Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 27th March 2024

Committee Room, Ground Floor, Shire Hall, Westgate Street, Gloucester, GL1 2TG

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** Apologies: Mark Cooke	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 31st January 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** *(ICP patient story)*	Discussion	**Mark Walkingshaw/Becky Willmoth**
7.	2.30 – 2.50pm	**Health & Wellbeing Partnership update**	Discussion	**Cllr Carole Allaway-Martin** **Siobhan Farmer** **Mark Walkingshaw**
8.	2.50 – 3.00pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	3.00 - 3.10pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.10 – 3.30pm	**Integrated Finance, Performance, Quality and Workforce Report including Primary Care Access Recovery Plan**	Discussion	**Mark Walkingshaw** **Tracey Cox** **Marie Crofts** **Cath Leech**
		Decision items		
11.	3.30 – 3.45pm	**Progress Report – Public Sector Equality Duty and the Equality Delivery System**	Approval	**Tracey Cox**
12.	3.45 – 4.05pm	**Joint Forward Plan**	Approval	**Ellen Rule** **Mark Golledge**
13.	4.15 4.25pm	**ICB Interim Procurement Strategy**	Approval	**Mark Walkingshaw**
		Information items		
14.1	4:25 – 4:30pm	**Chair's verbal report & ARAC assurance report on the Audit Committee** meeting held on 7th March 2024 and approved minutes of the Audit Committee from 7th December 2023	Information	**Julie Soutter**
14.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** meeting held on 1st February 2024 and approved minutes from 7th December 2023		**Ayesha Janjua**

14.3		**Chair's verbal report on the System Quality Committee** meeting held on 15th February 2024 and approved minutes from 13th December 2023	**Prof Jane Cummings**
14.4		**Chair's verbal report on the People Committee** meeting held on 8th February 2024 and approved minutes from 26th October 2023	**Karen Clements**
14.5		**Chair's verbal report on the Resources Committee** meeting held 7th March 2024 and approved minutes from 16th January 2024	**Prof Jo Coast**
15.	4.30pm	**Any Other Business**	**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 29th May 2024 – 2.00-4.30pm

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 2.00pm to 4.00pm on Wednesday 31st January 2024

Virtually and at Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Dame Gill Morgan	GM	Chair, NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, NHS Gloucestershire ICB
Ayesha Janjua	AJa	Non-Executive Director, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Douglas Blair	DB	Chief Executive Officer, Gloucestershire Health & Care NHSFT
Ellen Rule	ER	Deputy CEO & Director of Strategy and Transformation, NHS Gloucestershire ICB
Dr Jo Bayley	JB	Chief Executive, GDOC Ltd.
Prof Jo Coast	JCo	Non-Executive Director, NHS Gloucestershire ICB
Prof Jane Cummings	JCu	Non-Executive Director, NHS Gloucestershire ICB
Karen Clements	KC	Non-Executive Director, NHS Gloucestershire ICB
Kevin McNamara	KM	Chief Executive Officer, Gloucestershire Hospitals NHSFT
Marie Crofts	MCr	Chief Nursing Officer, NHS Gloucestershire ICB
Prof Sarah Scott	SS	Executive Director of Adult Social Care, Wellbeing and Communities, GCC
Tracey Cox	TC	Director of People, Culture & Engagement, NHS Gloucestershire ICB
Participants Present:		
Ann James	AJ	Executive Director for Children, Gloucestershire County Council
Benedict Leigh	BL	Director of Integration, NHS Gloucestershire ICB and Gloucestershire County Council
Carole Alloway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHSFT
Graham Russell	GR	Vice Chair, Gloucestershire Health & Care NHSFT
Helen Goodey	HG	Director of Primary Care, NHS Gloucestershire ICB
Ingrid Barker	IB	Chair, Gloucestershire Health & Care NHSFT
Mark Cooke	MCo	Director of Strategy & Transformation, NHSE
Mark Walkingshaw	MW	Director of Op. Planning & Performance, NHS Gloucestershire ICB
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
In Attendance:		
Christina Gradowski	CG	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Maniza Rahman	MR	Associate Non-Executive Director, NHS Gloucestershire ICB
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
Karl Gluck (Agenda Item 6 & 9)	KG	Head of Integrated Commissioning (Adult Mental Health) NHS Gloucestershire ICB
Jo Tym (Agenda Item 6)	JT	Lived Experience Practitioner, Complex Emotional Needs Service, Gloucestershire Health & Care NHSFT
Rachel Furmage (Agenda Item 6)	RF	Peer Support Worker, Complex Emotional Needs Service. Gloucestershire Health & Care NHSFT
Jo Greenwood (Agenda Item 6)	JG	Clinical Development Lead, Complex Emotional Needs Service, Gloucestershire Health & Care NHSFT

Jan Marriott (Agenda Item 6)	JM	Co-Chair, Gloucestershire Health and Wellbeing Partnership Board, Gloucestershire Health & Care NHSFT
Laura Price (Agenda Item 6)	LP	Lead Psychologist for Complex Emotional Needs Service, Gloucestershire Health & Care NHSFT
Derek Hammond Agenda Item 10)	DH	Deputy Chief Operations Officer, Gloucestershire Health & Care NHSFT
Helen Ford (Agenda Item 10)	HF	Deputy Director – Integrated Commissioning, NHS Gloucestershire ICB and Gloucestershire County Council

1. Welcome and Apologies

1.1 The Chair welcomed five new members; Kevin McNamara, the new Chief Executive of Gloucestershire Hospitals NHS Foundation Trust (GHFT),and looked forward to him participating in meetings and bringing his experience to the Board.

Dr. Ananthakrishnan Raghuram, the new Chief Medical Officer was welcomed along with Ayesha Janjua, Non-executive Director who was now the Chair of the Primary Care and Direct Commissioning (PC&DC) Committee, Marie Crofts, the new Chief Nursing Officer and Karen Clements, a new Non-Executive Director who was Chair of the People Committee and the Remuneration Committee.

Apologies were received from Olesya Atkinson, Julie Soutter and Siobhan Farmer.

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

1.3 The meeting was declared to be quorate.

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 new declarations of interest for this meeting.

3. Minutes of the Public Board meeting held on 29th November 2023

3.1 The minutes from the Public Board meeting held on the 29th November 2023 were approved as a true and accurate record of the meeting. There was nothing to raise that was not already on the Agenda for this meeting.

4. Action Log and Matters Arising

4.1 There were no matters arising and no other actions to be noted.

4.2 Due to the issues around Maternity, having been highlighted by the BBC's Panorama television programme on 29th January 2024, KM updated members of the Board on this. KM had watched this with the Midwifery team at GHFT which had raised issues from 2019-2021.

A significant amount of time had been spent in preparing the organisation for this programme to ensure that the momentum was maintained around improvements already underway within the Trust, but also to support mothers currently under the care of the Trust to ensure that their fears or concerns were allayed.

KM felt that as the programme coinciding with his early tenure in the Trust this meant he could look at not only prioritising Maternity services with fresh eyes, but also examine the leadership in action which so far, he had found impressive and reassuring and had over the past two years, led to significant changes within Maternity services.

The work undertaken to drive recruitment and retention had resulted in an extra 21 midwives being recruited since the time the Panorama programme had referred to. The safety systems and processes in place within the Trust now included a flow midwife to ensure that staff were sent to areas of key pinch points, as well as regular monitoring of issues requiring swifter resolution throughout the day. Positive progress had been made on improvements albeit further recruitment needed to be addressed during what was a national recruitment crisis.

The programme drew attention to data issues which suggested that maternal deaths in the Trust were twice the national average. KM had sought additional assurance from MMBRACE, an independent organisation hosted by Oxford University, who were asked to examine the Trust's data to see whether this was at odds with that of the BBC's interpretation of it whilst assuring the Trust as to whether it was on the right track. The analysis of Gloucestershire Hospitals NHS Trust maternal mortality rate through Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries across the UK (MMBRACE) from 2017-2023 concluded that the rates were not statistically different from the UK rate. KM did not want to present this as a story about data; it was a story about loss for which the Trust continued to offer its profound apologies and condolences.

KM had felt the evident distress from staff about events that had taken place and how mothers and their families felt about the service now. There was a real sense of determination to continue with the Trust's journey of improvement, which KM hoped could be described in greater detail at a future meeting.

The Chair informed members that a very supportive letter had been issued by Members of Parliament which recognised all the hard work that had been undertaken by the Trust and which also involved them in being engaged and understanding around the issues. This included having seen this through a rounded perspective rather than a single prism and had been very helpful. The Chair also expressed a collective feeling of sympathy on behalf of her colleagues.

5. Questions from members of the public

5.1 There was one question from a member of the public :

What awareness, education, training and support does the Gloucestershire Integrated Care System have in place in relation to menopause for staff. What measure(s) and evidence does the Gloucestershire Integrated Care Board have in place, to have assurance and re assurance that the structures in place (awareness, education, training and support) are positively impactful for the staff across the Integrated Care System.

TC read out the following in response:
The Integrated Care System's Health and Wellbeing Group comprising system partners including GHFT, GHC, ICB, GCC and Gloucestershire Care Providers Association had collaborated on a range of measures made relevant to their own staff with regard to the Menopause; the following list provided examples of the work undertaken.

- Menopause Policy - Working Well Occupational Health Services run by GHC had produced a system wide Menopause policy adopted by GHC and GICB and GCC had its own Menopause policy.

- Intranet resources on the Menopause and women's health issues – GHC, GICB, GHFT and GHFT.
- Lunchtime drop in sessions on the Menopause and regular Health and Wellbeing sessions and drops in for staff on the Menopause etc – GHC, GHFT and GICB.
- The Electronic Staff Record allowed the reporting of menopause symptoms as a reason for sickness which enabled health organisations to monitor the occurrences and tailor measures and actions accordingly.
- The ICS promoted the Menopause World Heath Day last October – GHFT, GHC, ICB etc.
- A Women's Health Day was organised on 18th October Menopause World Heath Day at the ICB.
- E-learning for Health had a new education programme that enabled staff to access information on the Menopause promoted by GHFT and GHC etc.
- Social care – Skills for Care held a menopause awareness session last year. Riki Moody presented flexible working and the menopause at a Regional Retention event in 2023.
- Bitesize menopause webinars which run from 17th October to February 2024 had been promoted across the system.

Additionally, all organisations promote work-life balance and flexible working as a mechanism to help women with managing the menopause at work. A full response is included on the ICB's website.

6. <u>Patient Story – Complex Emotional Needs Service – (CEN)</u>

6.1 JT explained how the Complex Emotional Needs (CEN) service at GHC was an excellent example of co-production and practice. JT demonstrated the ladder of production on the slides and how there had been a big shift nationally towards co-production, the aim of which was to achieve an equal and reciprocal partnership between the service and recipients.

6.2 JT explained how she had started a petition in 2018, to campaign for a Personality Disorder service in Gloucestershire. The petition received 1200 signatures and was presented to the Clinical Commissioning Group (CCG) Board in 2019. The Mental Health Clinical Programme Group (CPG) then devised a three year Personality Disorder Strategy for the county. Four distinct workstreams were organised which consisted of members from the VCS, Experts by Experience and NHS staff to determine the shape and scope of the Complex Emotional Needs service, as it then became, in preference to becoming a Personality Disorder service.

6.3 JT from Gloucestershire Health & Care NHSFT (GHC) described the role of a Lived Experience practitioner in a typical week which also included engaging in the sister service, the Frequent Engagement Response Network (FERN), seeking to support those who were the highest users of blue light services due to their mental health.

The service also assisted with the delivery of the Knowledge & Understanding Framework training whose aim was to raise awareness and to support those with complex emotional needs. Clients were supported with their housing needs and there was help available for those attending Friends and Family groups.

6.4 RF was new to the team and over the last year had been an Expert by Experience, working with the Complex Emotional Needs Steering Group which comprised professionals and people with lived experience of CEN. The Steering Group had been involved in a variety of activities including:

- Tendering out and interviewing potential partners with which to run the service, ensuring that the same ethos and passion about co-production was met.
- Ensuring that the entire service would be trauma informed
- Visiting and choosing the best site for the service to run from
- Deciding on the structure and days/times the service would run.

A new co-facilitated Open Access Therapeutic Support Service (OATS) had been designed which enabled people easier access to services. Once registered, people could attend peer therapeutic support three times a week. The service had been co-produced and co-delivered with Kingfisher Treasure Seekers and would be piloted in Gloucester City. RF stated that being part of the team allowed her to meaningfully engage. She had a voice and was able to help others. The co-production working alongside professionals enabled an understanding of the lived experience and this had created a unique and valuable service that was truly able to be trauma informed.

6.5 TC expressed gratitude to the presenters and their approach with this. TC asked whether there was any evidence nationally to back up the outcomes and feedback from service users as a consequence of having that embedded lived experience, in terms of how the service was performing. JG responded that the University of Oxford had conducted a randomised control trial which had demonstrated that lived experience therapy was just as good as any other national approach. Although lived experience was relatively new to GHC, RF confirmed that it had been running for some time in the bigger cities, with jobs available that were suitable for Lived Experience practitioners to apply for, which recognised this experience as equal to that of a professional qualification.

6.6 SS had enjoyed the presentation and stated that in Adult Social Care, inspections would be conducted differently by the Care Quality Commission (CQC) and central to this change approach would be co-production, which Adult Social Care needed to use more. SS suggested to put RF in touch with some members of her team as they might find the input useful.

6.7 MH stated that this approach was important to hear as it could be built into other services. The development of the service and the way it had evolved was a huge credit to the team who had embraced this new way of working which could be built into future thinking. It was helping people rather than adding burdens to their lives. MH thanked the team for their time today which had demonstrated the value of this service to people of Gloucestershire.

The Chair also extended her thanks to the CEN team which had demonstrated something special that everyone aspired to, combining many facets and hard work, which had been very uplifting and heartening. The presentation had been energetic, inspirational and been very much appreciated by the Board.

6.8 ***Resolution: The Board members noted the content of the patient story from the Complex Emotional Needs Service.***

7. Chief Executive Report

7.1 MH presented her report and started by highlighting the system-wide Dementia Strategy which was also been a good example of co-production. The comprehensive piece of work had involved a consultation with key stakeholders. The key objectives of the Strategy aimed to prevent, diagnose, and support those living and dying with dementia. This Strategy had been to various groups in the ICB for their input and would be approved by a board sub-committee and then made available more widely for staff.

