients who might register but future planning was being made for this around the use of space and staffing. The partners were keen to future-proof the Practice by bringing in additional staff, having recognised the potential demand for services in the proposed increased Practice area, and also being mindful of the numerous new building projects in the surrounding area.

7.7 A Quality Impact Assessment had been conducted by the ICB Quality Team who noted that:

- There were no patients in nursing and residential homes falling outside the proposed amended Practice area.
- It was unlikely that a change would have a negative impact on patient safety, safeguarding or infection, and no issues had been raised regarding access to medicines or pharmacy provision.
- There was a negligible risk that additional patients registering with the Practice would increase clinical and workforce pressures, but the potential requirement for additional staff would be planned in.
- The proposal was unlikely to have a negative impact on compliance with NHS Constitution partnerships.

7.8 This Practice proposal was first discussed at the Primary Care Operational Group (PCOG) on 9th May 2023 but there had been reservations regarding a potential deregistering of children at three years of age, the size of premises and the impact on the smaller Practices in the area. Clarification had been sought from the Practice and brought back to PCOG on 11th July 2023. Responses received had been discussed and the following had been noted:

- Babies born to patients currently residing in the area would be registered with the Practice who could not foresee a situation where a three-year old patient would be asked to register elsewhere.
- The Practice had confirmed that they expected any additional patients could be accommodated with enough existing clinical capacity in the main and branch Surgery premises which would accommodate any increase in local population size.
- The Practice again reiterated that they had no intention to aggressively advertise the changing boundary and saw themselves very much as part of a collaborative, forward-thinking member of the Forest of Dean PCN. Neither did they have any intention to destabilise the local Practices by changing the boundary, with nothing to be gained from doing this.

7.9 Summary:

- The proposed change in the Practice area will place both the Yorkley and Bream sites more centrally within the revised boundary;
- Patients new to the area will have a choice of other Practices and by increasing the Practice area, more choice could be offered to those patients around registration;
- It is anticipated that by increasing the Practice area, this will offer more security to the existing workforce and help attract staff for future succession planning.
- Should the proposal be approved, the Practice had confirmed they had no intention to remove patients in the short or long term and were committed to providing continuity of care for their patients.

7.10 CG asked AS, as Chair of the Primary Care Operational Group (PCOG), whether he had any concerns. AS said there had been some points of clarification following first scrutiny of the proposal, which had since been satisfied. On second examination, the PCOG had been happy to sign off the proposal.

7.11 AJ referred to inconsistencies such as the Practice having said the change would give more security to current staff and would enable them to attract future new staff whilst also stating they had no intention to destabilise neighbouring smaller Practices. AJ wondered how this inconsistency was being approached. JG said this was not something that the Practice would envisage happening very quickly; rather it would happen over a period of time. There would be no aggressive promotion of the change to the boundary and any new patients coming into the area could examine NHS Choices to see which Practices covered their particular address.

7.12 JW said when a Practice was keen to extend and grow, particularly in the current climate, then as long as the criteria was being met by that Practice, then the ICB should support these practices to move forward. This particular Practice was both well run and well organised and they continued to consider their patients, hence the support for the proposal put forward.

7.13 CG said that the strategic intent of the Practice was not clear, with expansion being fine long term, but in the short term their patient list size may be penalised. It was noted the Practice would have to apply for new dispensing rights for any areas within the revised boundary, in line with pharmaceutical regulations. CG said this could result in Blakeney becoming destabilised due to Yorkley and Bream Practice having pharmaceutical rights on that boundary change for some considerable time. CG stated that he felt uncomfortable with this Committee supporting that particular aspect.

7.14 AJ supported the Practice expansion but still did not understand the case for change. Some patients would need to travel further and one patient said that it had not been made clear as to why the change was being proposed. The proposal would need to ensure that smaller practices did not lose their viability, and the dispensing rights control was a way of ensuring this. It was considered also that the Practice might be trying to become a “super-practice” to ensure their own future-proofing.

7.15 JW said that work was ongoing in the Forest of Dean around resilience and stability for Practices, as the future landscape was uncertain and said it was unlikely that some of the smaller Practices in the area would be destabilised as a result of this boundary change. The Practice were probably trying to embed any changes in order to better suit the new landscape more favourably.

7.16 MH said she did not see how bringing in dispensing rights would help to safeguard the

smaller practices. CG explained that one of the negatives for attracting people to go from the new area that was being expanded and joining Yorkley, would mean that the patient would not get dispensing from Yorkley Practice. This was a deterrent in the short term. CG said the economic landscape in the Forest of Dean was fragile enough without seeing further destabilisation. DM said he had looked into this and the advice he had received from NHSE given current guidelines, was that it would be unlikely that the Yorkley Practice would have new dispensing rights approved in the expanded practice area.

7.17 JC noted the following key issues:

1. Context and reason for the proposal changes had not been made clear with some patients having strong feelings about this change.
2. There needed to be assurance that any potential increase in new patients could be managed without detriment to the existing patient list.

7.18 AS posed the question as to whether there was a good reason why this request should not be approved. CG stated he would prefer to see the Forest of Dean develop slowly; however, AH said that significant changes had already been taking place in the area.

RESOLUTION: The Committee

- ***Noted the recommendation from the Primary Care Operations Group (PCOG);***
- ***Approved the recommendation for Yorkley and Bream Surgery's request to change their Practice boundary and requested that comments from this Committee meeting be fed back to Yorkley and Bream Practice.***

8. Application to close White House Practice Branch Surgery at Blockley

8.1 JG introduced a verbal update regarding this item. JG informed the Committee that White House Surgery have a relatively small list size of just over 5000 and currently have two sites. Running these two sites is challenging for a small practice, both financially and resourcing personnel. The location of the premises and the patient spread is shown on the map in the paper. Patients have the option to register with alternative Practices in the area.

8.2 Appropriate patient engagement was conducted and the ICB also contacted neighbouring Practices and all other relevant organisations as part of the Standard Operating Procedure (SOP). Chipping Campden and Stow Practices support the proposal for closure. Healthwatch and the Local Medical Committee (LMC) were also asked for responses and these are included in the paper.

8.3 In terms of the responses, the main concern was dispensing and the Practice said they will provide a service to those unable to collect prescriptions from Moreton-in-Marsh. As another alternative, patients can also choose to have their prescriptions delivered from another NHS prescription delivery provider.

8.4 The White House Surgery informed patients at the time that the closure was a consequence of infection control restrictions due to the Covid pandemic but Blockley branch has since remained closed for three years and did not reopen after the pandemic.

8.5 The main reason for asking for the closure is that the building, after being inspected by the Infection Control Officer was deemed to be too small for adequate infection control measures and nothing would make it compliant. This is a converted building and there was a risk of it being closed again should there be another similar pandemic event. An alternative site had not been identified and DM said further spending involving

improvement grants, would not be appropriate in terms of high costs involved in making this building compliant.

8.6 The building was a converted house situated on a very steep bank and driveway, and the entrance doors are exceptionally narrow, making it unsuitable for both wheelchair user access and those living with disabilities to gain access. There is also very limited parking, offering just 2-3 spaces before vehicles have to then use roadside parking on a small lane.

8.7 White House Surgery said during and since Covid, working practices had changed and there are now many more telephone consultations which had reduced the need for physical patient space across the Practice as a whole.

8.8 A Quality and Sustainability Impact Assessment had been undertaken and as the branch closed when Covid commenced, no impact on patient safety was identified in the supporting information. The proposal should not impact negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards.

8.9 The closure of the branch surgery will contribute to a reduction of access and patient choice to residents of Blockley. However, patients were able to access services via the main surgery following the Covid pandemic. There will be no effect on the provision of safeguarding to both adults and children and the Practice and various patient engagement surveys obtained patient responses regarding the closure of the Blockley Branch.

8.10 The closure of Blockley was discussed in the Primary Care Operational Group (PCOG) meeting on 11th July 2023 and the points made in Items 8.6 and 8.7 were noted. PCOG's decision was to recommend the closure of the branch surgery at Blockley. JG summarised the reasoning for closure as above and said the permanent closure would increase White House Practice's resilience and sustainability. The Practice has addressed the main concerns of dispensing of medication for patients.

8.11 With the exception of this application, there are no list closures, mergers or other branch surgery applications in this area of Gloucestershire. For those patients wishing to access GP surgeries at an alternative practice, options are available. AS had nothing to add from a Primary Care Operational Group viewpoint.

8.12 CAM asked whether the White House Surgery had enough capacity to deal with the closure of the branch surgery. JG said that as far as she was aware there was nothing on the horizon around new buildings that would increase the population in that area.

8.13 JC said that for all the reasons stated, and if the prescribing was not an issue, then there would be no reason as to why the Committee would not support this closure.

8.14 CG queried the postal prescribing service and whether it worked satisfactorily. JG assured CG that if good procedures were in place, this worked very efficiently.
Action: Primary Care Team to organise a site visit by a team member to White House Practice. **PC**

RESOLUTION*: The Committee reviewed the application and supporting information and unanimously approved the closure of the Branch Surgery at Blockley.*

9. <u>PCN Quality Improvement - Proposals and Process</u>

9.1 CG introduced JW who gave a verbal overview of Primary Care Network (PCN) quality

improvement proposals and processes, which were supported through local funding, informing the Committee that there has been a slight change in focus around the refunding of the PCN Quality Improvement initiatives this year to ensure that the initiatives will better meet the ICS objectives as well as patient need in each PCN, identified through a Population Health Management approach. The paper was to: agree the process, make the Committee aware of where things stood in that process, and the criteria being used this year.

9.2 The report provided details of the PCN Quality Improvement (QI) Projects approval process and outlines key emerging themes from PCNs proposals that have been submitted to date. The report will ensure appropriate governance for effective use of Quality Improvement funding and to make a difference to PCNs patient populations.

9.3 The Business Intelligence team have delivered training to the Quality Improvement Project Managers on outcomes and measures to ensure that data sources are identified to enable them to evaluate their projects and to link in with the Integrated Locality Partnerships (ILPs). Proposals will go to the Operational Executive team to ensure that they meet other ICB projects, initiatives and direction of travel. Many of the projects are supported by the Virtual Whiteboard project which is of great benefit around frailty. Updates to the Committee will be shared against delivery and expected outcomes and evaluations as the projects progress.

9.4 AJ asked for assurance that PCN staff had the capacity to be able to do this work. AJ also asked how the PCNs would be encouraged to align to the ILPs so that there would not be overlaps in the work. JW said it would be important to complement and build on work but to avoid duplication. Coding and reporting will be examined as the projects proceed. PCNs will be expected to share progress on their projects at ILP meetings.

9.5 JW said GPs have been presented with an opportunity to do something differently and there was great enthusiasm around this, which was reflected in the recent PCN away day. OA said that the majority of the frustration in Primary Care related to national contract issues and the Quality Improvement projects were a breath of fresh air bringing excitement and positivity to the PCNs. Eight PCNs have shared proposals which have a frailty theme but it was important for the other PCNs to deliver frailty-related proactive care because this links with the Urgent and Emergency Care programme on frailty.

9.6 HE said that more alignment was coming through with the ILPs, particularly around the prevention agenda. The wider partners already have a range of programmes, schemes and services in place. The difference is that PCNs are able to use their registered list, using the Population Health Management approach to identify those patients that would benefit and then work with the wider partners to connect those patients more effectively than had been done previously.