7.2 MH informed the Board that there had been an Ofsted and a Special Educational Needs and Disabilities (SEND) inspection towards the end of 2023 which had been very intense with significant information collated for the inspection. The Report was expected mid-February 2024 and would be available to the Board. AJ commented that a check was being made on the draft SEND report and significant investment had been made in children with Special Educational Needs with continued work to further the ambitions countywide.

7.3 Cheltenham Primary Care Network (PCN) had won PCN of the year which used a Population Health Management approach to showcase work focused on the health needs of those experiencing health inequalities. As well as other initiatives a virtual whiteboard had been created, working with the frailty team, which recorded all those with particular needs who were nearing End of Life which had been very successful. This was now something that would be rolled out to all the other localities in Gloucestershire.

7.4 The ICB recently hosted a visit from the National Team for Children, Young People & Perinatal Mental Health Services, to showcase our Young Adults Mental Health Service for 16-25 year olds, as a model of best practice. Members of the team and the ICB had been invited to join the National Young Adults Working Group which would allow the ICB to share good practice with other health systems.

7.5 MH made a special mention of Go Volunteer Gloucestershire. Following on from the Covid-19 pandemic it became clear that Gloucestershire was short of volunteers and it had proven difficult to match volunteers with opportunities. Go Volunteer Gloucestershire had been set up by the Voluntary and Community Services Alliance (VCSE) and had really grown and become well known and used across the county. It was noted that there would be a page for Trustees to encourage them to volunteer in Gloucestershire due to the current shortage.

7.6 MH explained that each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS2), an improvement framework designed to assist organisations in assessing their performance and identifying future improvement actions.

The PSED included a requirement that the ICB will publish equality information about both the communities it serves and the staff it employs. It also required ICBs to have one or more published equality objectives, which were specific and measurable and cover a period of up to four years. More information on this will be brought to the March ICB Board meeting.
Action: RB to place PSED on the March ICB Board Agenda. **RB**

7.7 MH spoke about the planning guidance for 2024/2025 from NHS England (NHSE), which was due shortly There would be further details in that planning guidance to be considered by the ICB when it arrived.

7.8 JCo commented that that she had been really impressed with the ease of navigating the Go Volunteer website and the ability to find volunteering opportunities and felt that it was a good area in which to be involved.

7.9 JCo also queried how any resource implications in the co-produced Dementia Strategy were built into current planning. MH explained that the Strategy at this point did not have resource indications outlined as these were already in place with pilots underway for improving the diagnosis of dementia. The ICB was working with the voluntary sector and other partners to develop ongoing support at a locality basis. Further resources may be required in the coming year but currently the focus was to re-shape and target those resources in line with the Dementia Strategy.

7.10 JCu asked whether the Dementia Strategy contained any information on delirium pathways as this was an important distinction. **Action: MH to check on the delirium element within the Dementia Strategy and report back to JCu.** **MH**

7.11 The Chair suggested that Dementia Champion training could be undertaken together at a Board Development session as she had found this useful and enlightening and enabled her to think and be able to talk to others about dementia. The members expressed enthusiasm regarding this. **Action: Dementia Champion training to be placed on a future Board Development session.** **PMO**

7.12 ***Resolution: The Board noted the content of the Chief Executive Report.***

JB joined the meeting at this point.

8. Integrated Finance, Performance, Quality & Workforce Report

8.1 MW stated that it would be helpful to have feedback from Board members on the Integrated Performance Report and whether this was meeting the needs of members. New members would also have an opportunity to put forward their contributions around future reporting.

8.2 MW updated on Performance:

- Due to the dedication and commitment of front line staff during the two recent periods of industrial action, the system had avoided any cancellations of urgent cancer treatment and there had been strong support in Urgent and Emergency Care (UEC) which enabled swift system recovery.
- Cancellations of elective work in December and January had impacted delivery against year-end targets, particularly for GHFT and other providers in and out of county.
- Elective performance continued to deliver against the national target and the system was on track to deliver the year-end position as set out in the report. This would attract additional investment through the Elective Recovery Fund (ERF) and help reduce waiting times.
- Diagnostic performance was in recovery against the national 6 week standard and GHFT had significantly improved turnaround times for diagnostic results.
- Significant performance pressures remain in UEC around Emergency Department (ED) performance and in ambulance handovers. Work continued with Newton Europe to aid performance recovery.
- 65 and 78 week wait standards had seen a small deterioration of the positions with particular pressure in Ear Nose & Throat (ENT) and oral surgery specialties. Additional lists conducted over evenings and weekends, assisted also by private sector colleagues, were helping with recovery.
- Endoscopy capacity and performance continued to be a concern due to increased numbers of surveillance patients being placed onto diagnostic waiting lists.
- GHFT had conducted some work on assessing demand and capacity around endoscopy and some additional non-recurrent resource had been made available from NHSE to help support further inroads.

8.3 TC updated on Workforce:

- Funding had been successfully secured for the Wellbeing Line enabling ongoing support for staff across Gloucestershire.
- Work continued around the International Recruitment project and 18 providers had been shortlisted as being eligible for the project.
- Two funding opportunities had arisen, one was for Volunteering for Health which would help with growing the volunteer workforce across health and care. A bid will be submitted before the February deadline. The second opportunity was around a

WorkWell Programme where funding would support people who were experiencing barriers to returning to work. A bid had been submitted and results will be known in April. TC extended thanks to partners who had assisted with the submission.

- Both Trusts had been below the cap for reducing agency and temporary staffing spends in the last couple of months which was positive.

8.4 MC updated on Quality and commended the impressive system working during the time of the industrial action. MC stated that she would be happy to examine the Performance report in order to aid improvement around the Quality aspect and will work with colleagues on this.

- A lot of hard work had gone into migrant health and the ICB continued to work with the MOD in Monmouth to ensure that these vulnerable people were being supported.
- The Quality Improvement Group established for Berkeley House continued to note improvements and unannounced visits had not noticed any further concerns.
- MC attended her first Local Maternity & Neonatal System (LMNS) meeting which she will be chairing from now on and noted significant improvements having taken place in the last few years, particularly around the recruitment of midwives. There was further work required around CQC actions. A single integrated action plan was being worked on to drive through the 3 year delivery plan.
- The implementation of the Patient Safety Incident Response Framework (PSIRF) was on track and MC thought that the learning and language around this would be important as it would change how things were undertaken, completed and lessons learnt. The policy would going to the Quality Committee meeting in February.

8.5 CL updated on Finance:

- A deep dive had taken place on the financial position at the end of November and the forecast for the system for 2023/24 was one of break-even. In the Month 9 forecast position, there was a small overspend of £1.65m, which was made up of £1.95m industrial action costs relating entirely to December and January. Some small mitigation actions were applied to bring the figure down to £1.65m.
- Mitigating actions were being examined to bring that figure to a break-even position and it was unclear whether there would be any additional funding for this. The ICB position was in surplus of £3.5m to bring the system position back to a break-even position.
- GHFT had been working on their recovery plan and had seen significant changes from Month 8 due to controls put in place which had started to have a positive impact for both Trusts, enabling agency costs to decrease significantly.
- The productivity work in GHFT in theatres and outpatients had started to make a difference and would enable a greater number of procedures to take place going into next year.
- There were some non-recurrent mitigating actions but the focus will be on recurrent savings for all organisations to help the start position for next year.
- ERF is at 105% and there is some additional funding assumed within that forecast position and continue to deliver over and above the target of 103%. There were some remaining risks to the end of the year which included possible industrial action for February and March. Placements continued to be a concern and there was an increasing trend in the number of Continuing Healthcare packages. The impact will be greater next year than that for the remainder of this year as the trend continued to grow.
- The Better Payment Policy continued to deliver more than 90% and is a focus to ensure that the ICB pays suppliers on time.

- The capital forecast overspend was £4.6m due to the impact of the International Financial Reporting Standards (IFRS)16 finance leases where nationally funded and received insufficient funds to cover costs. The Month 8 (November) allocation was significantly below the actual costs so there was a forecast overspend. Further work had been undertaken since the report to mitigate that and the forecast, as of today was c£3.6m. There was further work underway and some of the mitigations also included bids against contingency funds held by NHSE. If there was an overspend on capital, this would come from the 2024/2025 allocation and would create a pressure into next year.

8.6 The Chair invited MCo from NHSE to comment on system performance from a regional perspective. MCo started by recognising the hard work in diagnostics and maternity and in UEC which was an issue across the country. NHSE was working with all systems across the South West to focus on UEC. There had been a lot of respiratory disease in the early part of 2024 and some cases of measles. It had been recognised that staff had been working incredibly hard to address those issues in Gloucestershire and to deliver good care for the population. The way about people felt about the NHS was really important and would be an area of focus for the NHSE as a region.

8.7 MCo commended the open style of reporting of the Board around subject matter and the resulting actions taken. MCo also approved of the integrated approach to Performance reporting. NHSE was currently working with all seven ICB's in the South West to develop a more consistent approach to performance reporting with the aim to cut down on the bureaucracy and overhead that NHSE created. It was hoped that this would have an impact in the near future as both NHSE and the ICB reduced their headcount and so it was important to help use resources in the best possible way, allowing stronger focus on areas of importance and improvement.

8.8 The Chair stated that performance reporting was a work in progress and some other things needed to be included, for example how the ICB was performing on population measures. The Chair was concerned about measuring Primary Care outcomes, some of which could be undertaken by conducting deep dives. Ubiquitous measures were needed to ensure that performance took Primary Care into account. The Board was well aware that the extra demand on Primary Care which was more significant than in any other part of the system.

8.9 DE said that when the Chair's visit on End of Life care took place in December, an issue was raised which was a known risk on the Risk Register, about choice of place to die, where it appeared this was being slowed due to financial constraints on the Continuing Healthcare (CHC) budget. DE questioned whether there was an update on this, as it was of concern.

8.10 DE reported that she had been with the trauma team looking at fractured neck of femur and hearing about swifter theatre access and improvement of outcomes. The team was very focused on discharge arrangements but they were experiencing difficulties around discharge to P2 beds and the number of people in hospital with No Criteria to Reside. DE wondered whether there was an update on this.

8.11 MH replied that the ICB was very aware of the P2 bed issue. There was significant P2 capacity in Gloucestershire and there is still a 70/30 split between P2 and P1 pathways on discharge. The plan is to move to a 50/50 split with too many people being placed on the P2 pathway when there was P1 capacity available. Work was being carried out to examine better capacity use in P1.

8.12 MH explained that there were no waits for CHC assessments and no CHC capacity issues. There were issues around the End of Life capacity and each of the issues were being worked through as they presented, with a fair amount of redesign and change in the culture.

8.13 ER recognised the points that DE had raised and the challenges in P2 which had been due to extending capacity in P1. There had been some constraints on P2 whilst trying to achieve that culture change. The performance report noted a No Criteria to Reside figure of 205 which had been at a particular peak. The number had been somewhere between 160/180 over the last few days and the list was fluctuating as people went onto and came off that list. Placement times had reduced significantly and had reduced from 16 to 5 days. Whist numbers were still higher than preferred, the turnover and duration was also an important aspect of progress being made. There was still more work to be undertaken.

8.14 ER acknowledged that there were issues with the End of Life pathway and added that a deep dive review on CHC had taken place in December. This had shown that the issues were not due to CHC capacity. This had been addressed and BL was part of that review.

8.15 BL stated that the issues may lie with fast-track instead of CHC. BL confirmed that they were aware of the issues anecdotally, but they were not borne out by the data. Fast-track assessments and awards were made as speedily as possible and Gloucestershire remained a fast track outlier with a high level, with a caveat that it was difficult to make a full comparison with the national data. Gloucestershire awarded fast tracking far more than many other areas.

8.16 BL explained that they were confident that those who needed to be awarded fast track, were awarded it, but there would always be some people who would not meet the criteria. Moving into fast track for frail, older people with multiple conditions, meant that outcomes were far more difficult to predict. Some people were appropriately, clinically assessed and were refused fast track, but then very sadly, went on to die in the wrong place. BL acknowledged this needed to be examined further and that the P1 discharge (home pathway) needed to be right. The team was working with domiciliary care agencies to support people who were not eligible for fast track but were at End of Life.

8.17 IB commented that the Chair's visit spanned everything from district nursing and community through to End of Life on the ward and had also included some commentary around Primary Care. The strength of the disconnect from what was heard on that visit. and what the data appeared to be saying was very significant. It was suggested that this might be one area where listening and working jointly with the people on the ground, including the families, might prove to be fruitful.

8.18 GM suggested that a meeting be convened with the appropriate system partners to collectively understand the scale of the issues and what was being measured against and that this be monitored through the System Quality Committee. Once identified, the scale of the issues could be presented back to the Board so that a common approach is recognised across the system. **SQC**

8.19 HG commented that there had been a significant increase in activity due to increased demand for Primary Care to around 26-27%. Although additional monies for winter pressures had been put into Primary Care to support additional capacity, there were still a significant number of practices that were struggling financially. Work would continue with the Local Medical Committee (LMC) to improve the Operational Pressures and Escalation Levels (OPEL) reporting to ensure that this would be systematic and accurate and would reflect the current challenges being faced by Primary Care.

A survey would be undertaken, led by OA which would conduct a deep dive into a number of practices to start to examine activity levels and what could be done as a system to alleviate some of that demand, including bureaucracy and pathway challenges. Further updates would follow.

AR confirmed that he would like to place on record his thanks to the entire system particularly Primary Care, who had gone above and beyond the call of duty during the periods of industrial action. The insatiable demand at present meant that Primary Care was struggling and there was so much clinical and financial risk in the system. AR would like to see what the system could do to tackle this to ease pathways and to ease the situation for Primary Care.

8.20 AJa also stated that risk had been highlighted to her by other colleagues. Financial destabilisation was not well recognised, understood or voiced. The Primary Care team was working hard to prevent practices from collapsing in Gloucestershire, as some had in other parts of the country, but at some point, the external factors could lead to a risk of this happening in the county. This risk needed to be understood by all parts of the system.

8.21 AJa spoke about incident reporting in Primary Care and how that could link into the reporting that was seen by the Board. Incident reporting was conducted for POD for example but was not seen for general practice so it would be good to see this come to fruition.

8.22 JB explained that Gloucestershire had been protected so far from some of the disturbing things that had happened in other areas due to the efforts of the Primary Care team who had done a marvellous job in very difficult circumstances. There was only so much that could be done whilst the Primary Care system was under such strain, added to by measles which was likely to advance into the county.

8.23 The Chair recognised the work around the Performance report, stating that this would be a continued area of focus for the Board.

Resolution: The Board members noted the content of the Integrated Finance, Performance, Quality & Workforce Report.

9. All Age Mental Health & Neurodiversity

9.1 BL introduced the presentation, recognising the benefit of having the Experts by Experience at the Board, as that work and the approach was at the core around the work on mental health. This was something that needed to be collaboratively worked on with the people who used the services and their families and to ensure that those who had issues with any aspects of their mental health, had the right support. The aim was to provide an update on the transformation work taking place and the impact this was having on the performance of those services.

9.2 The Integrated Care Strategy was built around 3 pillars, reflecting commitment to prevention and community/neighbourhood based care. The presentation described collective contributions to improving mental health services across those three pillars, and BL spoke about the work that had been undertaken to support self-care and mental wellbeing for children and young people with a promotion in localities, on prevention and early intervention.

9.3 Transforming services was key so the community mental health offer had been improved, along with that of improved support in schools and access to young people by testing a new navigation hub. Tackling waiting times in Eating Disorders and for Children & Adolescent

Mental Health Services (CAMHS), and by combining pathways for Autism and ADHD were some of the things that had been addressed.

9.4 BL described the various interventions available for supporting self-care and mental wellbeing for children and young people, in a way which worked for them, which included web and text chat, online support groups, working with Young Gloucestershire and offering creative health programmes.

9.5 Since March 2021, Primary Care Networks (PCNs) had received non-recurrent funding totalling c£3.5million across the last 2.5 years, in order to identify the local health needs for their population. Focus had been on the implementation of Locality Community Partnerships (LCP) of which there were a couple to go before the end of March. These would be put together by health, care and VCSE to support adults with early triage and offering the best treatment early on. 15 new Mental Health Practitioner roles had been introduced to help with this. The community mental health approach would be mainstreamed into the local offer.

9.6 Support to over 130 schools was being given by the introduction of seven Mental Health Support Teams (MHSTs) across Gloucestershire, locally known as "Young Minds Matter". Gloucestershire was delivering the best performing MHSTs in the South West and beneficial impact was being seen which was helping in the broader partnerships of education, mental health and social care. This Quality Improvement approach to developing a Children and Young People's Multi-Agency Navigation Hub was being tested in order to develop learning for a county-wide model. DB had participated in the triage process which had included multiple partners working in collaboration to give the best possible early intervention service.

9.7 In Eating Disorders, the National Access Key Performance Indicators (KPIs) for Children and Adolescents were being consistently met, but an ongoing focus would be required for routine Children and Adult referrals. The route to improving would be to transform the approach by improving engagement with VCSE partners, and early triage in the pathway, ensuring sufficient and appropriate support was being offered during that wait.

9.8 For young people who arrived at the CAMHS front door, the best benefit would be from VCSE support. CAMHS would support onward referral enabling young people to reach the right destination. There was still workforce issues to address here, but job descriptions had changed to enable recruitment from a wider pool of resources. Waiting lists had dropped and substantial improvements had been made into the backlog.

9.9 The Board had signed off increased investment for the Adult's and Children's Neurodiversity pathways with recruitment underway for the significantly increased demand.

9.10 Future priorities would mean a focus on collaborative working with communities and the Voluntary, Community & Social Enterprise (VCSE) to bring about long term sustainable change. The long term demand model was not yet known as the system came out of Covid and some of the responsive planning would need to reflect how much of this was compressed demand and how much was long term demand shift.

9.11 The Chair recognised that a lot of progress had been made on this subject and liked the way that the work had been presented under the 3 pillars and had collectively co-created something which kept a focus on the goal rather than the here and now.

9.12 HG commended the way that this was working within the neighbourhoods, by keeping that lower end of acuity in Primary Care where it was needed, along with wrap-around services, which had demonstrated a reduction in the referrals into secondary services, which was the way that services should continue to be built.

9.13 MC asked whether working with the parents had been considered. KG explained that there was an all age Autism Strategy which had been co-produced with Experts by Experience and family members. Work with families was being undertaken and Autism and ADHD would be taken through the Partnership Board and through the Clinical Programme which was an all age approach. DH commented that this was an area of focus and needed more development in order for it to have a meaningful impact.

9.14 TC asked about the Mental Health Investment Standards (MHIS) and whether these had been considered in the transforming of services and changed pathways. TC also queried the sustainability of the overall delivery model given potential future nationally funded priorities.

KG clarified that MHIS funding had not covered ADHD. Whilst the ICB received separate transformation funding for Autism, this had not been received for ADHD. It was welcome that the investment had been made into ADHD services for Children and Adults but there was no national funding relating to that; it was received for mental health and for Autism and Learning Disabilities.

DH responded that the transformation model had been built around sustainability which was at the heart of this, and would remove pressure from specialist services, allowing people to take more control of their own health. Central funding had helped build the structures but what had been built now and what would be rolled out five years hence, would look very different. The needs of differing neighbourhoods would have to be considered. DB added that looking at the workforce blend would allow more of this work to take shape.

9.17 The Chair said she was very enthused and impressed with the work that was currently being undertaken and thanked all those involved.

9.18 ***Resolution: The Board noted the content of the All Age Mental Health & Neurodiversity presentation.***

10. Local Maternity Neonatal System (LMNS) Update

10.1 MC updated the Board The report by speaking about the LMNS three year delivery programme attached to which was a very detailed Risk Log and a variety of papers. One key risk was around workforce. Three new obstetricians were being recruited and there had been a reduction in the vacancy rate for midwives. Close work would need to be undertaken with the Trust around the antenatal scanning pathway and how the system could solve the issues there.

10.2 KM thought that although there was a current focus on midwifery, it was important to look at things through a multi-disciplinary team perspective rather than one particular area. KM stated that recruitment and retention was positive and was progressing, although there was still more to do. The Aveta Birthing Unit in Cheltenham and the post-natal beds at Stroud Maternity Hospital were still closed due to staffing issues. Consolidation of staff on the GRH site had seen the number of safety incidents drop and so the decision had been the right one. Re-opening those services could be challenging due to the BBC programme and the possible effect this might have on recruitment and retention. However, the Trust was committed to working through this over the coming weeks.

Co-ordination of oversight on Maternity Services was dependent on good leaders wanting to drive forward the improvements with the Trust's backing. KM stated that this was a conversation he was keen to have with the service. KM considered that assurance across

stakeholders and regulators was something that could strengthen assurance and provide a single view of maternity. Following the BBC programme, KM had written to the Maternity Advisor (MIA) asking for her support in a review of the number of maternal and neonatal deaths as it was important to have the real version of the truth. This would shape the Terms of Reference with the input of the ICB and LMNS and would subsequently be shared with the MIA. There were some systemic issues, such as national recruitment issues, and some of the issues were organisational in terms of culture. Culture was a top priority and there was more work to do to understand what that would look and feel like in the Trust. Currently there were many different action plans and surveys taking place and the teams were somewhat fatigued by that. It was hoped that as a result of this work some real clarity and a single voice would strengthen the assurance that could be given through these routes but also in the confidence that could be given to prospective mothers in the community around GHFT's services.

10.3 It was noted that midwifery attrition was above the national targets. 75% of the attrition was in midwives who were 40 and above. KC wondered whether there was an experience/competency issue in midwifery as well as a numbers issue.

10.4 This was an issue for the NHS workforce generally. There was a pipeline for internationally educated midwives to come through, although a measured approach would be needed in terms of the support they would need regarding the different exams and compliance and this applied across all the services. The Chair stated that there was a need to make the midwifery profession more attractive otherwise the problem in 5-10 years would be even more profound.

10.5 JCu said there had been a lot of work around recruitment and the County was far better placed than in some areas. When this was balanced against the CQC rating and the BBC programme this had an impact on morale and on recruitment to be able to solve some of the issues raised. JCu felt the new leadership team had made a big difference and the new posts created by the Trust had been positive. She mentioned the Kings Fund work on the experiences of newly registered nurses and midwives – Follow Your Compassion where midwives had talked about what had been important to them. JCu would be happy to share the outcome of the work with Matt Holdaway and the team as there may be some useful lessons which could be useful in terms of retention of new staff.

10.6 IB praised KM for his remarkable compassion and candour exhibited during the television interviews; she wished him well with the cultural journey he would be embarking on. IB asked about the ethnicity data and the experience around this. Unfortunately, maternal mortality for Black women was currently three times higher than that of White women and so IB wanted to know what the lens would look like to ensure that cultural awareness, sensitivity and other factors would be built into the plan.

10.7 KM reported that there was a programme of work called Black Maternity Matters that the Trust were heavily involved with which was supported by the Academic Health Science Network. KM chaired the Patient Safety Collaborative for the AHSN so was familiar with this work. They had recently written out to organisations to seek support from members of their senior leadership to take part in that programme so that the management could make decisions and support that. Matt Holdaway would be attending that programme.

10.8 DE responded that she had watched the BBC programme, and noted the real distress felt by maternity staff and the women interviewed. She had seen the service through the new leadership and management lens vs. previous times. The culture in DE's view had changed for the better due to the whole ethos of the new management and there was far more

openness with people feeling able to speak up helped by the new Freedom to Speak Up Guardian.

10.9 JB mentioned the digital element inclusion/exclusion in that patient autonomy in understanding their condition was really important. Some people did not have access to antenatal Apps, due to not having continual access to a smart phone or access to the internet. Any system that completely relied on digital access was at risk of excluding some of the neediest patients and should be borne in mind when thinking about communications. The Chair agreed that this was a really important consideration.

10.12 The Chair raised membership of the LMNS noting that new people had joined the ICB and asked that consideration be given if the right people were included and whether more challenge could be built in. This was important to help KM and MC to accomplish future requirements. **Action: MC to examine membership of the LMNS.** **MCr**

***Resolution*: The ICB Board noted the content of the Local Maternity Neonatal System update.**

11. Committee Updates

11.1 Chair's verbal report and ARAC assurance report on the Audit Committee meeting held on 7th December 2023 and approved minutes of the Audit Committee from 4th October 2023

11.1.1 CL provided a brief overview of the meeting held in December pointing out that work on risk management and the Board Assurance Framework (BAF) had been thoroughly reviewed and that the March Committee will see a see a more comprehensive approach to that. The BAF would then be reported to the Board at its March meeting.

11.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 7th December 2023

11.2.1 AJa informed the meeting that previous minutes contained within the papers had only required one item of approval which was around the decision to merge two practices. The meeting on 7th December discussed financial resilience in Primary Care as a key risk. There had been good progress in securing additional activity in dentistry. An engagement event had been held for providers which had proved useful in rebuilding relationships and trust and would be helpful in driving the dental strategy forward. There had been an update on the Primary Care Strategy and the PCDC had highlighted to the MOD the significant impact on Primary Care and community services around migrant health.

The Chair noted that there would be a report on dentistry which would be important for the local population and thought also that there should be a longer item around Migrant Health as this was a really challenging area in which to work for staff. HG responded that the migrants at the MOD base in Monmouth were being supported through a bespoke Primary Care service which would be delivered by GDoc Ltd.
Action: Primary Care Team to bring a detailed report on Migrant Health to a future Board meeting. **PCT**

11.3 Chair's verbal report on the System Quality Committee meeting held on 13th December 2023

11.3.1 JCu reported that there was a review of an audit conducted on the Discharge to Assess beds (now P2). JCu spoke about the importance of sending the most appropriate patients to those beds and ensuring that they received the correct support. A new System Experience Group had been established and there had been an update on the People Panel. A variety of different policies had been approved which would be coming to the next meeting.

11.4 Verbal report on the Resources Committee meeting held on 16th January 2024 and approved minutes from 17th November 2023

11.4.1 The framework on Capital Planning was discussed and how priority areas could be balanced with equity across partners. The evaluation on Benefits Realisation was also discussed.

Resolution*: *The Board members noted the updates from the Committee meetings.

12. Any Other Business

There were no items of Any Other Business.

The meeting concluded at 4.20pm.

Time and date of next meeting

The next Board meeting will be held on Weds 27th March 2024 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

March 2024

Open actions only

Meeting Date Raised	Reference	Action	Due	Updates	Status
29/11/2023	**Min 14.9 Delivery Plan for Recovering Access to Primary Care**	The next steps will be to progress the Plan and to bring an update to the March 2024 Board meeting.	**27th March 2024**	An update is due as part of the agenda for the March 2024 ICB Board Meeting. The Primary Care Delivery Plan for Recovering Access is appended to the Integrated Performance report	**Action to be closed**
31/01/2024	**Min 7.6 Public Sector Equality Duty**	PSED to be placed on the March ICB Board Agenda.	**27th March 2024**	This has been included within agenda item 11 of the March Board meeting. **Actioned.**	**Action to be closed.**
31/01/2024	**Min 7.10 Public Sector Equality Duty**	MH to check on the delirium element within the Dementia Strategy and report back to JCu.	**27th March 2024**	In section 10 of the Dementia Strategy Delirium is included and referenced in other relevant places in the strategy for example training.	**Action to be closed**
31/01/2024	**Min 7.11 Dementia Champion Training**	Dementia Champion training to be placed on a future Board Development session.	**27th March 2024**	This has been forward planned for the 28th August Board Development session. **Actioned.**	**Action to be closed.**
31/01/2024	**Min 8.18 P2 beds/EoL**	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	**May 2024**	A discussion has been included on June agenda for the System Quality Committee with regards to EOL.	**Action to remain open.**

31/01/2024	**Min 10.12 LMNS membership**	MCr to examine membership of LMNS.	**May 2024**	The review of the LMNS Board is currently underway following a meeting and advice from the SW perinatal team on 4th March. MC will confirm at the May Board this has taken place.	**To remain open**
31/01/2024	**Min 11.2.1 Migrant Health Report**	Primary Care Team to bring a detailed report on Migrant Health to a future Board meeting.	**July 2024**	A detailed paper will be submitted to the July ICB Board on Migrant Health	**To remain open**

Patient Story

The following patient story demonstrates the importance and impact of opportunistic testing at community based events, particularly for issues like Hypertension which may have no symptoms .