9.7 MH informed the Committee that Primary Care demand is up by 18% and the contract value this year is lower than inflation, which is not good and cannot continue. The ICP Strategy clearly sets out that localities are one of the areas for transformation. The Frailty Prevention workstream should sit firmly in localities which is where the registered patient list sits. The position on frailty should be overarching and resources should be matched to the need. There is now a model for this with frailty being the first, followed by other programmes.

9.8 CG expressed disappointment in not having been invited to the PCN away day as he felt this was a missed opportunity to have been able to speak to PCN Directors and others. OA apologised for this oversight and noted that CG's successor as Chair of the Primary Care and Direct Commissioning Committee, would be invited to any future events.

RESOLUTION*: The Committee approved the governance process for PCN Quality Improvement Bids.*

10. Delivery Plan for Recovering Access to Primary Care

10.1 JW introduced the Delivery Plan for recovering access to Primary Care. The recovery programme will require intensive resources in practices, PCNs and the ICB to be successful. It is dependent on practices engaging with the support available which mainly focusses around digital tools and telephony and moving towards a modern general practice model. It does not properly address the significant issues facing Primary Care in terms of staffing, demand and financial issues.

10.2 The ICB will receive £1.85 million in 23/24, which is less than last year, for system development but there is massive commitment against this, involving transformation, workforce programmes, GP IT, estates, training hubs, and GP local retention.

10.3 An update will be taken to the ICB Board in October/November 2023 and then another update for April/May 2024 to reassure NHSE how the ICB are performing against the plan.

10.4 There are risks around sufficient funding not being available to support the extensive plan; practices may not be stable enough to engage and patient expectations around access are likely to increase through this national commitment. The ICB has also recognised it is challenging for PCNs to support the access work to achieve the Investment and Impact Fund (IIF) since this is mainly individual Practices core business and the funds available should be passed directly to support Practices..

10.5 CG found the report slightly confusing as was unsure as to whether it was for practices, PCNs or both. OA agreed and said it felt as though definitions of practices and PCNs are being used interchangeably but most of the work was practice based. There was an opportunity to look at taking advantage of shared learning. Practices will wish to retain their autonomy but reporting will be at a PCN level.

10.6 CG stated that there were direct instructions coming from NHSE about how PCNs should operate and how the processes should be conducted which was something that needs be corrected with the regional team. PCNs report to the PC&DC Committee which is delegated from the ICB. There is a lack of understanding around Governance operation. OA agreed that things were bypassing the ICB and coming straight from region to the PCNs instead of going through the correct channels.

10.7 MH requested that this be documented and said she would take this back to region as according to the Hewitt Report the ICB are supposed to slim down the amount of contact in order to simplify the way people work and using numerous sources was not meeting this criteria. Things that are documented can be changed. **Action: JW to bring an update on recovering access to Primary Care to the next PCDC meeting prior to being presented to the ICB Board.** **JW**

10.8 CG referenced Patient Participation Groups as part of this work and BP said that a survey of Practice Managers had taken place earlier in the year and work is ongoing with 15 Practices to help the reinvigoration of their Patient Participation Groups (PPGs). All Practices are recording that they have some kind of PPG in their E-Declaration and the ICB are actively supporting them. BP said she had just returned from a PPG in the Forest of Dean where there had been 88 Expressions of Interest in joining a Forest of Dean practice PPG and 35 people had turned up spontaneously today, for an open meeting which was very encouraging and unexpected. Some Practices are still

somewhat reluctant to engage in PPGs but will continue to be supported by the ICB.
Action: BP to bring back a report on Patient Participation Groups to a future Committee meeting. **BP**

RESOLUTION: ***The Committee noted the Delivery Plan for Recovering Access to Primary Care.***

11. Primary Care Risk Report

11.1 JG said there was currently one risk on the corporate risk register relating to provision of Primary Medical Services for Practices that are facing resilience challenges. This was mostly due to partnership changes or impending partnership changes, but there was growing concern around general workforce resilience and retention. The GP Locum shift fill is becoming more difficult and expensive. There were also financial challenges being faced by practices.

11.2 In terms of controls, there is ongoing support for all practices. The Gloucestershire workforce status is reviewed on a monthly basis with updates to the Primary Care Operational Group (PCOG) and to this Committee. Extraordinary meetings are held as required, and monthly reviews of practices are conducted where there are resilience concerns.

11.3 Colleagues are working very hard with PCNs in terms of their Additional Roles Reimbursement Scheme (ARRS) planning to make sure this is optimised. There is continued focus on supporting existing programmes and developments of new programmes and initiatives to support both the retention of existing roles and recruitment to new roles in Primary Care. The BI team are working on a dashboard with a focus on workforce numbers. This risk continues to be reviewed on a monthly basis and updated. CG said this seems to be trending in a worse direction and needs to be kept under review.

11.4 OA said there was concern about the level of Additional Roles Reimbursement Scheme (ARRS) funding post March 2024. This is a national issue, which takes a lot more top up to sustain the roles, because most of them will expect salary above what can be claimed. Everyone is working very creatively to use other funding streams. At the moment there is no information from NHSE as what this will look like, so potentially this could be a massive risk. OA said this will go to the Strategic Group to be discussed and can be brought back to the Committee if required. CG said NHSE are committed to the Scheme, although details are not yet know, and said funding will continue.

11.5 AS raised a risk around GP training and noted that whilst it was good news that more people wanted to become GPs, there was no training having been put in place for them which was worrying due to there being a surplus of people wanting to become GPs this year. AS said solutions are being examined. CG thought this was a lower level of risk but nevertheless was still a risk. **Action: GP training to be noted on the Risk Register at the next iteration.** **CGr**

RESOLUTION: ***The Committee noted the content of the Risk Register.***

12. Highlight Reports

12.1 JW informed the Committee members that these reports covered practices, PCNs, POD and ILPs and are sent to the Board for information. JW highlighted that there are patients still arriving at the contingency hotels and there are 60 patients who have recently been registered from the Wilson Centre. More information is awaited on the flu

and Covid vaccines for the autumn.

12.2 CG asked whether things had changed regarding the contingency hotels since the report had been written and MAE responded that nothing had changed and there was a summary in the Quality Report about the hotels. This was still a big pressure on all the services which would be picked up in MAE's report.

RESOLUTION*: The Committee noted the content of the highlight reports for PCN, General Practice and Pharmacy, Optometry & Dentistry (POD).*

13. Performance Report

13.1 JW said this report aims to pull together all the targets and performance indicators for primary care and was in development. It is still too early in the year to be able to get any meaningful activity data to inform the report against annual targets but there will be more activity moving towards the autumn.

13.2 The Network Contract DES specifications and their requirements implemented in previous years are still in place for 2023/24. To support monitoring of these specifications, it is planned to report on numerous indicators relating to each of the specifications listed on Page 5 of the Report.

13.3 The PCN Additional Roles Reimbursement (ARR) Scheme is reported here and the Serious Mental Illness Physical Health Checks and the Learning Disability annual health checks met the targets.

13.4 Regarding GP appointments, JW explained that some deep dives are being undertaken in this area to analyse the data. Overall, Gloucestershire GP practices are 18.1% ahead of 2019 activity which is high in comparison to other areas. Same day and face to face appointments are at good levels compared to other areas but the 14 day and 28 day waiting times were reported as not as good. It is an area being examined locally and regionally across the South West to understand what was driving it and how improvement could be made...

13.5 CG said that the waits were in line with what could be expected and this was reasonable for someone with a minor complaint, feeling that Primary Care should look beyond the numbers. OA felt that this demonstrated a good clinical model, as it wasn't unreasonable to have a two week wait for minor complaints, which would permit prioritising more urgent cases.

13.6 AS agreed and said that it was a very crude measure taken in isolation. Gloucestershire has a low attendance in ED and low daytime 111 usage because these patients were being seen in Primary Care. OA said the Patient Survey also reflected high satisfaction. MH said that more needed to be published about the low attendances in ED and MIU and low use of 111 and Out of Hours. It was very disappointing to see Gloucestershire being publicised as being the worst in the country for the two week wait but came top in the country out of the ICSs on the GP Survey for Patient Satisfaction. It was somewhat disappointing to have those two publications coming out at the same time. It was also discouraging for Practices who are working hard to keep access levels up. MH would prefer to believe the feedback from the patients.

13.7 BP referred to the GP postal survey and said just for the record, our overall experience rating was 9% better than the national average in Gloucestershire and this was really important to note. It was very unfortunate that those two pieces of data came out the same day. There are some lessons there potentially for NHSE and for the people that

published the GP Patient Survey results, which were delayed by a week possibly to do with the 75th birthday of the NHS. Next year steps can be taken to ensure results are not delayed again.

13.8 CG noted that in 2.1 of the Report, the word Podiatry was being quoted instead of Pharmacy, which will need to be changed.

13.9 CG asked whether Practices who were consistently low performers could be followed up and assistance provided to bring them to the required standard. JW said that data was now being presented for review at a Practice level to look at the indicators and some practices have been encouraged to take up the national General Practice Improvement programme offer. Some Practices had mixed indicators with some being higher than others in the same Practice and again, data is being analysed to better understand this. The new Practice General Practice model had been implemented early in some practices but was found to be hard to sustain given demand, workforce and financial pressures and some Practices had moved away from it, which could have had some effect.

13.10 AS pointed out that areas of deprivation had 14% more patients with more complex needs, compared to the more affluent areas and so naturally they would struggle to meet levels of expectation.

Resolution: The Committee noted the content of the Performance Report.

14. Primary Care Quality Report

14.1 MAE updated the Committee members on the Primary Care Quality Report. There was some pleasing news to share, in that the joint Targeted Area Inspection letter was published today. This inspection was carried out collaboratively between Ofsted, CQC and the Police Inspectorate and it was really pleasing to see that this letter gives considerable reassurance around the safeguarding of children in the county. MAE stated that, as chair of the Partnership Executive, she was pleased with this and also to see that governance arrangements were also in order. CG said he had read this letter earlier in the day was pleased with the outcome.

14.2 MAE informed the Committee that she had interviewed, and successfully appointed to the Designated Doctor for Children in Care role. There was , however, no Designated Doctor for Child Death in post; AS is involved at looking into options around this vacancy.

14.3 The Spring Covid booster campaign was pleasing with a 78% uptake across the over 75's and those who are immune-compromised. This was significantly above the national average and Gloucestershire is one of the top-performers in the uptake rate which was down to the commitment of the PCNs and the vaccination team from GHC. Currently the six month to four year-olds with complex medical conditions are being vaccinated and again, figures are far higher than national expectations with 92 appointments having already been booked.

14.4 Guidance has been received on influenza vaccination for the autumn which is for the over 65's, those with chronic conditions and school-age children. Covid guidance is not yet out which is inconvenient around planning for the winter. Vaccinations will start later in the autumn and there is not yet a GP contract for the vaccination service which is still being help up by the Department of Health which is concerning and GPs want to know the detail of this before they give final commitment around undertaking that service. Anyone proceeding to administer vaccines prior to the contract letter being finalised will not be paid for this service, with appointments unlikely to be available before October.

14.5 A workshop would be conducted around the new Patient Safety Incident Response Framework (PSIRF) which will ensure a common approach countywide. There was no requirement for Primary Care to participate in this new arrangement, but they would be encouraged to do so in order to benefit from the valuable learning opportunities this Framework would offer.

14.6 JS informed members that the Warning Notice issued to PPG reference the OOH service has now been lifted and close working continues with the team to ensure the outstanding actions against the Action Plan are completed. JS is meeting with the CQC team next week to discuss a review and a repeat visit to ensure that some of the more important points are now finalised. A full and thorough repeat inspection will take place in early spring of 2024.

14.7 The number of migrants in country now stands at 437. The migrant health nursing team and GP Practices are heavily engaged. Some 25% of the migrants would require some support from mental health and therapy services as many are psychologically traumatised by what they have been through. There is a risk of communicable diseases due to exposure of infection and being in close proximity for a period of time in the hotels, leading to continuous monitoring taking place, as well as looking after the new babies and their mothers.

14.8 BP informed the Committee members that the Patient Advice and Liaison Service (PALS) were fully recruited to the People's Panel for Gloucestershire with over 1000 people, wth a good demographic spread. The PALS Team had made contact with them and they would be approached in the autumn with the first series of questions to ask what was important to them about health and care in Gloucestershire.

14.9 Regarding the handover of Pharmacy, Optometry and Dentistry to the ICB, activity has increased and BP said this would be monitored against the capacity of the Team to ensure that any necessary adjustments are made.

14.10 Gloucestershire ICB were the first to complete the new process for complaints handling around Pharmacy, Optometry and Dentistry (POD) and MH was the first person to send out a complaints response letter assisted by BP and her team. HE and her colleagues worked collaboratively with BP on a suitable response for callers who were concerned about access to dentistry. This was fed back to the regional workshop and Gloucestershire ICB were the first to produce a positive, useful message. That message was now being shared across the region for others to use within the context of their own systems.

14.11 A priority area for Healthwatch Gloucestershire this year was improving access to GP services. Access to GP services remains one of the greatest areas of concern for local people. BP and HE would be working with them around GP premises and this would be carefully managed. This could also potentially be extended to Pharmacy.

14.12 BP said that Gloucestershire had maintained its positive Patient Experience level and five Practices in the county had shown a 10% improvement but 8 had seen a 10% drop in the overall satisfaction rate. A couple of Practices had seen a 20% drop from their patient group and the team was working closely with them. Data from the Patient Survey would be examined and a workshop would look at characteristics and demographics of the respondents so that information could be provided at a PCN and Practice level to help with quality improvement. The Patient Participation Groups are very interested in this and are keen to take this back to their groups to discuss improvements.

14.13 OA referred to PALS feedback in Section 2.6 of the Report around length of time to access a non-urgent GP appointment asked whether data could support the fact that the county were doing well. OA requested that if the data was available that this could be shared.

14.14 BP said that patients when asking about this were given some context in that there are good numbers around urgent appointments, but there was a common theme around the ability to access non-urgent appointments more swiftly, hence the involvement of Healthwatch Gloucestershire this year.

14.15 MH said that funding was not comparable to demand, which was up by 18% in comparison to 2019/2020 has inevitably led to dissatisfaction with access to routine appointments and arising to conflict between delivery of urgent and routine appointments. Work will be carried out to see why this concerning peak has been sustained and what was driving it. It was thought that following Covid, demand would stabilise but this has not been the case.

14.16 Referring to Item 14.1, OA said Practices should be given the opportunity to know how they were performing and whether they were in the top range or could improve and to learn from their progress. BP said she knew which of the practices were doing well, but this could be down to demographics, amongst other things. NHSE have anxieties about rankings, but for PCNs who have similar demographics, it could lead to interesting conversations to see where they are highs and lows within the PCNs. AS said that the two highest PCNs in the country were West Kensington and Salcombe, demonstrating that demographics do play a part in achieving higher rankings.

RESOLUTION: ***The Committee noted the content of the Primary Care Quality Report.***

15. Financial Report

15.1 CL informed the Board members that within the finance report for the end of June period there are a number of variances.

- Additional Roles and Responsibilities Scheme (ARRS) funding. The year to date overspend variance should resolve once additional funding has been drawn down from NHSE
- Enhanced Services – this was currently underspent; however, work was underway to assess whether there were claims outstanding from practices which would reduce this underspend.
- Premises costs were increasing and now show an overspend
- Other GP services were underspent this included areas such as claims for maternity and sickness, which could vary.

These variances were being reviewed to validate the year end forecast position of break-even against the delegated Primary Care budget. There remained a risk relating to the Investment and Impact Fund (IIF) funding where spend could be higher than budget. The remainder of the budget was under review to ensure this risk could be managed.

15.2 CG asked when the Committee would see a finance report on Pharmacy, Optometry and Dentistry (POD) and CL informed the Committee members that this reporting would come to the next Committee meeting now that monitoring information was starting to be received.

Resolution: The Committee noted the content of the Financial Report

16. ICS Transformation Programme & ILPs Highlight Report

16.1 HE gave a resume of the high level report which had been presented to the ICB Board. HE had spoken at the last meeting about three local projects having been presented to the Gloucestershire Integrated Care Partnership:

- Tewkesbury Frailty Project
- Inner City Smoking Cessation
- Children and Young People's Mental Health and Wellbeing (this was a good example of where the PCNs and the ILPs work very closely together).

Since then, Helen Goodey and Bronwyn Barnes had presented to the International Foundation for Integrated Care, who held their summer school in Oxford so the Primary Care Team were able to share with them some of the collaborative work that had been done.

Opportunities were taken to share the work that the Primary Care Team were doing, both with the partners, and with the PCNs and ILPs across the system. Another showcase event similar to that presented in July 2022, would be held in November 2023.

16.2 A key piece of work was working with the District Councils and partners in terms of the use of this year's non-recurrent Strengthening Local Communities grant. The funding in previous years had been disseminated through districts using a Grant Agreement and this would be the same process used this year, but with a far closer alignment to the Integrated Locality Partnerships (ILPs) and to the Integrated Locality Partnership priorities as well as seeking to build community capacity by supporting Voluntary and Community Sector organisations in those particular geographies.

16.3 The Primary Care Team were working with Business Intelligence colleagues to ensure that the impact of the funding could be evaluated. Some of that impact would be around some of those harder system metrics as would be expected around a health and care system and some would be around measures of health and wellbeing. Partners were very good at collecting that data and Primary Care needed to become better at utilising the data that was available across the system. Some of this information would be the softer type, such as patient stories, which were also insightful.

16.4 Work on the community Health and Wellbeing Hubs continued where these are placed in four of the areas of greatest deprivation in the county in the Core 20 areas; the Forest of Dean are due to open in Cinderford in September 2023.

16.5 There was an example in the Report of proactive care in Cheltenham with three PCNs working in wider partnership but the Quality Improvement proposals have not yet gone through the Governance process. There was a similar focus in the Forest of Dean and North Cotswolds.

16.6 HE pointed out the work conducted across the Stroud Practices as part of Carers Week, where texts were sent out to patients with coding automatically taking place if patients identified themselves as carers. This identified an additional 170 carers for support from that process. This exercise would be shared across the county enabling other practices to adopt this process should they so wish.

16.7 The risk was noted around the limited capacity in Primary Care impacting the agenda on Place and Partnership in some of the geographies. There were real issues and concerns around Primary Care capacity which were well noted, especially around burnout, so

whilst there were a lot of exciting things on the horizon, staff still needed to be supported around wellbeing and preventing burnout.

16.8 HE said that Primary Care were now being given opportunities in which to work differently, although HE recognised that these projects were often done over and above the work already being undertaken.

RESOLUTION*: The Committee noted the content of the ICS Transformation Programme & ILP Highlight Report.*

17. Any Other Business (AOB)

17.1 There were no items of any other business.

The meeting closed at 16:01

Date and Time of next meeting: Thursday 5th October 2023, 14.00-16.00pm, Shire Hall Gloucester.

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)

Minutes Approved by:

Signed (Chair): Colin Greaves, PC&DC Chair Date: 05/10/2023

NHS Gloucestershire System Quality Committee

Thursday 17th August 2023, 2.00–5.00pm

Boardroom & Virtually from Edward Jenner Court, 1010 Pioneer Avenue. Gloucester Business Park, Brockworth. Gloucester. GL3 4AW

Members Present:		
Prof Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Andy Seymour	AS	Chief Medical Officer, GICB
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
John Trevains	JT	Director of Nursing, Therapies and Quality, GHC
Suzie Cro *(deputising for Matt Holdaway)*	SC	Programme Director – Nursing and Midwifery Excellence, GHFT
Sarah Scott	SS	Executive Director of Adult Social Care and Public Health, GCC
Participants Present :		
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Julie Zatman-Symonds	JZS	Deputy Chief Nurse, GICB
Ryan Brunsdon	RB	Board Secretary, GICB
Robert Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Trudi Pigott	TP	Deputy Clinical Quality Director, GICB
In Attendance:		
Dawn Collinson	SS	Governance Officer, GCIB
Holly Howell *(agenda item 9)*	HH	Urgent Care Commissioner, GICB
Pauline Edwards *(agenda item 10)*	PE	Designated Nurse for Children in Care, GICB
Becky Parish *(agenda item 11)*	BP	Associate Director, Engagement and Experience, GICB

1. Introduction and Welcome

1.1 JCu welcomed members to the System Quality Committee meeting.

2. Apologies for Absence

2.1 Apologies were received from Marion Andrews-Evans, Christina Gradowski, Emily White, Sarah Morton, Alison Moon, Annalie Hamlen and Matt Holdaway.

3. Declarations of Interest

3.1 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.

4. Minutes of the meeting held on 12th April 2023

4.1 The minutes from the meeting held on the 12th April 2023 were deemed to accurately reflect the meeting held and were approved by members of the Committee.

5. Action Log and Matters Arising

5.1 **20/10/22, Item 8.1** - **Self-harm in schools.** This subject was changed to Self-harm in Children and Young People due to data access. **Action Owner: JT to bring an update on Self-harm in Children and Young People to the October meeting. Action to remain open.** **JT**

SS referred to **16/02/23, Item 14.8** where there had been discussion about the audit of outcomes for people in the D2A beds but not about defining metrics. This was not an action for SS or MAE.

20/10/22, Item 9.2 – Terms of Reference (TOR) Update. The updates to the Terms of Reference had been completed. **Action closed.**

12/04/23, Item 7.5 – Discharge Delays. JCu had discussed delay of discharges with Ellen Rule in relation to the Newton Europe work. **Action closed.**

12/04/23, Item 7.8 – Deep Dives on priority areas. A discussion had taken place at the System Quality Workshop held on 20th July 2023, which had been incorporated into the notes from that meeting, which had been recently circulated. **Action closed.**

12/04/23, Item 10.7.1 – Varicose Vein Policy. Further work is required on the policy before resubmission for approval, at which time it can be brought back to the SQC. **Action closed.**

5.2 It was noted during the meeting that the Terms of Reference (TOR) of the System Quality Committee should be reviewed to ensure that the relationship between the System Quality Committee and the System Quality Group, the Local Maternity & Neonatal System (LMNS) and the sub-committees of system effectiveness, safety and experience be clarified and included. **Action: MAE/TP to further examine the TOR to identify and include any sub-committees relating to the System Quality Committee.** **MAE/ TP**

5.3 JCu requested that updates on any open actions be obtained in the next two weeks, so that rather than requests for closure, there were just dates for review against any actions ready for the next meeting in October. JCu also requested that there be a System Quality Committee Forward Plan in place, to show timelines against which meetings the actions should come to.