Rebecca popped along to one of the community drop-in vaccination clinics delivered by the GHC Outreach Vaccination and Health Team to get her spring Covid booster and while there she took up the offer of a free health check.

Her blood pressure was found to be high and, with Rebecca's permission, her GP was informed. Within 24 hours she received a call from her GP, who arranged to see her in clinic the following day.

Rebecca's blood pressure was taken again and it was found to be borderline. She was also feeling generally unwell, so was referred for a chest X-ray, which identified she had an enlarged heart.

Her GP prescribed her medication to help control her high blood pressure and heart condition and carried out blood tests. These revealed Rebecca also had poor kidney function and a number of infections, for which she was prescribed antibiotics..

Rebecca said: "It is so amazing what a community event can lead to. I only went along to get my spring Covid booster."

"If I had not taken up the offer of that initial blood pressure check I would have absolutely no knowledge of my heart and kidney issues, raised blood pressure or infections."

"I am so grateful to the Vaccination Outreach team for giving me the opportunity to have a free health check. Their intervention means I'm now receiving the treatment I need."

Recent community focused events where Blood Pressure Checks have been part of the offer include a partnership event at the All Nations Community Centre, Gloucester City Homes event, Cheltenham Family Fun Day as well as the Know Your Numbers Campaign which toured the county in September and January.

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Agenda Item 7

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**Health and Wellbeing Partnership update**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	Describe the prior engagement pathways this paper has been through:						
	ICB Internal	**Date**	**System Partner**	**Date**			
			Meetings between ICB and GCC system partners	Feb-March 2024			
			Gloucestershire Health & Wellbeing Board	March 2024			
Executive Summary	This presentation provides an update on the Integrated Care Partnership, named the one Gloucestershire Health and Wellbeing Partnership (HWP). The presentation covers the key components of the strategy including the three pillars and exemplar themes as well as future focus of the HWP. It focusses upon Pillar 2: Transforming what we do, including the exemplar themes. The One Gloucestershire Health and Wellbeing Partnership brings together health care, social care, public health, district councils and other public, voluntary and community sector partners. The Partnership developed a comprehensive Interim Integrated Care Strategy, which seeks to encompasses the work we do across our system that contributes to this vision. To implement this Integrated Care Strategy the Health and Wellbeing Partnership has: ▪ Continued to build and grow connection and collaboration across the system. ▪ Generated action from the partnership conversation to optimise system delivery. ▪ Progressed the three exemplar themes to create impact for our population.						

Key Issues to note	▪ Seized the opportunity to use our collective size and scale to impact on our population's health, care and wellbeing through focussing on the exemplar themes. ▪ Offer from the blood pressure exemplar theme to work in collaboration with us to develop sustainable approach to offer blood pressure checks to our collective workforce of over 28,000 people.			
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There are no specific risks associate with the paper. The blood pressure checks for staff are a measure to mitigate any risks associated with having high blood pressure			
Management of Conflicts of Interest	None			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	There is no financial impact associated with this paper.			
Regulatory and Legal Issues (including NHS Constitution)	There is no regulatory impact			
Impact on Health Inequalities	Offering blood pressure checks to all staff working for NHS Gloucestershire organisations will help us to reach many more people from different socio-economic backgrounds including a diversity of staff			
Impact on Equality and Diversity	It is hoped this would have a positive impact on equality and diversity offer local NHS staff blood pressure checks			
Impact on Sustainable Development	The service will be offered locally to NHS staff			
Patient and Public Involvement	The HWP fully engages with Gloucestershire communities			
Recommendation	**The Board is requested to:** ▪ Note the HWP update. ▪ There is a specific ask of ICS partners to take up the offer from the blood pressure exemplar theme to work in collaboration to develop sustainable approach to offer blood pressure checks to our collective workforce of over 28,000 people.			
Author	**Becky Willmoth**	**Role Title**	**HWBP Support Manager**	
Sponsoring Director (if not author)	**Mark Walkingshaw, Director of Operational Planning and Performance, ICB** **Siobhan Farmer, Director of Public Health, GCC**			

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
JFP	Joint Forward Plan

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Health & Wellbeing Partnership

Integrated Care Partnership Update

Councillor Carole Allaway-Martin, Gloucestershire County Council
Siobhan Farmer, Director of Public Health, Gloucestershire County Council
Mark Walkingshaw, Director of Operational Planning & Performance, NHS Gloucestershire

@One_Glos
www.onegloucestershire.net

One Gloucestershire Health and Wellbeing Partnership

Our vision Making Gloucestershire the healthiest place to live and work - championing equity in life chances and the best health and care outcomes for all

- The One Gloucestershire Health and Wellbeing Partnership brings together health care, social care, public health, district councils and other public, voluntary and community sector partners.
- The Partnership developed a comprehensive Interim Integrated Care Strategy, that seeks to encompasses the work we do across our system that contributes to this vision.
- To implement this Integrated Care Strategy the Health and Wellbeing Partnership has:
  - Continued to build and grow connection and collaboration across the system.
  - Generated action from the partnership conversation to optimise system delivery.
  - Progressed the three exemplar themes to create impact for our population.

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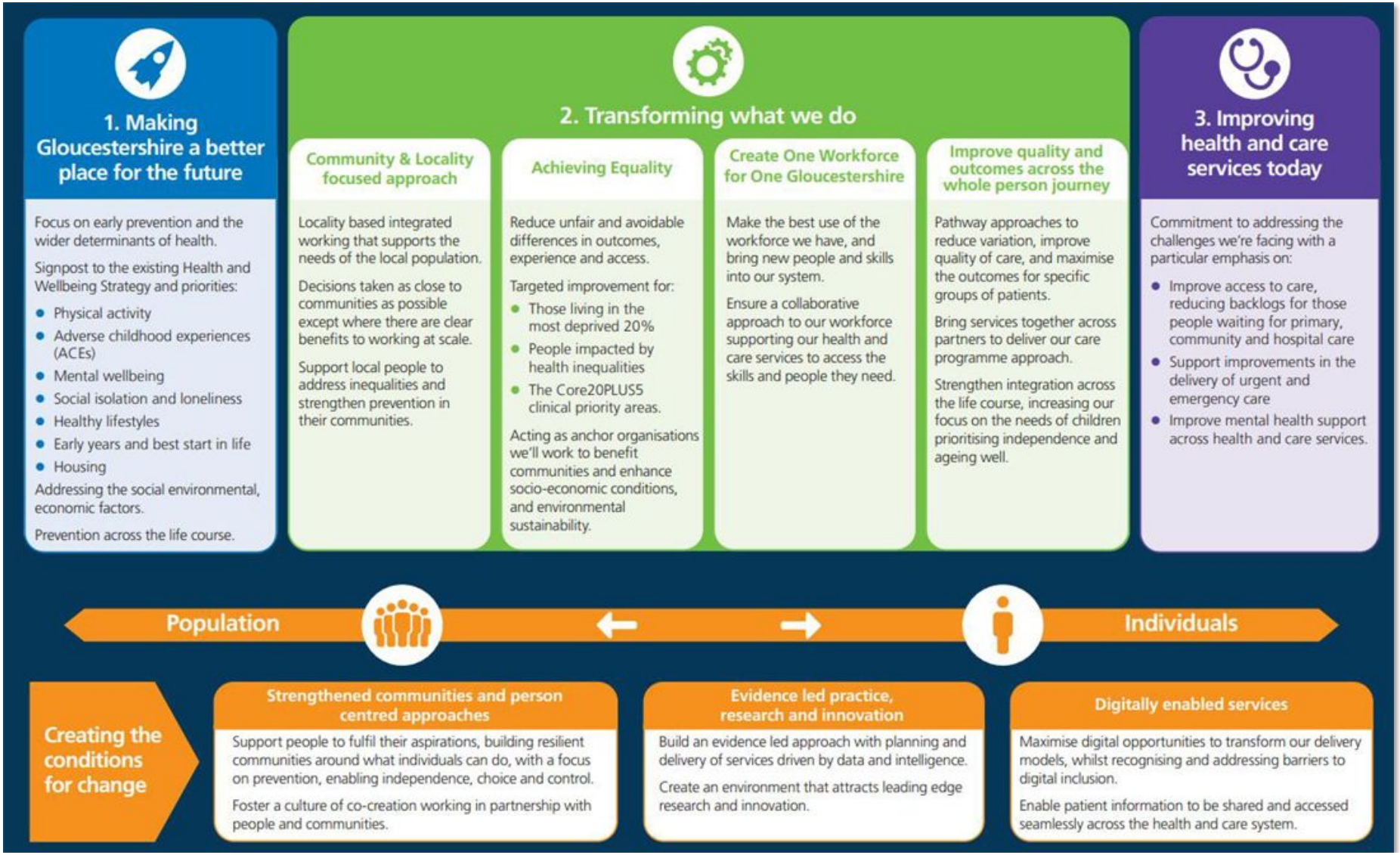
1

Integrated Care Strategy on a Page



Focus on pillar two: Transforming what we do

Community and Locality Focussed Approach

- Explored in the May 2023 HWP meeting, key themes discussed included connecting the work of partners, sharing learning and good work and supporting scale up of what works (where applicable).
- Locality contributions to the exemplar themes have been mapped to identify opportunities.
- A Locality and Neighbourhood wide event was held in November 2023 to showcase examples of good work.

Creating One Workforce for One Gloucestershire

- July 2023 HWP meeting focussed on the draft One Workforce for One Gloucestershire Strategy.
- Areas for further collaboration were explored and an initial focus on joint working on apprenticeships and youth engagement agreed to develop coordinated, inclusive practices in these areas.
- Systemwide leadership collaboration events are in development with the initial event planned for June 2024.

Improving quality and outcomes across the whole person journey

- In September the HWP explored how to build on the clinical programmes approach to collaborative working, bringing this work to a different audience and creating conversations that otherwise might not have happened.
- A collaboration event brought together over 100 representatives of clinical programmes and VCSE organisations.
- The blood pressure exemplar theme is changing how ideas are generated and how partners work together in the circulatory CPG.

Achieving Equity

- The November 2023 HWP meeting explored current examples of achieving equity from across the system with presentations from Mala Ubhi, Charlie Sharp and Graham Meanie.
- Key questions were discussed including the role of the partnership in health equity and how to systematically understand where we are not achieving health equity and what to do about this.
- It was agreed achieving equity would be explored in more depth at a future development session.

Exemplar Themes: Progress to Date

Theme 1: Employment	Theme 2: Smoking	Theme 3: Blood pressure	
Know Your Numbers Campaigns have led to 533 community blood pressure checks, with 105 signposted / 8690 new diagnoses of high blood pressure in the last year	27 Gloucestershire City Homes staff had blood pressure checks in their workplace with 8 people given either advice or signposting for high blood pressure	GL11 Community Hub blood pressure project commenced in Feb 2024 with an ambition of completing over 1200 tests over 12 months	A collective approach to exploring our data has generated greater insight into missing and high blood pressure for our population
Over 70 attendees at a collaborative Employment and Health Inequalities Summit in November 2023 with more than 40 people signed up for the next event on 19th June 2024	Employment Alliance set up with representation from 10 organisations across the system to progress the ideas generated in the summit	Joint expression of Interest submitted to collaborate on a new Department of Work and Pensions employment initiative worth £1.4m	Audit of Health and Wellbeing Partners on smoking cessation activities within organisations

What's Next for the Health and Wellbeing Partnership

- A year since the publication of the Interim Integrated Care Strategy, the Partnership held a development session to discuss the experiences of the last 12 months and how this should shape the partnership focus for next 12 months.

- The Integrated Care Strategy was agreed as an interim, however there was an acknowledgement that more time together is needed to allow the strategy to act as roadmap for action across the partnership.

- The Partnership will continue to focus on implementation by deepening the relationships across the system, focusing on our shared priorities and creating impact across the exemplar themes.

- A light tough refresh of the strategy is planned in 2024, exploring areas of strength, progress and any gaps or challenges to be addressed.

What's Next for the Exemplar Themes

Work in Progress

- Open space event around the exemplar themes led by VCSE partners
- Employment collaborative working together on the five big ideas
- Further insights research with hardly reached communities on smoking and blood pressure
- Collaborative exploration of blood pressure data with broader invitation for projects
- Anchor organisations approach for blood pressure checks

ICB as Anchor Organisations

- Anchor organisations are large organisations that are unlikely to relocate and have a significant stake in their local area.
- Opportunity to use our collective size and scale to impact on our population's health, care and wellbeing through focussing on the exemplar themes.
- Offer from the blood pressure exemplar theme to work in collaboration to develop sustainable approach to offer blood pressure checks to our collective workforce of over 28,000.

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Appendix

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Health & Wellbeing Partnership

Blood Pressure Data: Deep Dive

@One_Glos
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Overview

Background

High blood pressure is a **leading cause of heart attacks and stroke** in England and account for a quarter of premature deaths. CVD is identified within the NHS Long Term Plan (2019) as the biggest area where the NHS can save lives over the next 10 years.

Targets

Nationally there are ambitions to address hypertension:

1. **NHS Operational Planning Guidance** outlines an ambition to have 77% of the population treated to target by March 2024.
2. **Public Health England** outlines an ambition to have 80% of the expected number of people with high blood pressure diagnosed by 2029.

Purpose

The following slides provide an overview of Gloucestershire's local hypertension data for each locality in the county. The slides are broken down by the hypertension deep dive analysis (slides 2-12) and the most updated CVD prevent data (slides 13-16).

Deep Dive Analysis

Context

As part of the Integrated Care Partnership blood pressure 'Exemplar Themes' work, a deep dive analysis was completed with the aim of categorising all patients over 40 into different cohorts to highlight where there are gaps in blood pressure monitoring.

Methodology

The analysis used the local primary care data flow (up to 31 October 2023). All **Gloucestershire registered patients over 40** are included in the analysis. Gloucestershire GP registered patients were looked at as this meant we had the full picture of their primary and secondary care data. The data is limited to ages 40+ because this was deemed the most clinically relevant group to analyse.

Cohorts

The different cohorts that patients have been split into are below *(see slide 3 for full breakdown)*:

- Missing BP
- Unknown
- Diagnosed High
- Diagnosed Uncertain
- Undiagnosed High
- Diagnosed Controlled
- Not Hypertensive
- Other (catch all group)

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Cohort	Definition	Desired Outcome
Missing BP	Patients that have no previous diagnosis of hypertension and had no blood pressure reading in the last five years but has had at least 1 primary care appointment in the last year.	• **Diagnosis:** A **decrease** in the number of patients with a 'missing BP' by increasing blood pressure testing in the community.
Unknown	Patients that have never had a confirmed hypertension diagnosis, does not have a blood pressure reading and has not seen their GP in the last year.	• **Diagnosis:** A **decrease** in the number of patients who are 'unknown' by increasing blood pressure testing in the community. • **Engagement**: Understanding why certain groups may not be going to their GP and if there are any barriers that can be addressed.
Diagnosed High	Patients with a confirmed hypertension diagnosis that have a blood pressure reading in the last 12 months that is over 140/90mmHg (or 150/90mmHg if aged 80+).	• **Treatment:** A **decrease** in the number of patients who are 'diagnosed high' by encouraging healthy lifestyles and increasing the number of patients regularly taking hypertension medication.
Diagnosed Uncertain	Patients with a confirmed hypertension diagnosis that have not had a blood pressure reading within the last 12 months.	• **Treatment:** A **decrease** in the number of patients who are 'diagnosed uncertain' by encouraging follow up BP checks and ensuring BP is being managed effectively.
Undiagnosed High	Patients that do not have a hypertension diagnosis but their latest 2 blood pressure readings are above the threshold.	• **Diagnosis:** A **decrease** in the number of patients with an undiagnosed high BP through increased testing. • **Engagement:** Understanding why patients have not received a confirmed diagnosis.
Diagnosed Controlled	Patients that have had a confirmed hypertension diagnosis and their latest blood pressure reading (in the last 12 months) is less than or equal to 140/90mmHg (or 150/90mmHg if aged 80+).	• **Treatment:** An **increase** in the number of patients with a 'diagnosed controlled' BP by 'treating to target' those patients within the diagnosed high cohort.
Not Hypertensive	Patients that have never had a hypertension diagnosis and their latest blood pressure reading (in the last 12 months) is less than or equal to 140/90mmHg (or 150/90mmHg if aged 80+).	• **Diagnosis:** An **increase** in the number of patients who are 'not hypertensive' by increasing testing in the community to reduce the missing BP and unknown cohorts.

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Deep Dive Analysis: Highlights

Gloucestershire residents with a **missing blood pressure reading** are more likely to be:

1. Male
2. Aged 40-49
3. Living in the most deprived areas (Gloucestershire IMD1)*
4. Living in Gloucester

Gloucestershire residents who are in the '**high risk**' group are more likely to be:

1. Aged 70-79
2. Black/ Black British**
3. Living in the most deprived areas (Gloucestershire IMD1)
4. Living in Gloucester

- **Diagnosed high BP**
- **Diagnosed uncertain BP**
- **Undiagnosed high BP**

***** there is a correlation between age and deprivation, with more deprived deciles tending to have younger patients – this means that the deprivation analysis is not independent from age

****** there is a large proportion of patients with a 'blank' or 'not stated' ethnicity and an underrepresentation of patients identified as 'white' when compared to 2021 census data – this could be skewing analysis

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Gloucestershire (County Overview)

Diagnosis

To reach the target of '80% of expected hypertensive patients receiving a confirmed diagnosis by 2029', we need to diagnose an additional **33,201** patients in Gloucestershire.

Cohort	Gloucestershire %	Gloucestershire #	Top 5 PCNs (highest % of patients)
Missing BP	8.9%	33,340	**Hadwen & Quedgeley**, **Cheltenham Central**, **Berkeley Vale**, **Aspen**, Rosebank & Bartongate
Unknown	9.8%	36,819	**South Cotswolds**, Gloucester Inner City, **Aspen**, **Cheltenham Central**, North Cotswolds
Undiagnosed High	6.3%	23,780	North & South Gloucester, **Aspen**, **Berkeley Vale**, **Hadwen & Quedgeley**, **South Cotswolds**

If we focussed on the top 5 PCNs with the highest %s of patients in the above cohorts, we have the potential to reach **34,630** patients.

Management

To reach the target of '80% of hypertensive patients being treated to target by 2029', we need to treat an additional **11,030** patients in Gloucestershire.

Cohort	Gloucestershire %	Gloucestershire #	Top 5 PCNs (highest % of patients)
Diagnosed High	6.3%	23,478	**Aspen**, Gloucester Inner City, Forest of Dean, Berkeley Vale, **Cheltenham St. Paul's**
Diagnosed Uncertain	5.3%	19,871	Hadwen & Quedgeley, North & South Gloucester, **Aspen**, Cheltenham Peripheral, **Cheltenham St. Paul's**

If we focussed on the top 5 PCNs with the highest %s of patients in the above cohorts, we have the potential to reach **16,841** patients in Gloucestershire.

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Cheltenham

Diagnosis

- 3 out of the five GP practices with the lowest % of expected hypertensive patients with a **confirmed diagnosis** are located in Cheltenham*.
- Cheltenham Central PCN has the second highest % and number of patients with a **missing BP****.
- The practice with the highest % of patient with a **missing BP**** is located in central Cheltenham.
- Cheltenham Central has the second highest number of patients who are '**unknown**'**.

Management

- 2 out of the five GP practices with the lowest **treated to target** rates* are located in Cheltenham.
- The practice with the third highest number of patients that need to be **treated to target*** is located in St. Paul's, Cheltenham.
- Cheltenham St Paul's PCN has the fifth highest % of patients with a **diagnosed high BP***.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

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Cotswolds

Diagnosis

- South Cotswolds PCN has the highest % and number of patients who are '**unknown**'**.
- North Cotswolds PCN has the fifth highest % of patients who are '**unknown**'**.
- 3 out of the top 5 practices for the highest %s of patients who are '**unknown**'** are located in Cirencester and Northleach.
- The practice with the third highest % of patients with a **missing BP**** is in Chipping Campden.
- South Cotswolds PCN has the highest number (and fifth highest %) of patients with an **undiagnosed high BP****.

Management

- South Cotswolds PCN has the second highest number of patients that need to be **treated to target***.
- The practice with the fourth highest number of patients that need to be **treated to target*** is located in Cirencester.

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**Data covers the period up to 31 October 2023

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Forest of Dean

Diagnosis

- The Forest of Dean PCN has the highest number of patients with a **missing BP****.
- The Forest of Dean PCN has the third highest number of patients with an **undiagnosed high BP****.
- The GP practice with the highest % of patients with an **undiagnosed high BP**** is located in Blakeney.

Management

- The Forest of Dean PCN have the highest number of patients that need to be **treated to target***.
- The Forest of Dean PCN has the third highest % of patients with a **diagnosed high BP****.
- The top 2 practices with the highest % of patients with a **diagnosed high BP**** are located in Coleford and Lydney.
- The Forest of Dean PCN has the third highest number of patients with a **diagnosed uncertain BP****.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

Health & Wellbeing Partnership

Gloucester

Diagnosis

- North & South Gloucester have the fifth highest number of patients that need to be diagnosed in order to reach the 80% **diagnosis*** target.
- Hadwen & Quedgeley, Aspen and Rosebank & Bartongate PCNs are in the top 5 PCNs for highest %s of patients with a **missing BP**** and an **undiagnosed high BP****.
- The practice with the fourth highest % of patients with a **missing BP**** is located near Barton & Tredworth.
- The practices with the highest numbers of **missing BPs**** are located near Barton & Tredworth, Central Gloucester and Abbeydale.
- The practice with the highest number of patients with an **undiagnosed high BP**** is located in Central Gloucester.
- Gloucester Inner City PCN and Aspen PCN have the second and third highest %s of patients who are '**unknown**'**.
- The practice with the highest % of patients who are '**unknown**'** is located near Longlevens.
- The practices with the second and third highest numbers of patients who are '**unknown**'** are located near Barton & Tredworth & Central Gloucester.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

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Gloucester

Management

- 3 out of the top 5 practices with the lowest **treated to target*** rates are located in Gloucester.
- The practices with the highest numbers of patients that need to be **treated to target*** are located near Central Gloucester and Barton & Tredworth.
- Aspen and Gloucester Inner City PCN have the highest %s of patients with a **diagnosed high BP****.
- North & South Gloucester PCN have the second highest number of patients with a **diagnosed high BP****.
- Hadwen & Quedgeley, Aspen and Rosebank & Bartongate are all in the top 5 PCNs for the highest % of patients with a **diagnosed uncertain BP****.
- The two practices with the highest numbers of patients in the **diagnosed uncertain**** cohort are located are located near Barton & Tredworth and Central Gloucester.
- The practice with the fourth highest % of patients with a **diagnosed uncertain BP**** is located near Abbeydale.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

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Stroud

Diagnosis

- Berkeley Vale PCN have the fourth highest number of patients needed to reach the 80% target for expected hypertensive patients receiving a **confirmed diagnosis***.
- Berkeley Vale PCN have the third highest % of patients with a **missing BP**** and the third highest % of patients with an **undiagnosed high BP****.
- The practice with the fifth highest % of patients with a **missing BP**** is located in Uley.
- The practice with the second highest % of patients with an **undiagnosed high BP**** is located in Wotton-under-Edge.

Management

- Berkeley Vale PCN has the fourth highest % of patients with a **diagnosed high BP****.
- The practice with the third highest % of patients with a **diagnosed high BP**** is located in Wotton-under-Edge.
- The practice with the fifth highest % of patients with a **diagnosed uncertain BP**** is located in Stonehouse.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

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Tewkesbury

Diagnosis

- The practice with the third lowest % of expected hypertensive patients with a **confirmed diagnosis*** is located in Bishop's Cleeve.
- The practice with the second highest % of patients with a **missing BP**** is located in Bishop's Cleeve.
- The practice with the fourth highest % of patients with an **undiagnosed high BP**** is located in Brockworth.

Management

- The practice with the fifth highest number of patients that need to be **treated to target*** is located in central Tewkesbury.
- The practice with the fourth highest % of patients with a **diagnosed high BP**** is located in Brockworth.
- The practice with the highest % of patients with a **diagnosed uncertain BP**** is located in Bishop's Cleeve.
- The practice with the third highest % of patients with a **diagnosed uncertain BP**** is located in Winchcombe.

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*Data covers the period up to 1 September 2023
**Data covers the period up to 31 October 2023

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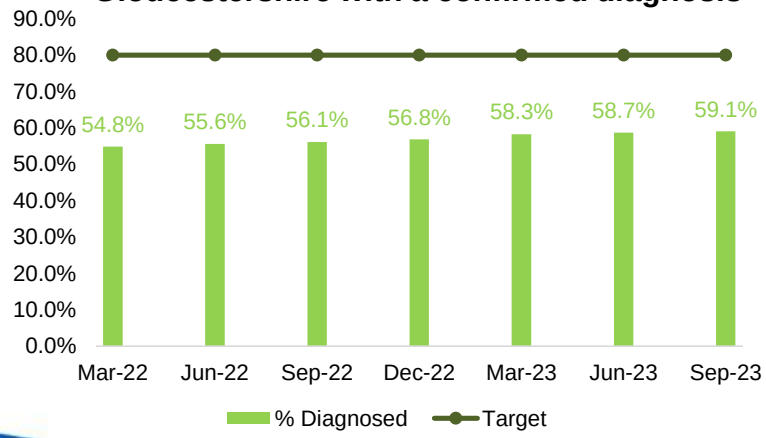
CVD Prevent: Expected Hypertension Diagnosis %*

Gloucestershire

The number of expected hypertensive patients has increased from 154,442 as of 1 June 2023 to 158,677 (4,235 increase). Our % of expected hypertensive patients with a confirmed diagnosis therefore appears lower (in June 2023, our % diagnosed was 60.3%) despite diagnosing more people (**an additional 660 patients** between 1 June and 1 September).

% of expected hypertensive patients in Gloucestershire with a confirmed diagnosis



PCNs

PCN	% Diagnosed	Additional Patients Needed for 80%
Cheltenham Central	**49.4%**	3,431
Cheltenham Peripheral	53.4%	**3,688**
North Cotswolds	55.4%	2,216
South Cotswolds	56.7%	3,533
Stroud Cotswold	57.1%	2,321

Berkeley Vale have the fourth highest # of patients needed to reach 80% diagnosis target (2,697) and North and South Gloucester have the fifth highest (2,619).

Practices

The practices with the lowest diagnosis rates are in:

1. Hester's Way, Cheltenham (40.2%)
2. Central Cheltenham (44.1%)
3. Bishop's Cleeve (44.8%)
4. Prestbury, Cheltenham (45.4%)
5. Central Stroud (48.9%)

Practices in Wotton-under-Edge (Stroud), Cirencester (Cotswolds) and Barton & Tredworth (Gloucester) have the highest # of patients needed to reach the 80% diagnosis target (1,397, 1,386 and 1,314 respectively).

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*Data covers the period up to 1 September 2023

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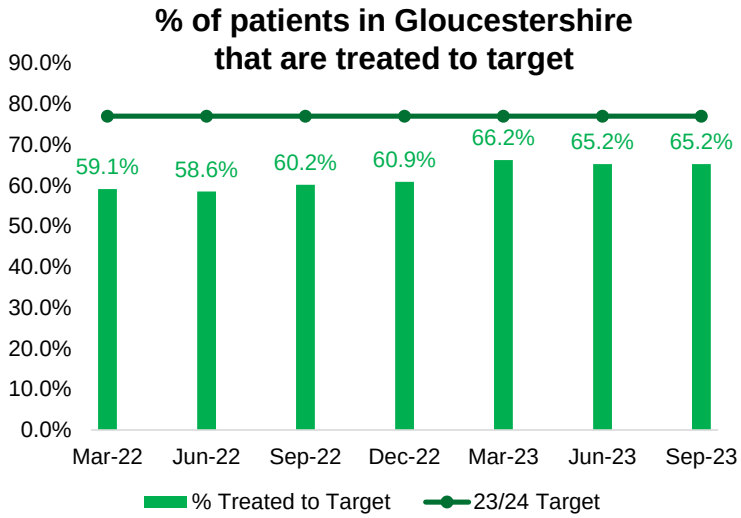
CVD Prevent: Treated to Target %*

Gloucestershire

As the number of patients with hypertension that are diagnosed increases, the treated to target % has remained stable. Between 1 June and 1 September an additional **425 patients** were treated to target, but as we diagnosed an additional 660 patients the % of patients TTT overall has not increased.