5.4 JCu had been in discussion prior to the meeting concerning policies being brought to System Quality Committee meetings. JCu had proposed that there should be clarity around any policies being for approval, or requiring input, which could be done virtually. Any policy coming for approval would need to go first through the partner ICB Governance procedures and also through the Lead Executive. Minor changes would be signed off by the Executives in the ICB, but more complex decisions would need to be supported by including the appropriate attendees at the System Quality Committee meetings. AS and JT were in agreement with this proposal.

5.5 JSo suggested that the minutes from the System Quality Group should come to this meeting. The System Quality Group will meet ahead of the System Quality Committee and following each meeting, TP said she would provide minutes and an Executive Summary. Any other papers could be requested separately if required. JCu said this would provide extra assurance to this Committee meeting and would enable System Quality Committee members to have sight of some of the work being done by the System Quality Group. **Action Owner: TP to ensure that the minutes and an Executive Summary from the System Quality Group are** **TP**

circulated prior to the System Quality Committee meetings, to inform planning and discussion for those meetings.

6. System Partner Highlight Quality Reports

6.1 **Gloucestershire Hospitals NHS Foundation Trust Quality & Performance Report**

6.1.1 SC updated on the Gloucestershire Hospitals NHS Foundation Trust (GHFT) Quality and Performance Report (as at June 2023), highlighting three main areas as below. Draft reports had been received from the Care Quality Commission (CQC) regarding the Section 29a inspection taking place today. An update will be given at the next meeting in October. B. Braun were awaiting their report from the CQC inspection against the Section 29a in early April as this had not yet been published. However, assurance had been given that the actions had been completed against the Section 29a Action Plan and had been closed.

6.1.2 SC informed the Committee that on 9th August 2023, the Chief Midwifery Officer for England had conducted a visit to GHFT and had attended the Maternity Group Delivery meeting, which was the meeting for Quality and Performance. This had been an encouraging visit with an offer of help or support proffered, should this be required by the Trust.

6.1.3 The recent industrial action, although difficult, had been well managed through the Business Continuity process. Staff had been, and continue to be very tired, due to covering additional hours over a long period of time.

6.1.4 As referenced Page 45 of the GHFT report which detailed a deep dive on the fractured neck of femur time to treat numbers. There had been a blip in June/July where the high level of waiting of around 90-95% went down to around 60%. AS wondered whether the Trust were aware of the drop and whether any actions were being taken by the Trust. SC stated that this had been looked at but she would take this as an action and would feed back to this meeting, as well as ensuring AS received an update. JCu said she would like assurance that GHFT had discussed and other important issues and had put actions in place at their own Committee meetings and to highlight things that might need help from the System Quality Committee.
Action Owner: SC to report back to the SQC on fractured neck of femur waiting times at the October meeting and also to send AS a separate update. **SC**

6.1.5 SC stated that the Trust were doing everything possible in taking actions to make improvements in Maternity, being aware of the issues and closely monitoring these. SC said she would be able to deliver more assurance on the difference where the Trust thought they were and where the CQC thought they were, at the next meeting.
Action Owner: SC to give a maternity update at the next System Quality Committee meeting. **SC**

6.1.6 JSo noted that the Serious Incidents were rated as Amber and the actions surrounding this had been explained which showed that the Trust were examining this from different angles with a temporary post having been put in place to support this. In a future assurance report, this would be covered off and this was what the Committee would be looking for. This approach could perhaps be taken with other areas in that things had been picked up, been noted by the Trust's Committee and actions had been followed up and then satisfactorily closed.

RESOLUTION: The Committee members noted the verbal update on the Quality and Performance Report (June 2023) from Gloucestershire Hospitals NHS Foundation Trust (GHFT).

6.2 **Gloucestershire Health and Care Quality Report**

6.2.1 JT spoke about the Trust's quality indicators evidenced in the dashboard which showed positive development in June with a further 16 Trust sites had installed Patient Safety and Quality noticeboards, which had been well received.

- As evidenced in the dashboard there were areas of increased focus and surveillance. The Nursing, Therapies and Quality Directorate (NTQ) continued to develop assurance, measures and metrics to monitor against closed culture risks. NHSE will mandate the work, including the additional assurance information currently being provided to the Board as part of GHCs period of enhanced surveillance following their recent rapid review of Wotton Lawn Hospital.
- Progress had been made in providing easy access to accurate statutory and mandatory and essential to role training data to enable effective quality monitoring and improvement in team level compliance. The August dashboard would reveal improved reporting in this area.
- Progress was being made improving patient safety data. Particular attention was being applied to the analysis and understanding of moderate harm events inclusive of pressure ulcer rates, improving recording of rapid tranquilisation and continued focused work in falls reduction. In partnership with operational colleagues the safeguarding team were providing additional focus to safeguarding supervision attendance.

6.2.2 JT updated on the Wotton Lawn Hospital Rapid Review work and spoke about some of the key issues:
Good progress was being made with staffing challenges by putting in place Band 5 staff as a proxy measure. Other grades were well recruited to and this had been successful due to the internal recruitment work and helped by the University of Gloucestershire.

- Wotton Lawn benchmarked highly against others nationally, featuring in the upper quartile regarding absconding. The national benchmarking data had only recently become available but did not clearly demonstrate how other Trusts measured and reported this. It is hoped to achieve a much truer baseline for data by September which should measure interventions to reduce absconding.
- Extensive measures had been taken to address new door access at Wotton Lawn which would be installed in September. This would be monitored and evaluated.
- A lot of work had gone into reducing length of stay and re-admissions at Wotton Lawn It would be preferable to put any money into community services rather than to have more beds at Wotton Lawn. If the length of stay goals could be achieved then the bed base for the county would be about right.

6.2.3 JM recognised that:

- Rapid tranquilisation and control and restraint - although small numbers were involved, this was traumatising for patients and JM was keen to see some solid progress in this work over time.
- Charlton Lane staff had done some sterling work on falls prevention whilst still being able to rehabilitate people.

- Pressure ulcer numbers remained a concern and had an impact on moderate harm statistics. TP had formed a system Pressure Ulcer Group which involved GHC and the Acute Trust. This was a CQUIN for both organisations and the Group could examine pathways and reporting. It was suggested that domiciliary care and home care provider representation should be involved.

6.2.4 JSo asked about impact of the recent industrial action on the community hospitals. JT said that Gloucestershire Health & Care (GHC) were not under the same level of pressure as that of the Acute Trust, but pressure had had been experienced by the Trust's psychiatrists and inpatient services. Staff had demonstrated goodwill in covering shifts which had proven much more difficult in the latest bout of strikes.

RESOLUTION: ***The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Health & Care NHS Foundation Trust.***

6.3 **Primary Care Quality Report**

6.3.1 Due to the numerous topics covered by Primary Care it was suggested that the Primary Care Quality Report could be reformatted so that it would be more appropriate for the different elements of the Committee. AS said due to the Primary Care Quality Report being sent to PCOG, some of the members had asked for information wider than just Primary Care, which was why the report was produced as it was. AS thought that a formal Primary Care Quality Group was probably needed, especially now that Pharmacy, Optometry and Dentistry (POD) would be included. *JSo raised that she was unable to open embedded documents and it would be more useful to add these as an Appendix.* A further discussion may be needed around the presentation of the Primary Care Quality Report at some point.

6.3.2 JSo queried the NHSE's module to allow incidents around patient safety to be viewed at an ICB level. RM said this would need to be driven by GPs and Primary Care teams in the PCNs who would register incidents on the Learn From Patient Safety Events (LFPSE) system. This was not mandated in GP contracts but would be encouraged by the ICB in order for Practices to see the benefits and for their CQC ratings to be enhanced.

6.3.3 JZS informed the Committee that the ICB are continuing to work proactively with PPG to support the work around the concerns raised at the previous inspection in November 2022 and the latest recommendation and updates from the re-inspection visit in April.

6.3.4 A recent meeting involving commissioning leads, the Deputy Chief Nurse and the GPN Strategic Lead, was held to discuss concerns around leg ulcers in the county and a recent piece of work was started around service provision with plans to support and improve the quality of services and to reduce the burden that primary care were currently experiencing. It was recognised that a great deal of work needs to be done in this area.

6.3.5 There was a conversation about the GP Patient Satisfaction Survey and whether more could be done to help those Practices and PCNs in areas of higher deprivation where inequalities were higher and where outcome improvements were most needed. AS said that there was no new money available and it was not possible to re-distribute Primary Care funding. Any funding that does come in would need to be recurrent in order to sustain and keep workforce. There may be some services that do not sit in Primary Care which could be examined.
Action Owner: JCu to take allocation of funding in areas of deprivation to a future development session. **JCu**

RESOLUTION: ***The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Health & Care NHS Foundation Trust.***

6.4 **Adult Social Care Update**

6.4.1 SS spoke about the preparations being made for the Local Government Association (LGA) Peer Challenge taking place between the 18th and 22nd September 2023. The LGA Peer Challenge is a programme where local government authorities received feedback and advice from a team of experienced peers. The objective was to support continuous improvement, enhance performance, and share best practices within the local government sector. Feedback will be focused on preparing councils/Gloucestershire County Council for the CQC assurance inspections.

6.4.2 The Peer Challenge will be held at Shire Hall, Gloucester and will take place over four days.

- Day 1-3 – meetings, focus groups with ASC staff, members, NHS Colleagues, VCSE, Providers and Partnership Boards.
- Day 4 – feedback presentation, full report provided after approx. 4 weeks and will be shared.

6.4.3 SS spoke about Delay related harm in Discharge to Assess (D2A) beds. A multi-agency programme of work had been established by ASC Director of Operations to improve outcomes, decision making, reduce bed based care and improve flow. This programme will be reporting monthly to JCPE.

6.4.4 The Programme will be aiming to move the hospital discharge form, from a 'prescription' to a 'description' model, involving the person and their family, where home will be the default position, with a D2A bed being sourced by exception. The decision making process will move to 'check and challenge' and appropriate decision making around resource allocation will happen within the appropriate pathway. Processes will be simplified and clarified. Clear goals around expected date of discharge and onward planning will happen early with oversight and tracking. The Social Work model will support a D2A model.

6.4.5 Risk minimisation in the current model is one of six workstreams within the programme. This will focus on developing a therapy pilot; improving the MDT approach; establishing a case tracker and weekly tracker meeting with escalation points; the feedback loop re: unsafe discharge; understanding current process and gaps around assurance, and duty of candour.

RESOLUTION: ***The Committee members noted the verbal update on Adult Social Care.***

6.5 **Summary Report from System Quality Group**

6.5.1 TP gave an update summary presentation on the 15th August 2023 meeting held by the System Quality Group (SQG). A reference on Slide 1 showed guidance and a summary of the three tiers of quality assurance and support.