PCNs

PCN	% Treated to Target	Additional Patients Needed for 77%
Gloucester Inner City	**55.4%**	843
Rosebank & Bartongate	57.3%	**838**
Aspen	58.8%	890
Cheltenham St Paul's	61.2%	979
North & South Gloucester	64.3%	1,018

The Forest of Dean have the highest # of patients needed to be treated to target (1,117) followed by South Cotswolds (1,055).

Practices

The practices with the lowest TTT rates are in:

1. Hester's Way, Cheltenham (52.5%)
2. Central Gloucester (54.2%)
3. St. Paul's, Cheltenham (55.1%)
4. Barton & Tredworth, Gloucester (55.5%)
5. Kingsholm, Gloucester (55.5%)

The practices with the highest # of patients needed to be TTT to reach 77% are in:

1. Central Gloucester (890)
2. Barton & Tredworth, Gloucester (838)
3. St. Paul's, Cheltenham (453)
4. Cirencester, Cotswolds (365)
5. Central Tewkesbury (364)

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*Data covers the period up to 1 September 2023

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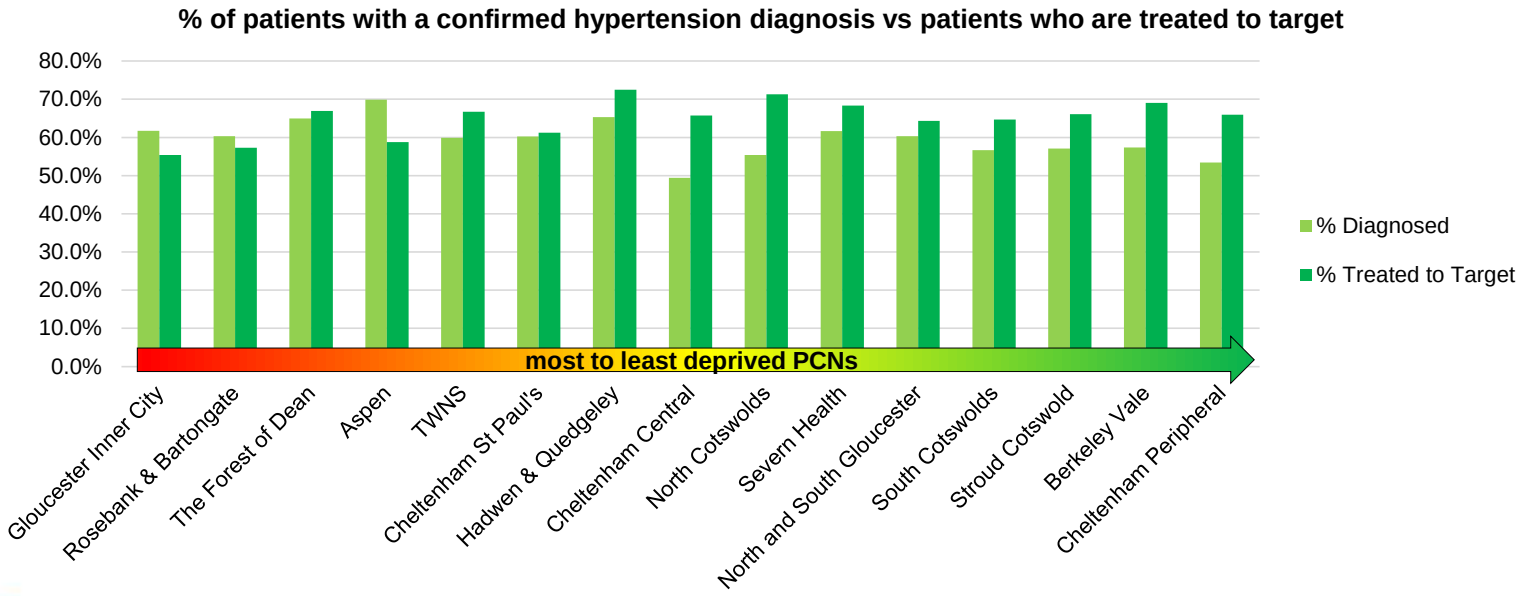
CVD Prevent: Diagnosis & Treatment by Deprivation*

% Summary

The most deprived PCNs in Gloucester (Gloucester Inner City, Rosebank & Bartongate and Aspen) are the only PCNs to have a higher diagnosis rate when compared to treated to target.

Gloucester Inner City, the most deprived PCN, has diagnosed 61.7% of the expected hypertension prevalence, compared to Cheltenham Peripheral, the least deprived PCN, which has diagnosed only 53.4% of the expected prevalence.



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*Data covers the period up to 1 September 2023

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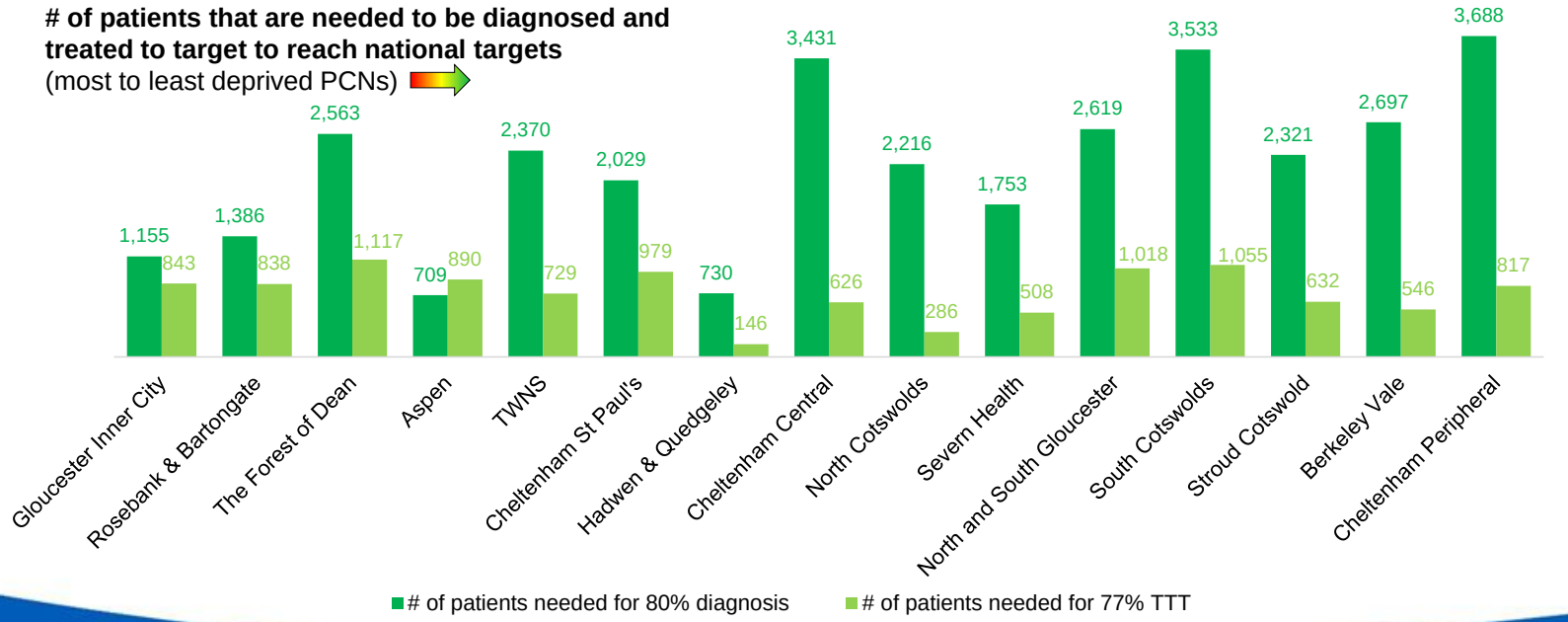
CVD Prevent: Diagnosis & Treatment by Deprivation*

 # Summary

The number of patients needing to be diagnosed to reach the 80% target ranges from 709 (Aspen) to 3,688 (Cheltenham Peripheral). The top 5 most deprived PCNS need to diagnose an additional **8,183 patients** and the top 5 least deprived PCNs need to diagnose an additional **14,858**.

The number of patients needing to be treated to target ranges from 146 (Hadwen & Quedgeley) to 1,117 (the Forest of Dean). The top 5 most deprived PCNs need to treat **4,417** patients to target and the top 5 least deprived PCNs need to treat **4,068** patients to target.



*Data covers the period up to 1 September 2023

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**Chief Executive Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X						
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.						
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer.						
Key Issues to note	This report covers the following topics: • **Social Prescribing Day** • **Arts and Health** • **First National GP Leadership Event** • **System Operational Planning 2024-25** • **National Staff Survey 2023 Results**						
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)	There are no regulatory or legal issues contained in this paper						
Impact on Health Inequalities	N/a						
Impact on Equality and Diversity	The National Staff Survey contains questions and results relating to the WRES and WDES						

Impact on Sustainable Development	N/A
Patient and Public Involvement	
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

Agenda Item 8.1

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Chief Executive Report

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. Social Prescribing Day

2.1 Social Prescribing Day is an annual celebration of the people, organisations and communities who make social prescribing happen.

2.2 Social Prescribing is a term used to describe people connecting to local groups, activities and services that can help them with their wellbeing, to live their best life. It could be a change in circumstances has left you feeling at a loss – a bereavement, redundancy, a relationship breakdown; these can be difficult to navigate on your own. Or it could be due to the ongoing challenge that people need help with such as a long term health condition, or troubling finances.

2.3 There are many amazing places to get support from community and voluntary groups within Gloucestershire , full of people who want to help and have the necessary skills and training to do so. A number of Voluntary and Community Groups that supported this Social Prescribing Day to make people aware of the different ways and places that people can access help and support included:

- The Music Works https://themusicworks.org.uk/
- Tewksbury Nature Reserve https://tewkesburynaturereserve.org.uk/
- Cinderford Artspace https://artspacecinderford.org/

2.4 The website provides details information about getting help from the Community Wellbeing Service: https://www.nhsglos.nhs.uk/your-health-services/healthy-communities/community-wellbeing-service/

3 Arts and Health

3.1 The National Centre for Creative Health (NCCH) has been working in partnership with NHS England Personalised Care Team and Integrated Care Systems (ICSs) in Gloucestershire;

Shropshire, Telford and Wrekin; Suffolk and North East Essex; and West Yorkshire, to develop this toolkit to support other ICSs to embed creative health in their systems.

The **Creative Health Toolkit** can be found here: https://creativehealthtoolkit.org.uk/

3.2 This a fantastic resource which explains what Creative Health is, alongside how and where it fits in systems, context and action. There are lots of excellent illustrative examples of Creative Health best practice in Gloucestershire (and wider) and a further resources area containing links which give policy context, evidence, tools and guidance in support of the development of Creative Health solutions.

This is hugely timely and exciting for the University of Gloucestershire and Gloucestershire Integrated Care Board's joint Arts, Health and Wellbeing Centre development venture.

4. First National GP Leadership Event

4.1 Dr Olesya Atkinson attended the first national GP leadership in London on Jan 31st. The meeting brought together single GP leaders from each of the 42 systems representing general practice as a provider.

4.2 There will be subsequent leadership events for dentists, pharmacists, nurses and the Additional Roles Reimbursement Scheme (ARRS) roles with regional events in the summer bringing the collective primary care leaders together. The event was opened by NHS England's chair Richard Meddings, with keynote speech from Navina Evans on the long term workforce plan. Break out groups covered estates, primary/secondary care interface, GP retention and patient safety in primary care. The day closed with Claire Fuller in conversations with Amanda Pritchard and Amanda Doyle.

4.3 The group will reconvene in person potentially discussing primary care provider collaboration, continuity of care, leadership development in the autumn, but will have subsequent virtual sessions in the interim.

5. System Operational Planning 2024-25

5.1 At the time of writing, full national planning guidance is still to be published. Although we expect a further update from NHSE in advance of the Board, we do not expect to receive the full planning guidance (including detailed performance objectives) in advance of the next Operational Plan submission on Thursday 21st March.

5.2 A high-level submission of key metrics was completed at the end of February. In addition, work on the full system plan has continued in line with the interim planning guidance and

locally agreed objectives for areas of performance not covered by the interim planning guidance.

5.3 Good progress has been made in the development of these system plans with good engagement from all partners and operational teams. There will be a further final system Operational Plan submission on 2nd May. When the full planning guidance is published, we will review our existing plan to identify any potential changes required.

5.4 Further work is still required to meet the significant financial challenge of developing a balanced system plan and to meet the productivity and workforce challenges associated with this. We will continue to refine our plan over the coming weeks in readiness for the full and final submission at the start of May, with further updates to the Board to follow

6. National Staff Survey results

6.1 Over 1.4 million NHS employees in England were invited to participate in the national staff survey between September and November 2023. With approximately 268 NHS organisations taking part, including all 213 trusts in England. At each organisation, all eligible staff were invited to take part in the survey including bank staff. Since 2021, the survey questions have been aligned with the NHS People Promise, which sets out in the words of NHS staff the things that would most improve their working experience. The reporting is designed to track progress against the seven People Promise elements, and against two theme scores reported in previous years (morale and engagement). The 2023 survey used the same methodology and timings as in previous years. All questions and key indicators reported in 2021 and 2022 were retained in order to maintain comparability of trend data.

6.2 Approximately 707,460 staff responded to the staff survey with a 48% participation rate up from 46% in 2022. The staff survey is mandatory for NHS Trust and optional for non-trusts such as ICBs. However most ICBs choose to participate in the national survey allowing for benchmarking data to be included in the reports. Half of Integrated Care Boards (ICBs) have offered the General Practice Staff Survey to staff in their systems. The results provided to organisations include summary reports, detailed benchmarked reports with other similar organisations and locality reports. The benchmark reports compare an organisation to the best, average and worse organisations. Previous years findings are available from 2018 onwards.

6.4 The National Staff Survey contains questions that are included in the Workforce Race Equality Standard and the Workforce Disability Equality Standard. For the first time questions were asked in terms of unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public and from other colleagues.

6.3 The People Committee considered the system wide Staff Survey reports, including improvement actions at its meeting on 8th February. This also covered Gloucestershire County Council's staff survey key findings and actions; reports can be found here on https://www.nhsstaffsurveys.com/results/national-results/

Some of the key findings and improvement from each organisations are summarised below:

6.4 **NHS Gloucestershire ICB**

Headlines:-

- Improved response rate of 76.8% compared to 74% in 2022
- Staff would recommend the ICB as a place to work, 74.8% (compared to 80.6% in 2022 which was equivalent to the 'Best'. (ICB average is 51.7%)
- 79.9% of staff had an appraisal in the last 12 months compared to 86.3% in 2022
- 85.3% of staff say their immediate manager values their work
- Level of satisfaction with pay has increased from 48.6% in 2022 to 51.9% in 2023 (but below national average of 55.9%)
- 88.2% of staff are satisfied with opportunities for flexible working patterns (compared to 79% as ICB average)

6.5 In terms of those areas where the ICB scores performed below the organisational average were as follows

- Satisfied with the level of pay 52% compared to the organisational average of 56%
- Not felt pressure from manager to come to work when not feeling well enough 85% compared to the organisational average of 88%
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public 90% compared to the organisational average of 92%
- Appraisal helped me agree clear objectives for my work 33% compared to the organisational average of 35%
- Never/rarely felt frustrated at work 15% compared to 16% organisational average.

The improvement areas agreed with the ICB Staff Partnership Forum (SPF) focus on tackling bullying and harassment, wellbeing at work, appraisals and career development which is incorporated into an action plan and monitored via the SPF. Each Directorate has also received its locality scores for each of the questions and is developing their own actions made relevant to the directorate.

6.6 **NHS Gloucestershire Hospitals NHS Foundation Trust**

GHFT has seen a dramatic increase in the response rate in staff completing the staff survey - from 50% in 2022 to 68% in 2023, which is just below the highest response rate nationally of 69.5%. Overall, the Trust remains considerably below the average for Acute Trusts for all People Promise scores. However, all People Promise elements have seen a statistically significant improvement in their score. 56 out of 87 questions (64%) which are directly linked to the People Promise themes have seen a statistically significant improvement. Apart from two questions that show a small deterioration, all the remaining questions show a modest improvement. Of the Trusts who use Picker as their survey provider, GHFT was the second most deteriorated in 2022. This year the Trust was 12th most improved (12/62).

6.7 Of the three 'net promoter' questions, two of these have seen a statistically significant improvement (this is in line with the national average trend). The question 'Care of patients/service users is my organisation's top priority' has dropped by 0.5% compared to 2022 (although not a statistically significant change), and this bucks the national average trend. The Staff Experience Improvement Programme is using the latest results to inform the focus of activity around the three workstream priorities which are each linked to the NHS People Promises.

6.8 GHFT has also identified additional priorities for each division to concentrate on based on division-level analysis of the results. Divisions will report throughout the year on their progress at Divisional Board, monthly Executive Performance Review meetings. At Trust level progress of the Staff Experience Improvement Programme is monitored via the Trust Leadership Team meeting and People & OD Committee.

6.9 **NHS Gloucestershire Health and Care Foundation Trust**

The response rate for 2023 was up from previous years to 58% from 55% in 2022 and 53% in 2021.

Key headlines:

- 1st = Staff Survey overall rating across South West Provider Trusts (tying again with Dorset Healthcare University Trust)
- Nationally 5th highest rating for being recommended as a place to work in England (Mental Health, Learning Disability & MH/LD/Community Provider Trust benchmark group)
- Improved ratings across all Seven People Promise themes, 6 above average, one – We Work Flexibly – average
- Compared with 2022, circa 60% questions have improved ratings, 39% have worsened & 1% remained the same
- In Staff Engagement & Morale themes, results improved from 2022 & remained above sector & NHS average
- Decreases in the number of colleagues thinking about leaving or looking for another job in next 12 months

- Improvements in Friends & Family Test (Place to Work & Place to Receive Treatment) - both 10% above benchmark comparator average at 73.39% and 76.62% respectively

6.10 There are a number of areas for improvement including focusing on Mental Health inpatients, discrimination on the grounds of ethnicity, appraisal effectiveness & pay satisfaction are particular hot spots. These form part of the organisation's staff survey action plan.

7 Recommendation

7.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**Board Assurance Framework**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting	Risks are sent to lead directorates and executives each month.					
	ICB Internal	**Date**	**System Partner**	**Date**		
	ICB Operational Executive	05/03/2024	Audit Committee	07/03/2024		
			Strategic Executive	20/03/2024		
Executive Summary	The BAF was refreshed in October and November to align with the three pillars, updated strategic objectives and the key priorities. Following the submission of the BAF to the November 2023 ICB Board, board members discussed the BAF with feedback obtained in relation to some of the key risks particularly: • BAF 1 and BAF 3 around inequalities with a suggestion that they should be merged as there was duplication. • BAF 5 UEC to cover performance in the risk as well as the transformational programme around improvement. Additionally, since the BAF was submitted to the Audit Committee on 7th March 2024, further changes have been made notably to BAF 6 Primary Care risk and BAF 7 Recovery / productivity risk (see a full list of changes below). It should be noted that the Audit Committee has all BAF and CRR risks reported to it at each of its committee meetings.					
Key Issues to note	**Key changes since December 2023 report** • BAF1 and BAF 3 on health inequalities have been merged into one risk and updated following feedback that they appeared very similar from the ICB Board meeting held in November. • BAF2 community and locality transformation has been re-aligned with the Director of Primary Care & Place and updated. • BAF 3b Equality, Diversity and Inclusion Risk is a new risk that has been included following the People Committee meeting held on 8th February where partners agreed this was a key priority and fundamental risk to the system. • BAF 4 Quality Risk has been reappraised by the new CNO and risk description has been updated, as well as controls, actions and risk rating. • BAF 5. Urgent and Emergency Care risk, has been reappraised following the November Board meeting and the risk now clearly incorporates performance as well as improvement; the controls, assurances and actions have been updated. • BAF 6. Primary Care risk has been rearticulated and updated with an increased risk rating, this followed a meeting with the Chair of PCDC, Dr Atkinson and members of the primary care team; this followed on from a PCDC Committee meeting held on 1st February. Additional detail has been incorporated into this risk since reporting to the Audit Committee on actions, assurances and Director's update.					

	• BAF 7 Recovery / productivity risk has been reappraised following Audit Committee feedback and there has been an increase in the score from 12 to 16 and in the risk appetite from Zero/minimal to Cautious. • BAF10 Estates Infrastructure is a new risk following various discussions at committee meetings. • BAF 11 EPRR is included as the ICB is a Category 1 Responder and includes the findings of Internal Audit's Review of EPRR and discussion at the Audit Committee in November. • BAF 12 Cyber Security is new onto the BAF and follows discussions at the Audit Committee and a reappraisal by CCIO and Deputy. The risk rating aligns with GHFT due to the close work between the ICB and GHFT on cyber. All the risks have been updated and include a director's quarterly update.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The risk associated with not reporting risks is that key issues may not be identified and/or discussed at committee and board level. (4x3) 12 (4x2) 8
Management of Conflicts of Interest	There have been no conflicts of interest in producing this report. If there are conflicts of interest identified, they should be managed in line with the Standards of Business Conduct Policy.
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	Risk around finance have been included within this report.
Regulatory and Legal Issues (including NHS Constitution)	The ICB Constitution requires the ICB to have appropriate arrangements for the management of risk.
Impact on Health Inequalities	There are risks pertaining to health inequalities within the BAF see BAF 1 to note the two risks that related to Health Inequalities in the November version reported to the Board have been amalgamated into one risk.
Impact on Equality and Diversity	An Equality Impact Assessment is included in the Risk Management Framework and Strategy
Impact on Sustainable Development	No specific risks relating to sustainable development included in the BAF
Patient and Public Involvement	There are no risks included in the BAF on Patient and Public Involvement
Recommendation	The Board is asked to; • discuss the system wide strategic risks contained in the BAF • note the report.
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System

ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise

Strategic Risks – Refreshed Board Assurance Framework

Summary March 2024

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 Strategic Objective 3: Achieve equity in outcomes, experience, and access**								
Making Gloucestershire a better place for the future	BAF 1	The failure to promote and embed initiatives on health inequalities and prevention.	13/11/23	23/02/2024	Dir Operational Planning & Perf	**4x3=12**	**4x3=12**	**4x2=8**	ICP Resources Committee Quality 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 are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change.	14/11/23	26/02/2024	Director of Primary Care & Place	**4x3=12**	**4x3=12**	**4x1=4**	Quality Committee
	Strategic Objective 4: Create a One Workforce for One Gloucestershire								
	BAF 3a	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	23/02/2024	Dir of People, Culture & Engagement	**4x4=16**	**5x4=20**	**3x2=6**	People Committee
	BAF 3b	Equality, Diversity and Inclusion: There is a risk that as a system we fail to deliver on our commitments to having a fully	15/02/24	23/02/2024	Dir of People, Culture & Engagement	**4x3 = 12**	**4x3=12**	**3x2= 6**	People Committee

		inclusive, diverse and engaging culture for staff we employ							
	Strategic Objective 5: Improve quality and outcomes across the whole person journey								
	BAF 4	The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients.	07/11/23	22/02/2024	CNO & CMO	**5x3 = 15**	**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 5	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.	13/11/23	27/02/2024	Deputy CEO / Dir Strategy & Transformation	**5x4=20**	**4x3=12**	**4x2=8**	Resources Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 6	Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures.	15/11/23	08/02/2024	Director of Primary Care & Place	**4x4=16**	**5x4=20**	**5x1=5**	Primary Care & Direct Commissioning Committee
	BAF 7	Failing to deliver increased productivity requirements to meet both backlogs and growing demand	01/11/22	11/03/2024	Director of Operational Planning & Perf	**4x4=12**	**3x4=12**	**3x2=6**	Quality Committee / Resources Committee
	BAF 8	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	23/02/2024	Director of Integration	**4x3=12**	**4x3=12**	**4x1=4**	People Committee
	BAF 9	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	20/02/2023	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16**	**4x2=8**	Audit Committee / Resources Committee
	BAF 10	The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and	30/01/23	23/02/23	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16**	**4x2=8**	Audit Committee / Resources Committee

		replacement programmes for equipment and digital infrastructure enabling deliver of high-quality care							Audit Committee
	BAF 11	EPRR - Failure to meet the minimum occupational standards for EPRR and Business Continuity.	01/11/22	23/02/2024	Chief Nursing Officer (CNO)	**4x3=12**	**4x4=16**	**4x1=4**	Quality Committee
	BAF 12	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.	15/02/204	23/02/2024	Chief Information Officer	**5x4=20**	**5x4=20**	**4x2=8**	Audit Committee

NB. The Audit Committee receives all BAF reported risks at each of its meetings throughout the year

Key changes since December 2023 report

- BAF1 and BAF 3 on health inequalities have been merged into one risk and updated following feedback that they appeared very similar from the ICB Board meeting held in November.
- BAF2 community and locality transformation has been re-aligned with the Director of Primary Care & Place and updated.
- BAF 3b Equality, Diversity and Inclusion Risk is a new risk that has been included following the People Committee meeting held on 8th February where partners agreed this was a key priority and fundamental risk to the system.
- BAF 4 Quality Risk has been reappraised by the new CNO and risk description has been updated, as well as controls, actions and risk rating.
- BAF 5. Urgent and Emergency Care risk, has been reappraised following the November Board meeting and the risk now clearly incorporates performance as well as improvement; the controls, assurances and actions have been updated.
- BAF 6. Primary Care risk has been rearticulated and updated with an increased risk rating, this followed a meeting with the Chair of PCDC, Dr Atkinson and members of the primary care team; this followed on from a PCDC Committee meeting held on 1st February. Additional detail has been incorporated into this risk since reporting to the Audit Committee on actions, assurances and Director's update.
- BAF 7 Recovery / productivity risk has been reappraised following Audit Committee feedback and there has been an increase in the score from 12 to 16 and in the risk appetite from Zero/minimal to Cautious.
- BAF10 Estates Infrastructure is a new risk following various discussions at committee meetings.
- BAF 11 EPRR is included as the ICB is a Category 1 Responder and includes the findings of Internal Audit's Review of EPRR and discussion at the Audit Committee in November.
- BAF 12 Cyber Security is new onto the BAF and follows discussions at the Audit Committee and a reappraisal by CCIO and Deputy.
- All the risks have been updated and include a director's quarterly update.

Strategic Risks

Pillar 1: Making Gloucestershire a better place for the future					
Strategic Objective1: Increase prevention and tackle the wider determinants of health and care **Strategic Objective 3: Achieve equity in outcomes, experience, and access**					
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. **23-24 key priorities: Reduce unfair and avoidable differences in health and care – including improving outcomes for specific groups of our population**					
Risk Ref: BAF1 **Strategic Risk** ***(previous BAF 3 integrated into this risk)***	**The failure to promote and embed initiatives on health inequalities and prevention.** **Due to:** long-term, entrenched and multi-faceted social, economic and racial inequalities which have profoundly impacted racially minoritized and socially marginalised communities; as well as insufficient resources and capacity to effectively tackle long term entrenched health inequalities arising from the wider determinants of health. **Impact:** Can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions and ultimately higher mortality - all associated with greater cost to the individual, society and 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**	**4x3=12**	**4x3=12**	**4x2=8**	⟷
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	**GHC Risk ID 2** There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities (Red 16)				
Aligned to current ICB Risks	No relevant risks in the CRR				
Committee	**ICP/ Resources Committee / Quality Committee**	**Last Review and Updated:**	**23 February 2024**		
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 oversight • Health inequalities embedded in transformation programmes. This includes activity in Gloucester City ("Core20"), race relations ("PLUS") and 5 nationally identified clinical areas. • Research into engagement with underserved communities will commence following funding awarded. • Health inequalities is a standing item at the Planned Care Delivery Board.	• Some gaps remain in data quality and data sharing between ICS organisations. • Lack of a social value policy to guide proportionate universalism in funding allocations.	• Health inequalities measures built into strategic outcomes framework with Board-level assurance. • Regular reporting to System Resources Committee & Strategic Executive. • Quarterly activity reporting to NHSE. • Oversight by SROs. • Children's CPG to have oversight of the data for the Core20PLUS5 for CYP	• Coordinated reporting on both longitudinal health inequalities and medium-term control impact (e.g. Core20Plus5). • Public reporting of health inequalities still under development. • Monitoring effectiveness and impact of interventions.