6.5.2 A presentation by the trust's Nursing Director at Wotton Lawn had been given at the meeting. Risks at Wotton Lawn were being well-managed with continuing improvement work ongoing. Main areas of previous concern such as staffing and absconding numbers are being addressed by the trust and showing marked improvement. Although Wotton Lawn currently

remains on Enhanced surveillance, a review in October will examine whether or not this could be reduced to Routine surveillance following the improvements.

6.5.3 Since last SQG, System Mortality Group had met twice. The aim was to discuss and share themes across all partners and work collaboratively in order to identify any themes that may not be addressed by individual system partners.

6.5.4 Maternity - Section 29A remains in place from 2022. A large number of varied action plans were in place and would be collated into one overall action plan. Staffing remains the most significant risk. Smoking at time of delivery remains an outlying metric and review work was underway. A supportive visit had been welcomed by the National and Regional midwives to support the new leadership team.

6.5.5 The Patient Transport Advice Centre (PTAC) is a commissioned service from CSU running eligibility assessments and booking transport. Current metrics needed immediate improvement with only 31% of calls answered and an average waiting time of 28 minutes across all SW areas using PTAC. Monitoring was ongoing and system partners were sighted.

6.5.6 Patient Safety Incident Response Plan (PSIRP) and Learn from Patient Safety Events (LFPSE) - Trusts had now agreed that they would present their PSIRP to their own boards by November which will then come to ICB System Quality Committee for ratification in December. Whole ICS training had been procured which was expected to start in October. The system plans for the formal switch over to PSIRF will take place on the 1st January 2024.

6.5.7 This summary update will be regularly produced along with the minutes of the System Quality Group and circulated to members of the System Quality Group. Any additional papers would be available on request. It was noted that a summary update and minutes from the System Quality Group will be included as part of the papers at future System Quality Committees and sent to members prior to the meetings of the System Quality Committee.

RESOLUTION: The Committee members noted the update from the System Quality Group.

7. Gloucestershire's Communicable Disease Plan Review 2023

7.1 TP informed the Committee that she and Katie Hopgood had been working on this Plan together and all the learning from the pandemic had now been incorporated into the new updated Plan which crossed all the NHS services and outlined logistic arrangements in the event of an outbreak or disease happening.

7.2 TP described the way the Plan worked and explained the summary of changes :

1. Roles and responsibilities had been updated to include a split between Preparation and Response
2. Public Health actions had been reviewed and updated
3. The Communications section updated
4. Appendices had been reviewed and compressed
5. There had been development of local action cards to inform specific actions

7.3 TP asked Committee members:

- Did they feel that the role and purpose of the organisation was clearly represented in the plan?
- Did they feel that there were any gaps in the plan?
- Was there anything that was not clear?

Feedback would be welcome from Committee members and the Plan would be tested out which would likely reveal some gaps which would be addressed to ensure that things were as good as they could be.

7.4 JSo asked whether there had been any shared learning amongst other ICBs. TP said she had not heard of any but that it would be tested in various ways and thought that some more complex authorities would have robust plans. TP said there was an opportunity to share learning and she would check with Katie Hopgood who had a network of Consultants in Public Health. The Plan had gone through various local groups and Trusts and their feedback had been considered. TP invited members to send any further comments directly to her.

7.5 JCu queried at what level the representatives for the ICB and GHFT should sit. It was also noted that there could be more transparency between a relatively minor outbreak in a school requiring mass vaccination, for example, and something which was bigger and more deadly to the local and/or global population.

RESOLUTION: ***The Committee members noted Gloucestershire's updated Communicable Disease Plan 2023.***

8. <u>System Quality Workshop: Committee Priorities & Future Agenda</u>

8.1 The notes from the System Quality Workshop had been circulated as part of the papers for this meeting on 20th July 2023. It was noted that there had been good representation. Individual Trust priorities had been identified. JCu had also added some comments around how different Groups should link in whilst avoiding any duplication of work. Alison Moon had talked about developing a heat map in referencing inequalities, which could involve Douglas Blair and Siobhan Farmer. A timeline would need to be worked out for what the System Quality Group wanted to achieve. The System Quality Risk Register, which was on the Agenda later in the meeting, would perhaps inform some of the topics which might need to be addressed.

8.2 Views would be welcomed from the Committee members around some of the actions on the Action Log, which would be circulated shortly, in order that some of the actions could be more accurately distributed.

8.3 JSo said that a meeting had been held around the Risk Register which would be presented as a report and would feed into the Board Assurance Framework (BAF). Another meeting will be held in October in order to be able to simplify the process and to reduce wording.

8.4 Overall, members felt that the workshop had proved very useful and if the Terms of Reference for this Committee could demonstrate more clearly the underlying work, which would be very helpful and would aid in the CQC assurance to demonstrate that the Committee were tackling the higher level areas. Children and Young People should be represented and assurance should be presented to the System Quality Committee. **Action Owner: JCu to meet with Ann James separate to System Quality Committee to discuss how Childrens & Young People's Services can be represented at the Committee.** **JCu**

8.5 JCu noted that a great deal of work on Quality Improvement was being conducted via Ellen Rule and it would be useful to have some visibility of that in the System Quality Committee meetings. It would be good for the lead on Quality Improvement to be part of this Committee and would also help in areas of risk where the Committee might have concerns.

RESOLUTION: ***The Committee members noted the comments on the System Quality Workshop and Action Log from 20th July 2023.***

9. Draft System Quality Risk Register

9.1 TP informed the Committee that HH had created a spreadsheet which could be used prior to those risks being added to the 4risk system, which was a powerful, yet easy to use risk management platform, which provided a complete picture of the organisation's risk, mitigation and assurance profile. Future Risk Reports would be available for this Committee and help with actions, controls and progress. A named person would need to take ownership of each risk and HH would be happy to tutor on scoring and risk control of the risks.

9.2 TP explained that there was currently very little on the register around quality for the ICB. It would be important to obtain the best use from the Risk Register and to understand it's purpose and how to progress risks forward.

9.3 **Discussion:**
JSo referred to the differences in risks and the means of sharing, mitigating and monitoring these.

- The meeting in October will examine reporting and the capture of ICB system risks.
- Each risk will have a named executive lead against it in order to be able to deliver updates on that risk.
- Cross-cutting risks could be brought to the System Quality Committee for discussion even if subsequently it was felt appropriate for these to be guided elsewhere for resolution. Some areas of risk then become a risk in other areas as they often link in.
- The Risk Register should be placed at the beginning of Committee meetings in order to allow items to be altered or scorings changed according to the items discussed throughout the meeting.
- It was recognised that some risks will be system-wide and some will be organisational and there will be elements of both within certain risks, such as workforce and finance.

Action: HH to circulate the Risk Spreadsheet to the Committee members to identify what risks are organisational, which are system-wide and where links to specific people should be made. **HH**

10. Children in Care Annual Report 2022-2023

PE spoke about the Children in Care Annual Report and highlighted some key facts of focus. This report outlined how the children's health and care system promoted and protected the health and well-being of children in care, in Gloucestershire. This report had been brought up to date since the pandemic.

10.1 There are challenges with the capacity of the health teams with ever-increasing numbers of children in care, children placed outside their home area and increasing complexity of need.

There was an ever-changing national landscape and fewer resources to manage the needs of this group.

10.2 Over the coming year, commissioners will be working with the designated nurse and named doctor and nurse to review the current provision, the impact of increased staffing, gaps and risks and the integration of three specialist health teams into one cohesive service whilst retaining their specialist elements.

10.3 Gloucestershire Health & Care were inspected by the CQC for Adults and Children's Physical Health Services and the Report highlighted some of the things picked up around the Children in Care (CiC) Nursing Team which had been pleasing to see.

10.4 A Designated Doctor for Children in Care had recently been appointed who is new to this role and will need a period of integration and induction. The Doctor comes with good recommendations from colleagues and it was hoped she would be eminently suited to the role. AS endorsed these comments and stated that the county were very fortunate in the filling of this position. PE thought that the workforce future looked bright for the medium and longer term if people could be retained and statutory roles could be filled.

10.5 JSo asked at what age the service ceased to be a service for children recognising that there was a transitional period and asked what the challenges would be in this year and in the coming year for those needs.

10.6 PE explained that children were usually in care until they were 18 with fewer leaving at 16. More services were needed that could transition across the age group from 16-25 years of age. Young Gloucestershire had been commissioned by the ICB to deliver the Linked Up+ service which was a mixed model of youth services and counselling. Other services worked alongside Young Gloucestershire to help with high end supervision, which worked well towards delivering social networking, training, education, benefits and housing.

10.7 PE said there was a gap in services as the Children in Care nurses were not commissioned to support young people beyond the age of 18 although they would never refuse a request for help. In those instances, they would provide signposting information but this would be limited due to capacity. It was hoped that commissioners would be considering providing a health service for those over the age of 18 over the coming months.

RESOLUTION: ***The Committee members noted and approved the Children in Care Annual Report for 2022-2023.***

11. Policies for Approval

11.1 ICB Complaints and Feedback Policy

11.1.1 BP and her team had updated this to reflect the new arrangements for the handling of Pharmacy, Optometry and Dentistry complaints. The Commissioning Hub was providing a service across the South West region and any complaints received were checked and signed off, then sent out with support for the Commissioning Hub to conduct the investigation. JC queried the line of sign off and BP said this Policy had been seen by Tracey Cox who was happy with it and had said it was a very comprehensive Policy and covered off all that she would expect to see. It had reflected conversations that had been held across the South West region and BP said that she would expect other ICBs to be undergoing similar processes.

RESOLUTION: ***The Committee approved the ICB Complaints and Feedback Policy.***

11.2 **Clinical Records Management Policy**

11.2.1 Due to an element of risk and the fact that the policy was not due for approval, there was nothing in it about Equality and Diversity and that there were still some errors in it, the Clinical Records Policy was not approved.

RESOLUTION: ***The Committee members were not able to approve the Clinical Records Management Policy and it will be revisited at a later time.***

11.3 **Business Continuity Policy**

11.3.1 This Policy was not approved due to some potential gaps and EPPR was a system-wide risk and not one of the strategic objectives as an ICS. JSo said there had been a cyber-exercise on 12th June 2023 which had been supported through the Audit Committee and cyber was rated red nationally due to various threats. The Policy said that the ICS were responsible for a cyber incident and this should be integrated into the Policy.

RESOLUTION: ***The Committee members were not able to approve the Business Continuity Policy and it will be revisited at a later time.***

12. <u>Meeting Review, Items of Escalation and Any Other Business</u>

12.1 JCu requested that members give their opinions on whether the format of the meeting had worked, and whether it could be conducted differently in future.

12.2 JSo requested that papers be circulated as soon as possible so that a full and proper discussion could be had. It was recognised that some papers had to go through various channels and TP and RM would try to support RB with this. There would be some overlapping subjects and it would be good to co-ordinate things going forward.

12.3 JT would prefer members to be present in person as hybrid meetings could be difficult in terms of being heard etc. AS agreed with JT's comments.

12.4 There were no items of Any Other Business and the meeting concluded at 17.00 hrs.

Time and date of the next meeting
Thursday 19th October 2023, 2.00pm – 4.30pm,
Shire Hall, Gloucester

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)

NHS Gloucestershire ICB People Committee

Thursday 20th July 2023, 14.00 – 17.00pm

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

Members Present:		
Jane Cummings	JC	Non-Executive Director, Committee Chair
Tracey Cox	TC	Interim Executive Director of People, Culture and Engagement, ICB
Dr Marion Andrews-Evans (part-meeting)	MAE	Chief Nursing Officer, ICB
Andrew Seymour	AS	Chief Medical Officer, ICB
Participants Present:		
Deborah Tunnell (part-meeting)	DT	Deputy Director for People & OD, GHFT (deputising for Claire Radley)
Zack Pandor	ZP	Strategic Workforce Transformation Programme Manager, ICS
Sophie Elizabeth-Atkins	SEA	People Programme Manager, ICB
Ali Koeltgen	AK	Deputy Director for HR and OD, GHC (deputising for Neil Savage)
Christina Gradowski	CG	Associate Director of Corporate Affairs, ICB
In attendance:		
Dorothy Bean (part-meeting)	DB	Regional Chief Nursing Information Officer, NHSE
Nick Oxlade (Agenda item 9)	NO	Strategic Lead Partnerships & Projects, University of Gloucestershire
Mandy Tuckey (Agenda item 10)	MT	Apprenticeship & Widening Participation Lead, ICS
Jenni Phillips (Agenda item 12b)	JP	Digital Communications Manager, ICB
Ryan Brunsdon	RB	Board Secretary, ICB
Nikita Davis	ND	HR and Governance Project Officer, ICB

1 Introduction & Welcome

1.1 JC welcomed the attendees and advised that she would be chairing the People Committee until a replacement for Clive Lewis, the previous Chair, was found. JC highlighted Clive's work as a member of the Committee and emphasised that we should continue to live his values through what we do.

2 Apologies for Absence

2.1 Apologies were received from Claire Radley, Mary Hutton, Sarah Scott, and Neil Savage.

2.2 It was confirmed that the meeting was quorate.

3 Declarations of Interest

3.1 No declarations of interest were received during the meeting.

4 Minutes of the Previous Meeting

4.1 The minutes of the previous meeting held on Thursday 27th April 2023 were approved as an accurate record of the meeting.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **12.01.2023, Item 6.11 –** the update on action long refers to Item 6.1.1 GP Leavers but should refer to Exit data. (Log to be amended). **Action needs to remain open.** TC will incorporate an update on this at the next Committee meeting in October when we will give a Recruitment & Retention update.

5.1.2 **12.01.2023, Item 6.11 –** GP & Registrar data. This action was requesting closure. Data was included in the performance metric pack for this month's meeting. **Action closed.**

5.1.3 **12.01.2023, Item 6.11 –** GP Leavers – update on action log relates to 6.1.1. (Log to be amended). This information is partly covered in the primary care data pack. This action was requesting closure. **Action closed.**

5.1.4 **27.04.2023, Item 7.1 –** Workforce Intelligence and Programme Highlight. **Remains open.**

5.1.5 **27.04.2023, Item 9.6 –** Draft People Strategy report. This action was requesting closure. A**ction closed.**

5.1.6 **27.04.2023, Item 11.2 –** Policy Updates. **Remains open.** Final work to be completed on refining menopause policy.

6 ICS People Function Summary Report

6.1 TC provided an update on the developments across the people agenda highlighting that in early June 2023 NHS England (NHSE) published an Equality, Diversity, and Inclusivity (EDI) improvement plan for systems and providers that included six high impact actions. TC outlined that there is an overlap between these and existing work in relation to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) monitoring and also the equality delivery system. TC explained that NHSE will not separately monitor Integrated Care Systems (ICS) on these actions, as the plan is an overarching document that brings an overview into one place, so the reference points and monitoring of these actions will take place through staff survey results and work around the equality delivery system.

6.2 TC raised the continuing industrial action, outlining that the NHS had just come out of five days of junior doctors strike action and were now in a 48-hour strike for consultants.

6.3 AK reported on behalf of GHC that they had been lucky in being able to secure cover in relation to the consultant strike. AK commented that the climate seemed to have shifted after the last junior doctor strike action and colleagues felt less likely to cover and less collegiate in informing GHC of their intention to strike. The position was therefore more difficult. AK raised concern around receiving notice of a consultant strike on the bank

holiday weekend in August as a High Court judgement that allowed organisations to cover striking staff with agency was challenged by trade unions, so obtaining agency cover will now be illegal again from 10th August 2023.

6.4 DT agreed that lots of planning had gone into preparing for the actions and at GHFT they were taking regular stock takes throughout day. That morning GHFT did not have large numbers of staff that had gone out, but this could have changed by the afternoon. DT highlighted that the theme being relayed by senior doctors was burnout and a feeling of relentlessness.

6.5 JC queried whether the consultant led services were managing to operate. DT advised that this was being reviewed at GHFT hour by hour, and whilst things were tight on the ground, it had not had a significant impact to the point where they have needed to stop services, but the situation was not ideal and the pressures on the staff who are in those services was an issue. AK agreed with this statement. JC acknowledged the work being done to keep services safe.

6.6 TC reported that there was in a slight improvement in the both the national and Southwest levels in relation to NHS vacancy data.

6.7 TC stated that Continuing Professional Development (CPD) and Workforce Development Funding (WDF) funding received by the ICS this year for was similar to previous years. Plans from providers for the proposed utilisation of the CPD monies, which is predominantly targeted at nurses and Allied Health Professionals (AHPs), will be submitted by 31st July 2023. The WDF is a relatively small pot of money and many requests have been made. A prioritisation meeting was taking place tomorrow.

6.8 TC explained that the work around a Gloucestershire recruitment campaign had commenced with a company called 10 Yetis. This will be a branded campaign aimed at advertising why Gloucestershire is a great place to live and work, that could sit across multiple clinical vacancy areas to attract people to Gloucestershire. 10 Yetis are starting with being a GP in Gloucestershire and met last week with GP's and the LMC to ensure we pitch the campaign in the right way and understand what motivates people to look at certain websites, but it is likely that the campaign won't begin until September or October of this year.

6.9 TC summarised that all NHS organisations across Gloucestershire have signed up to the GatenbySanderson talent management programme aimed at increasing the pipeline around future NED's and specifically targeting under-represented groups.

RESOLUTION: The People Committee noted the content of the ICS People Function – Summary Report.

7 Workforce Intelligence & Programme Highlight Report

7.1 SEA highlighted from the Workforce Intelligence report that the three steering groups had agreed their plans on a page so the final versions would go to the People Board in August 2023 for ratification, and they are now creating the delivery plans for the priorities underneath them.

7.2 The UEC cohort for Systems Thinking Masterclasses have been completed and SA reported that they went very well and generated good debate, engagement, and enthusiasm. Dates for cohort three and four are in the process of being agreed and will start in October with an aim to be completed by November.

7.3 The ICS Reciprocal Mentoring Programme has started and is progressing well. In order to have enough time to promote the programme, particularly for clinical staff, the next cohort will start in January or February 2024.

7.4 SEA referred to Workforce Metric report and advised that trend lines and benchmarking since the last financial year had been added to the workforce metrics, explaining that the direction of the arrow is compared to the last month or data point, and the colour of the arrow is whether that is a negative or positive direction. SA added that some of the previous metrics had been removed and some new ones added following revised guidelines from the national team.

7.5 SA reported a slight decrease in staff bank usage and slight increase in agency usage which equated to a reduction of 35 FTE of bank staff and an increase of 10 FTE of agency staff.

7.6 TC elaborated that the ICS has a bank and agency cap for the year and acknowledged that reducing agency expenditure is going to be a challenge. Based on data to month two the ICS is spending around £2.4 million a month on agency costs and the combined bank and agency position is 16% to 18% percent of total expenditure on staff. TC outlined that the expectation of the medium-term financial plan indicates that, over the longer-term, agency costs should not exceed 3.7% of the total pay budget for ICBs.

7.7 SEA outlined that sickness absence rates were 4.15% for secondary care which showed a slight increase. In social care there was a slight decrease to 3.4% (around 0.7% less). Social care staff who leave within twelve months of their start date had reduced by 3.9% since the last quarter.

7.8 SEA highlighted the following new metrics:

- The proportion of staff in senior roles who are of a black, Asian, and minority ethnic (BAME) background - 15.73%.
- The proportion of female staff in senior roles who are - 59.37%
- The proportion of staff in senior roles with a disability - 12%.

7.9 TC presented the Primary Care Workforce Analysis which contains workforce trend information about the primary care (PC) workforce in Gloucestershire since April 2021. TC highlighted a downward trend over the last couple of months in relation to GP numbers per 10,000 population, whereas the trends for PC nurses and other roles involved in direct patient care are generally increasing.

7.10 In Gloucestershire, the GP rate has historically been above both the national and regional averages, but numbers are now dropping closer to the national position. Nurses are above the national average but under the regional comparator. For direct patient care roles Gloucestershire are exceeding both the national and regional averages.

7.11 TC drew attention to the profiles of various staffing groups at Primary Care Network (PCN) level and the wide variation in terms of how PCN's deploy and use nurses and other roles, noting that this is partly due to the ability to recruit to inner city and deprived PCN areas.

7.12 AS agreed that it was a recruitment issue with these areas and commented that the lack of GPs was likely being compensated for by other health professionals. AS reported that the GP survey results had come out last week and whilst the overall GP satisfaction was very good and above the national average there were pockets in Gloucestershire where

it was extremely low with some areas recording 30% - 40% of patient satisfaction, which mirrors the areas where there is a poor GP workforce.

7.13 TC noted that the data produced by the Training Hub on what has happened to GP partners and salaried GPs over the last four years identified that regionally Gloucestershire had the smallest increase in number of GP trainees.

7.14 JC queried why Gloucestershire had the smallest increase in GP trainees, emphasising that there is a significant difference between Gloucestershire and the regional average. JC added an awareness that only seven out of the 69 GP practices in Gloucestershire will take student nurses for clinical placements so queried what could be done to increase both GP and nursing student numbers. AS responded that the longer-term plan is centred around the Three Counties Medical School which will train individuals who are already living in this area and will then hopefully want to remain and work here but recognised that this is not a quick fix.

7.15 SA explored the idea of GP ICS legacy mentors in order to take the burden of the supervision of trainees off PC staff.

7.16 TC outlined that Gloucestershire were performing at the highest in the region in relation to clinical pharmacists, but conversely have the lowest number of first contact physiotherapists by headcount. TC acknowledged the current challenges around employing to physiotherapist roles and advised that she will be facilitating a session to look at the potential for developing rotational physiotherapy posts across the ICS.

7.17 TC commented that it would be interesting to overlay some of GP staff survey results with the analysis data and concluded that there is a commitment to supporting the training hub by continuing to profile data to help understand what is happening to the PC workforce.

7.18 AS emphasised the significance of the drop in partner numbers and the impact this will have on the workforce, noting that many of them often perform extra discretionary work.

7.19 MAE advised that she was involved with a national study relating to additional roles in PC that was conducted by University of the West of England (UWE) that Committee members may be interested in so will send it to RB to distribute to the group. **MAE / RB**

RESOLUTION: The People Committee noted the content of the Workforce Intelligence & Programme Highlight Report.

8 NHS Workforce Plan - Implications for the ICS

8.1 TC outlined that the NHS Workforce Plan is a long-term 15-year plan which aims to address workforce demand and supply. TC handed over to ZP to provide some detail on the headlines outlined in the NHS Long-Term Workforce Plan Summary document that was shared with the Committee in advance of the meeting.

8.2 ZP explained that whilst the plan contains lots of data more detail is required because the delivery of the workforce numbers and some of the other assumptions depend on other elements (infrastructure, education funding beyond the £2.8 billion that has already been announced, and social care provision) which are outside of the scope of the plan.

8.3 The headlines of the report included:

- NHS staffing shortfall in March 2023 was 112,000. GHFT/GHC having 1,200 vacancies, with a nurse vacancy rate of around 14%.
- Three key themes are:
  - Train by significantly expanding domestic education, training, and recruitment.
  - Retain by improving culture, leadership, and wellbeing.
  - Reform with new roles, technology, and digital innovation
- Productivity assumptions include a shift from an acute to community-based workforce. Currently in Gloucestershire 59% of the nursing workforce are based in acute settings and 40% is in the community.
- Tackling regional imbalances in relation to training placements.

8.4 ZP showed the Committee an action plan put together by NHS Employers which contains each of the three themes, each of which have around eighty actions for systems to undertake. The plan will be completed with comments on what organisations and the system are doing against each in order to give focus on where further action needs to be taken.

8.5 CG provided some insight into medical placement issues and explained that before a university can submit a plan for student numbers they need to have found and locked in all of the placements for year three to five students which is a big challenge for many universities. CG added that more medical students than ever before are applying for hardship funds as the average debt is £84,000 - £110,000, and those that go on placement in countries such as Australia or New Zealand often do not come back.

MAE and DB left the meeting.

8.6 AS agreed regarding medical school placement issues. AS informed the Committee that the Three Counties Medical School, which aims to be a largely community based medical school, are planning for two hundred additional students for which they are already setting up meetings to look for GP and community Trust placements.

8.7 NO concurred with the comments around placement capacity and confirmed this as the reason the University of Gloucestershire (UoG) are unable to increase training numbers. Nationally, applications to all healthcare programmes are down approximately 20%, and whilst UoG have managed to close AHP programmes they have needed to actively chase nursing numbers for the first time.

8.8 NO reflected that being a rural county 80% of the placements require students to be able to drive and most of them can't afford cars or petrol and that whilst NHSE have been helpful in providing some hardship funds, UoG has also seen a large increase in requests for hardship funds or applications to the Vice Chancellor and other funding support packages, which they haven't seen before.

8.9 NO advised that in relation to bringing new people into the system UoG had met with BNSSG to see if there is any joint work they could do to try and attract students into the system and then keep them, which could link in with the 10 Yeti's campaign, by showing students why Gloucestershire is a good place to stay afterwards.

8.10 AK reported that one of GHC's biggest vacancy pressures is around community nursing and shares concerns regarding how to not only attract staff into the roles but to retain them. AK shared feedback from within GHC that the cost-of-living pressures, cost of running a car etc. are real driving forces behind why staff don't want to take community roles.

8.11 JC commented that it be sensible to look at this from a system-wide perspective rather than as individual organisations, which should also include Adult Social Care (ASC). TC agreed, adding that the recruitment and retention of staff as a system is key. Gloucestershire ICS doesn't benchmark as well as other systems who have implemented packages of high impact measures around retention. TC further added that a broader view to include a social care perspective will be taken when looking at the initiatives.

8.12 Further discussion was had around retention of staff in relation to accommodation.

8.13 JC summarised that whilst waiting for further detail on the plan the ICS would focus on identifying the most important actions for Gloucestershire to focus on for the rest of 2023 and into 2024, adding that the Committee would revisit the plan at the next meeting.

DT left the meeting.

RESOLUTION: The People Committee noted the content of the NHS Workforce Plan and agreed to revisit the plan and implications for NHS Gloucestershire ICS at the next Committee meeting.

9 <u>One Gloucestershire People Strategy</u>

9.1 TC explained that due to the publication of the NHS Workforce Plan it had been decided that the strategy would be sent to the Integrated Commissioning Board (ICB) in September for approval, rather than July as was originally planned. TC invited last minute feedback and reflections from the Committee, advising that the presentation would be reformatted before being submitted, adding that the strategy had been shared with system partners and their feedback had also been incorporated into the plan.

9.2 ZP presented the strategy to the Committee which had been shared with the group prior to the meeting, noting that the numbers contained within the strategy would be checked again for accuracy before submission to the Board.

9.3 ZP highlighted that Gloucestershire County Council GCC are drafting a workforce strategy around capacity, culture and capability which could be aligned with the ICS workforce strategy and identify system-wide opportunities for joined up working.

9.4 The four focussed themes of the strategy are:

- Recruitment and Retention
- Enabling innovation in care delivery and people services
- Valuing and looking after our people
- Education, training, and talent development

The four foundation themes of the strategy are:

- Leadership and culture
- Equality, Diversity, and Inclusivity
- Digital, Data and Technology
- Future Workforce Planning

ZP briefed the committee on some of the comments received during engagement sessions and ongoing work relating to each of the themes, which have been summarised in the slides in the updated strategy.

9.5 ZP outlined the measures that will be used to track progress in relation to the various themes:

- Vacancy rate
- Staff engagement
- Sickness absence
- EDI measures
- Staff turnover
- Apprenticeship levy utilisation
- Agency spend

9.6 TC mentioned the vision statement of the strategy which is currently "Developing One Workforce for One Gloucestershire" and queried whether there were any alternative suggestions for a statement that is short and memorable and encapsulates what the ambitions of the People Strategy are. Any recommendations can be sent to TC after the meeting.

9.7 JC commented that the strategy included everything she would expect to see and how it had been positive to see where the ICB is now and also the future ambitions but debated whether there should be further ambitions set against each of the measures, such as where the ICS would like to be in five years so there would be something to track against.

9.8 TC asked AK to give a provider perspective and whether they set targets for tracking measures. AK confirmed they do have targets around some of the measures but will conduct a review of which ones and how when the national people metrics are released to prevent measuring the same things in different ways. AK added that they are also beginning to scope some work around measures that reflect a good culture and how people feel they experience an organisation as this is equally important, but harder to quantify.

9.9 ZP agreed and commented that the staff survey does try to capture this information but as results are recorded at organisational level and not across the system it is hard to aggregate or average those scores.

9.10 JC commended the hard work that had been put into developing the strategy and clarified that the strategy would be circulated virtually for final comments and sign off before being submitted to Board in September. **TC / ZP**

RESOLUTION: The People Committee noted the content of the One Gloucestershire People Strategy and agreed that the plan would be circulated for final approval and sign off before being submitted to Board in September.

10 <u>Strengthening our approach to Careers & Engagement</u>

10.1 MT outlined that she had joined the ICS in February 2023 and whilst working alongside Jossette Jones who is the Systemwide Retention Lead they had noticed that whilst there was brilliant work going on within organisations, there was potential for an overlap of work but also for collaboration and sharing of resources.

10.2 MT explained that GHC and GHFT have fixed term funded Careers and Education Engagement posts that are shortly to end, but opportunities they had developed led to them to see where there could be potential for a systemwide opportunity to utilise Gloucestershire's careers and engagement offer more effectively and efficiently by pooling resources and sharing good practice. The purpose of a systemwide Careers and Engagement Team would be to look at how to promote health and social care careers, widen the activities they are currently delivering and start to improve provision.

10.3 MT advised that organisations who had collaborated on this had been able to reach a wider target audience and had been able to deliver bespoke, tailored engagement activities, the advantage of which had enabled them to tap into populations who historically wouldn't have considered a career in the NHS, such as people Not in Education, Employment or Training (NEET) and children in care working closely with GCC services.

10.4 MT relayed a conversation with a trainee level graduate who didn't want to leave home or move out of the area but wanted to be able to progress in her career and is now doing an apprenticeship programme with her local NHS organisation. MT emphasised this as being a prime example of being able to support someone in staying local and supporting them from the beginning of their career development all the way through to now potentially starting training and a subsequent degree programme, commenting that this type of work aligns with other ICS objectives in relation to recruitment and retention.

10.5 MT summarised by drawing attention to the paper submitted to the Committee that outlined some of the work that was undertaken by the current Careers and Engagement postholders and how continuing to support some of the projects by coordinating them at a systemwide level would then allow individual organisations to take ownership of certain aspects of the activities and continue to build on the great work that has been started.

10.6 TC clarified that the proposition was for an agreement in principle to move from an organisational approach to careers and engagement to a collaborative one in order to have a more strategic plan, with more targeted results to maximise the benefits. A more detailed proposal inclusive of costing will be required to enable a bid for s256 monies.

10.7 TC queried what metrics or evidence were being used to track progress. MT advised that one aspect was based on the number of people on the talent database. Another was tracking how far through the process people went after engaging in individual coaching, after they had initially been unsuccessful at shortlisting or interview, and ten candidates across GHC and GHFT have now been employed following this route. They are also beginning to be look at how to align a work experience opportunity to an employment or apprenticeship opportunity of which the conversion rates would also be measurable.

10.8 MT commented that changes with NHSE could mean losing some regional support and therefore the opportunity to see what is happening regionally and ensuring oversight of the activities being undertaken by individual organisations would be valuable in allowing the ICS to move forwards.

10.9 JC confirmed the Committee agreed to support the proposal.

RESOLUTION: The People Committee approved support for the proposal of a systemwide Careers and Engagement Team.

11 People Committee Board Assurance Framework & Risk Register

11.1 TC outlined the changes to the updated risk register and that the number of risks dropped down from seven to six. The scoring was also changed on a couple of risks.

- Inadequate Workforce Supply (risk score 16, reduced from 20).
- On-going industrial action (risk score 16 – no change)
- Band 2/3 HCA pay issue (risk score 16 – no change)

- Cost of living impact of staff (risk score 16 – no change)
- Workforce risk in relation to less effective service transformation plans due to non-recurrent funding and lack of appropriate join up with Clinical Programme Groups (risk score 16 – no change).
- Placement capacity expansion (risk score 16 – no change)
- Band 2/3 pay issue. Kept cost of living impact on staff – highlighted ongoing risk of clinical programme groups and risk transformation. More work on strengthening connections.
- Placement capacity issue – been on register for a while.

11.2 TC advised that the risk score in relation to inadequate workforce supply was reduced on the basis that there are further plans around international recruitment and that GHFT have the opportunity to bid for another fifty-five international recruits this year, adding that there are some implications in terms of system funding.

11.3 JC queried whether it was appropriate to reduce the score for this risk, due to the considerable number of vacancies, notwithstanding the proposed mitigating actions which may be potentially helpful regarding the workforce. JC commented that there are pockets of improvement in areas such as nurse and social care recruitment, where progress has been made. AK agreed with comments regarding nurse recruitment and the reduction in the risk score. JC summarised that improvements in separate areas will have an impact on the overall score so was also in agreement to keep the reduced score.

11.4 TC highlighted the ongoing risk relating to connectivity between the work of the clinical programmes groups and workforce transformation and suggested more work would be required to strengthen the connections.

11.5 There was discussion around the potential for helping vacancy numbers by re-purposing vacancy funding to help support apprenticeships for backfilling staff. It was agreed that this would be a mitigation rather than a risk.

11.6 TC advised that the board assurance framework had also been updated to reflect the strategic risks on the workforce and some of the actions to address them.

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

12 Policy Updates

JP joined the meeting.

12.1 RB provided an update stating that the Domestic Abuse and Lone Working policies had been amended and any changes tracked so they could be viewed by the Committee. Any comments would be communicated to the policy leads if the policies were not approved. RB advised that JP had joined the Committee to provide an update on the social media policy.

12.2 CG advised that they had consulted Sarah Jeeves from the Continuing Healthcare (CHC) Team as the appendixes in the Lone Working policy applies more to CHC than any other team, had been and that the.

12.3 The People Committee approved the Domestic Abuse policy.

12.4 JC thanked JP for joining the meeting. JC commented that the policy refers to the CCG so this would need updating to ICB. JP agreed to amend this and advised that the only other amendment would be including definitions for libel and copyright in the appendixes.

12.5 ZP speculated whether staff engagement may be useful following release of the updated policy as staff may not go away and read it but there may be things they need to be aware of in relation to personal social medic activity. JP agreed this was a good idea and would look into arranging some lunch and learn sessions for staff, and that the move to Shire Hall could also present some opportunities for refresher training for staff.

12.6 JC clarified that there was an agreement in principle for approving the policy, subject to the glossary of terms being updated as described by JP. It was agreed that the policy will either be discussed at the next People Committee meeting in October or, should it need approving before then, the policy will be circulated virtually with tracked changes for sign-off. JC thanked JP for the update.

12.7 The People Committee approved the Lone Working policy.

RESOLUTION: The People Committee approved the Domestic Abuse and Lone Working policies.

13 Any Other Business

13.1 JC thanked the attendees for their time and contributions. There was no other business.

The meeting closed at 16.06pm.

Date and Time of next meeting: Thursday 26th October at 2pm in Shire Hall.

Minutes Approved by:

Signed (Chair): Jane Cummings Date: 26th October 2023

Gloucestershire ICS: System Resources Committee

Minutes from the meeting held on
Thursday 7th September 2023; 14:00 – 17:00

Initials	Name	Job Title	Organisation
Present			
JC	Joanna Coast *Chair*	Non-Executive Director; System Resources	ICS
AP	Angela Potter	Director of Strategy and Partnerships	GHC
CL	Cath Leech	Chief Financial Officer	ICB
ER	Ellen Rule	Deputy Chief Executive & Director of Strategy and Transformation	ICB
KJ	Karen Johnson	Director of Finance	GHFT
MW	Mark Walkingshaw	Director of Operational Planning and Performance	ICB
SBe	Sandra Betney	Deputy Chief Executive & Director of Finance	GHC
SBr	Steve Brittan	Non-Executive Director	GHC
In attendance			
CB	Chris Buttery	Finance Programme Manager	ICB
GA	Gemma Artz	Programme Director, Clinical Programmes	ICB
HJ	Haydn Jones	Associate Director of Finance (Business Intelligence)	ICB
JS	Julie Soutter	Non-Executive Director	ICB
KD	Kat Doherty	Senior Performance Management Lead	ICB
MG	Mark Golledge	Programme Director for PMO and ICS Development	ICB
SR	Shofiqur Rahman	Interim Deputy Chief Finance Officer	ICB
TH	Tom Hewish	System Operational Planning Lead	ICB
Apologies			
IQ	Ian Quinnell	Interim Director of Strategy and Transformation	GHFT
MH	Mary Hutton	Chief Executive	ICB
JMD	Jaki Meekings-Davis	Non-Executive Director	GHFT

Item	Details	Owner
1.	**Introduction, Welcome and Apologies**	
	JC welcomed the group and noted the apologies as listed above. Quoracy confirmed with members present at the start of the meeting.	
2.	**Declarations of Interest**	
	No new declarations were noted.	
3.	**Review of minutes from the last meeting, held on Thursday 6th July 2023**	
	The minutes from the last meeting were taken as read and approved as a true reflection of the meeting.	

4.	**Action Log Review**	
	The action log was reviewed and updated appropriately. **<u>Outstanding Actions:</u>** **10. A further update on strategic risks, the awareness of these and what is required from the System Resources Committee is to be brought to the next meeting.** *Mark updated that there had been discussions on risk reporting and the Committee would need to have oversight of risks assigned to them. The role of the Committee was to ensure that the risk was being appropriately recorded and that mitigations were in place and being acted on to reduce the risk. Further work was underway within the Corporate Governance team on reporting to ensure that the report which comes to the Committee is relevant and meaningful. Action to be closed but further work to be undertaken on the risk report.* **11. Risk matrix and summary of assigned risks to be sent to members.** *See above action.* **14. It was agreed that a further update on the financial risk share proposal would come to the Committee.** *Currently in 'final version' awaiting sign off. Finance team to share with members virtually. Action remains open to be signed off at the next meeting.* **15. MG to combine feedback regarding Health Economics from SRC with that from Board Development Session and circulate to both ICB and System Resources Committee.** *Action completed & closed. Feedback obtained from board development session on Health Economics, follow on session booked for October.* **16. A 'follow on' Board Development session to be arranged to finalise the definition of value, confirm principles for allocative and technical efficiency and consider the role of the Board.** *Action completed & closed. Feedback obtained from board development session on Health Economics, follow on session booked for October.* **17. STAR pathway documentation to be shared with members virtually.** *Action completed & closed. STAR documentation circulated virtually.* **18. Update to be brought to next meeting around the learning from the STAR programme and future plans.** *Action completed & closed. Item on the agenda for this meeting.* **19. Amendments on the approach to the Medium-Term Plan and Medium Term-Financial Plan to be made (e.g. incorporate the revised definition of value, ensure that opportunities are defined and owned by programmes – involving them at the outset).** *Action completed & closed. Item on the agenda for this meeting.*	

	20. Membership of the August workshop looking at the Medium-Term Plan and Medium-Term Financial Plan to be reviewed by Executives within the ICB and with system partners (as well as System Resources Committee) to ensure that the right Executive, programme leads and clinical leads are involved. *Action completed & closed. Workshops have taken place.* **21. Autumn 'Evaluation' Review approach to be adapted for those schemes which are yet to start/are in early stages of implementation. This should also include incorporating a small number of 'core services' into the Autumn reviews (particularly where there is most potential to improve). To be discussed at Evaluation T&F group meeting.** *Action closed. Delegated to Evaluation Task & Finish Group. Autumn Reviews are paused in light on the Medium-Term Financial Plan.* **ACTION: JC, MG & ER to prepare for the next Board Development session on the follow-up from the Health Economics Session.**	**JC, MG & ER**
5.	**Matters Arising**	
	<u>Value Definition and Principles - Allocative Efficiency & Technical Efficiency</u> The final deck incorporating all comments from board was shared with the group. A definition of value and set of principles for allocative and technical efficiency has been established and agreed. SB queried whether we are incorporating our agreed definition of value into the work on the Medium-Term Financial Plan. It was agreed that this would be picked up as part of those discussions. It was also agreed that our priority system outcomes would sit in the Joint Forward Plan / Integrated Care Strategy. Programmes also have their own programme outcomes (which should feed up and into our system wide outcomes).	
6.	**ICB & ICS Finance Report (M4) and forecast/potential actions**	
	The report was shared with the group ahead of the meeting, CL referred them to this document. This showed that the system was forecasting a break-even position for 2023/24. In year there was a deficit position of £3.8m (of which £2.087m in GICB and £1.7m in GHFT). A number of pressures were driving this pressure including ICB prescribing cost increases and workforce pressures leading to high expenditure on agency and locum staff in GHFT. There was also slippage in savings plans. Work was underway on recovery across all of these areas. The context and challenges identified were outlines within the presentation.	

	CL provided an overview of the ICB finances, advising there is scrutiny on prescribing and the finance team are working with programmes to review their spend. The Committee queried how many levers we have for prescribing. CL discussed the work underway to go and work with practices and identify opportunities and get commitment to the plans. It was also noted the Directors of Finance (DoFs) are planning a session to review each organisational plan. KJ updated on additional GHFT oversight, with the committee identifying actions around the run rate reduction. It was noted GHFT are working through the national checklist and undertaking 'ward by ward' establishment checks. KJ noted that agency spend is reducing but there is still work to be done on this. KJ outlined the additional actions being taken to reduce spend and to quantify savings. The Committee held a discussion about the likelihood of meeting ERF targets. MW highlighted that we had hit targets for Q1 but that there were challenges – including the impact of industrial action. CL explained the risks if we were not able to deliver a break even position for 23/24. This would include greater scrutiny of our spending as well as restrictions on capital spend. Given the challenges around our financial position, there was a discussion about whether we should move to formal system oversight of our spend. This was set out in our financial framework that was presented by CL. This meant that we were formally recongising that the risks could not solely be managed within an individual organisation. In practice this would mean that spend over a specific threshold (£50k for GICB and GHFT / £100k for GHC) would need system approval. **Decision: DoFs recommendation is that we move to system oversight, no objections were raised.**	
7.	**Medium-Term Financial Plan** ***Including run rate analysis***	
	CL presented an update on the Medium-Term Financial Plan. There was a requirement to deliver a 5 year plan that delivers revenue balance by 24/25 and recurrent revenue balance by 28/29. This also needed to align with work on the Operational Plan and Joint Forward Plan submissions for 24/25. The group were advised of the submission deadlines in September for the Medium-Term Financial Plan (initial submission on 8th September and final submission on 28th September). The Committee queried the robustness of the Medium Term Financial Plan at this point. CL responded to say that this was variable and that further work was being undertaken to strengthen and develop the plan. ER stated that we need to ensure that double counts across programmes are not included in the Plan.	

8.	**Performance Report**	
	MW referred the group to the August report, providing a brief overview of the performance. KD presented the key points from within the report and described the metrics being analysed. Good progress had been made in reducing the number of patients waiting for cancer treatment and IAPT recovery rates were at their highest since 2020. However, the presentation described that industrial action was continuing to have an impact on both urgent care and elective recovery across the system. It was expected that the August bank holiday weekend would be extremely disruptive to elective care in particular. A discussion was held about the national decision to reduce the ERF targets in response to industrial action and the impact of this for Gloucestershire was under review. It was noted the metrics report is being developed at present to reflect the metrics included within the Joint Forward Plan (JFP) and are linking into more in-depth dashboards. This would be further discussed with the Committee at the next meeting.	
9.	**Committee Risks**	
	MG shared the committee risk report and explained the process for reviewing and updating corporate risks. MG noted that each risk has been allocated to a committee to review and provide a level of challenge to ensure they are mitigated and are being moved forward. The group reviewed each of the risks allocated to the committee. **Action: MG to liaise with the Corporate Governance team to move the risks that do not sit with System Resources Committee.** It was also agreed that the consistency of scoring should be reviewed.	**MG**
10.	**Developing an approach to Allocative Efficiency – STAR approach for diabetes**	
	HJ set the context for the approach that has been developed. Including the pathway mapping, patient survey, evaluation and the workshops & research carried out. Interventions requiring focus were identified. Work has since been undertaken to establish how this process could be replicated within the ICS, without CSU involvement. MG and HJ presented the proposal developed, noting if this was to be adopted it would be integrated into the way we work, rather than a ‘stand-alone’ process, therefore additional resource would be required.	

	It was noted that this approach is based on engagement with patients and practitioners/clinicians. JC noted the challenge around quantifying the information gathered.	