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
1. Prevention Delivery Group and Health Inequalities Improvement Manager stocktake of work across the system to Identify gaps and opportunities. 2. Development of new operational plan for 24/25 currently in progress with extensive ambition on health inequalities including inclusive elective recovery. 3. Review of referral process and elective waiting list has commenced with clinical input from the PHM Clinical lead for Health Inequalities (Dr Charlie Sharp). 4. Development on health inequalities reporting including development of annual published report on Health Inequalities across programme areas in line with our legal duties on Health Inequalities (first publication for year 23/24). 5. ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery. 6. Commitment to patient participation in all workstreams. 7. ICB SROs for health inequalities confirmed as Siobhan Farmer (Director of Public Health) and Douglas Blair (CEO for Gloucestershire Heath and Care NHS Foundation Trust). 8. 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.	**Q4 23/24** 1. The Prevention Delivery Group and Health Inequalities Improvement Manager has completed a stocktake of work across the system to identify gaps and opportunities with the aim of making the report available by March 2024. 2. Work on the system health outcomes framework is under development and following agreement on the approach at the System Resources Committee will continue to be developed during Quarter 1 2024/25. 3. A review of the Core20Plus5 strategy is underway and will be completed by April 2024. 4. The Board Development Session on Health Inequalities will be led by SROs on the 28th February 2024. This will focus on the system approach to identifying and addressing health inequalities. 5. National guidance on reporting system position on health inequalities has been reviewed and report is being developed (a summary will be included in the annual report with the full report available/ published separately). 6. Development of an ICS Health Inequalities Intelligence Group to work collaboratively to build the intelligence around health inequalities across the system and ensure a coordinated approach to health inequalities analysis. 7. Roll out of the Gloucestershire Prevention and Health Inequalities Hub; an online compendium of information, resources, and tools designed to help the workforce better understand and take action to improve health equity in their areas of work.

9. Stocktake of prevention and health inequalities initiatives (has been completed). 10. System representation at Regional Inequalities Group and links with local and regional networks. 11. Citizen's Panel being recruited to provide anonymous feedback which will be used to shape health and care services and support. 12. Insights Hub being developed. 13. Project to increase and improve engagement with underserved communities in Gloucestershire around research is soon to be completed.	8. Elective workstream has identified potential for work with patients on multiple waiting lists, this is being scoped with GP/secondary care and a working group is being set up. 9. Additional health inequality focus on cancer services is underway as a collaborative project between the ICB and GHFT – a health inequalities toolkit for the cancer CPG is being developed which will help identify areas of focus. 10. Inner City Gloucester Health Inequalities Project convened to design, resource and implement a healthcare model that improves the population health outcomes for the Core20PLUS5 population of inner-city Gloucester.
	Relevant Key Performance Indicators: • Under development. Health inequalities narrative at programme level to be included in bi-monthly integrated performance report. • Performance against NHS constitutional targets (e.g. RTT, Cancer Wait times, Diagnostic access, UEC waiting and response times) • Joint Forward Plan metrics.

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 are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change. **Due to: Multiple and competing demands to transform services, couple with i**ncreased demand for services and challenging staffing recruitment and retention. Delivery requires prioritisation across GHC and primary care as well as GCC teams to ensure progress is delivered in 24/25. **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**	⟷
Strategic Risk Owner (Director)	**Helen Goodey, Director of Primary Care & Place**				
Aligned to other system partners risks (include ref no.)	There are no correlating risks.				
Aligned to current ICB Risks	**Integration 7:** Risk to the capacity of the Care Market **Integration 14:** complex and vulnerable children in nonhealthy care settings (e.g. school nursery) are not supported with their medical needs **Integration12**: Market instability as a result of price rises				
Committee	**Quality Committee**	**Last Review & Updated:**	**26 February 2024**		

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	• Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence.	• Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG)	• Availability of data from community providers

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. • Working with BI colleagues to understand our cohorts. • Robust metrics to understand impact Developing team in teams at neighbourhood level	• Project management support and capacity	• Reporting through the UEC prevention programme. • Ongoing monitoring	

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 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: BAF3 **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 ID3** 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 (Red 12) **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	**PCE 1:** Risk of industrial action: There is a risk that industrial action will be taken impacting delivery of services. (Residual score 4x5=20). **U&EC 3**: Risk of insufficient expansion of UEC workforce. (risk score 4x4=16)				
Committee	**People Committee**	**Last Review and Updated:**	**23 February 2024**		

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 National 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 relating to leadership development (Capacity now in place to map current leadership development offers across ICS and make an assessment of needs and gaps)	• 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 supporting delivery of NHS Workforce Plan. • Uncertainty relating to 2024/25 funding mechanisms to sustain targeted work.
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 incl. options for a shared approach 3. Retention programme pilot (NHSE Funded) (started April 2023) 4. Implementation of five high-impact actions for recruitment 5. Collective focus on agency and temporary staffing spend 6. On-going recruitment activities at organisational level and at system level & development of a system wide recruitment campaign "Be in Gloucestershire" 7. On-going focus on health and wellbeing initiatives for staff		1. Delivery of approved schemes on-going with monitoring reports provided to NHSE. 2. Approval of business case for System wide housing support role to assist with needs of IR staff and development of a social care App to support pastoral care. 3. Completion of diagnostic position for system and development of organisational level retention plans. Both Trusts part of next cohort of Trusts undertaking the People Promise Exemplar programme 4. No change 5. Reduction in agency costs delivered across GHC and GHFT at Month 8 and 9. 6. Campaign narrative and branding for Be a GP In Glos nearing completion. 7. Review of staff survey results relating to health and wellbeing and piloting of new starter conversation with focus on staff wellbeing. .	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Staff Engagement Score (Annual) • Sickness Absence rates, Staff Turnover % & Vacancy Rates • Bank and Agency Usage • Apprenticeship levy spend and placement numbers		

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: BAF3b **Strategic Risk ED&I**	**Equality, Diversity and Inclusion**: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse and engaging culture for staff we employ. **Due to:** insufficient strategic focus and actions that make a real difference to improving diversity and representation of staff across the pay grades including senior positions (clinical and non-clinical); and improves staff experience in the workplace ensuring compassionate leadership and a compassionate culture is in place. **Impact**:. The system does not benefit from cognitive diversity and fails to enhance opportunities to reduce the negative impacts on recruitment, retention and poor staff workplace experience	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**4x3=12**	**4x3=12**	**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 ID3** 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 12) **GHC ID4** There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment (risk rating 6) **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	**ODSG Risk ID 20**				

<table>
<tr><td></td><td colspan="3">There are a plethora of national EDI reporting requirements, making it difficult to be clear on priorities with overlapping plans and reporting requirements and additional effort in maintaining reporting requirements (risk score Amber 12)</td></tr>
<tr><td>Committee</td><td colspan="2">People Committee</td><td>Last Review and Updated:</td><td>23 February 2024</td></tr>
<tr><td>Current Controls (what do we have in place to mitigate the risk?)</td><td>Gaps in Controls</td><td colspan="2">Current Assurances
(how do we know the controls are working?)</td><td>Gaps in Assurance</td></tr>
<tr><td>• Reporting through the ICS OD / HR Steering Group
• Reporting through the ICS Workforce Steering Group
• Monitoring from the Equality and Human Rights Commission on the Public Sector Equality Duties
• Annual reporting against Workforce Race Equality Standards, Workforce Disability Standards & gender pay gap with corresponding action plans
• EDI sub-group</td><td>Lack of system wide improvement targets for
• Recruitment
• Movement between pay bands
• Insufficient in metrics related to engagement and staff experience
• Significant volume of data but more granular analysis required to support improvement plans</td><td colspan="2">• Reporting to the People Board, People Committee & relevant Committees of providers
• Reporting to the ICB Board
• Audits undertaken by Internal Auditors</td><td>People Committee requested further system wide focus and commitment to discuss improvement trajectories.</td></tr>
<tr><td colspan="2">Actions to mitigate risk & implementation dates</td><td colspan="3">Director’s update on actions to date (quarterly update)</td></tr>
<tr><td colspan="2">1. One Glos People Strategy priority and commitment to ED&I
2. All NHS partners engaged in Equality Delivery System framework
3. Action planning in response to 6 high impact actions in national EDI Improvement Plan
4. System wide commitment to support agenda inc 2nd system wide Allyship Programme took place during 2023 & system wide Reciprocal Mentoring programme currently on-going.</td><td colspan="3">1.Clear and tangible actions being developed as part of 2024 work programme based on national EDI improvement plan and WRES/WDES analysis – to be shared with future People Committee.
2. EDS2 Assurance Report to March Board
3. Individual organisational level action plans in place or under development
4. Evaluation of 2023 activities to support decision making on approach for 2024 (Completion date tbc).</td></tr>
<tr><td></td><td colspan="4">Relevant Key Performance Indicators: Annual reports
• Workforce Race Equality Standard report (metrics on % of BME staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WRES metrics)
• Workforce Disability Equality Standard report (metrics on % of Disabled staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WDES metrics)
• Gender Pay Audit – gender pay gap includes data on pay gap (mean and median hourly rates)
• Racial Disparity Ratios
• Staff Survey results for each organization.</td></tr>
</table>

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: BAF4 Strategic Risk	The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients. **Due to:** Lack of robust oversight and intelligence to ensure high quality care is delivered by organisations. **Impact:** Patients and citizens will be potentially put at risk of harm or suboptimal outcomes and have a poor experience if providers 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/Minimal**	**5x3=15**	**5x2=10**	**5x1=5**	↓
Strategic Risk Owner (Director)	**Chief Nursing Officer** **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	**Integration 15** Women unable to access first trimester antenatal screening or growth scans; **S&T 2** A risk that our system partners cannot support or drive transformation programmes and projects due to operational and workforce pressures**.** **U&EC 6:** Risk of failure to meet core UEC performance metrics				
Committee	**Quality Committee**	**Last Review & Update Date:**	**22 February 2024**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

		(how do we know the controls are working?)	
• ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput. • Reporting from and attendance at Provider Quality Committee. • Learning from Case Reviews • System Quality Group • System Effectiveness Group • System IPC Group • System Mortality Group	• New PSIRF will turn on the previously mentioned Patient Safety System Group. • Colleagues leading the work on the System Safety, Effectiveness and Experience groups will be meeting to ensure new groups are aligned. • Until groups are in place and functional existing control methods will continue as a risk mitigation.	• Reporting to Quality Committee • Quality Assurance discussions • Intelligence gathering through data relating to all aspects of quality • Contract Management Boards • Regulatory reviews	• There are gaps in some of the controls as stated and while there is a sound governance system in place for oversight, we will not have full assurances until we assess if the controls around PSIF and alignment of groups (System Safety, Effectiveness and Experience groups) are working.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
1. NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. 2. System Safety and Learning Group to be instigate by 31st December. 3. PSIRF to be ratified by Quality Committee in February 2024 Continued focus on personalised care training across the system		1. The System Effectiveness Group is currently being redeveloped now that the new CMO in place 2. The system will go live with PSRIF on 1 March - GHC and GHFT PSIRF policies have now been approved and ratified, along with the ICB's own policy. Although current Primary Care contracts do not state they need to implement PSIRF we will be using the same language and encourage learning in this way, so we have added value at a system level. 3. This change will also 'turn on' the System Patient Safety and Learning Group and weekly Patient Safety Huddles. These changes will further strengthen oversight arrangements through using hard and soft intelligence to improvements in quality and safety and aim to reduce risk all patients. 4. Personalised care educator training lead has been appointed and commences in role April 24.	
	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: BAF5 Strategic Risk	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care. **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/Minimal**	**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. **GHFT SR5** Failure to implement effective improvement approaches as a core part of change management.				
Aligned to current ICB Risks	**U&EC 1**: Risk of insufficient access to alternative pathways to ED **U&EC 2:** Transformational change across U&EC **U&EC 6**: 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]) **U&C 4:** Risk of insufficient system Resilience				
Committee	**Resources Committee**	**Last Reviewed and Updated:**	**27/02/2024**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances**		**Gaps in Assurance**	

		(how do we know the controls are working?)	
• Strong system wide governance for system operational issues (daily and weekly rhythm including Exec oversight), supported by System Control Centre. • Strong operational governance through system meetings (e.g. UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG). • Transformation capacity and capability all in place since August 2023 including Board, Steering Group and workstreams in place including Benefits Oversight and Assurance Group. • Agreed reporting on priority improvements in place. • Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver improvements within UEC system flow. • Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. • System wide operating plan to align with Transformation priorities for 2023/24. • Agreed UEC Transformation Programme in place including Working as One across all system partners. • Annual Winter Plan to be developed and in place to communicate to patients about where to access services during winter.	• Enhanced outcome and performance reporting across governance structure (to be enabled by digital platform). • Agree funding for improvements as part of the 24/25 operating and financial planning process.	• Ongoing monitoring of system wide priorities including operational planning targets via TEG/SEG. • Reporting to the Board of the ICB on key metrics via Integrated Performance Report. • NHSEI Reporting. • Benefits Realisation for Working as One Programme in place.	• Further development of the performance and benefits realisation trajectories required for some measures. • Impact of Industrial Action on operational performance as well as the ability to continue at pace with the Working as One Transformation Programme.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• 1. 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 (action to be closed).		• 1. All workstreams have a trial mobilised or are in further iterations of trials (as at February 2024). • 2. Systemwide Event has been held and actions factored into the programme. Action complete (as at February 2024).	

• 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 (action to be closed – see right). • 5. Improvement trials targeted to areas where performance improvements are needed (ongoing action with regular review at UEC CPG).	• 3. Programme metrics for Working as One are in place. Workstream measures being developed (to be in place by end of March 2024). • 4. Working as One communications and engagement plan in place and core narrative shared and regular bulletins are distributed across the system. Action to be closed. • 5a. Integrated Hub went live on 19th February (4-week trial) to improve hospital flow and reduce no criteria to reside. • 5b. Audit of Ward 6A completed in GHFT to understand ambulance handover delays in order to create an improvement plan. • 5c. Implemented schemes through winter support resilience and reduce reliance on beds.
	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: BAF6 Strategic Risk	Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures. **Due:** Practices are facing new financial challenges due to the increase in costs associated with staffing, energy, goods and supplies as well as a significant increase in patient demand due to the changing nature of general practice, therefore impacting increasing workloads. Practices are increasingly unable to afford to replace staff and are having to consider ways to reduce costs at a time when they are holding more risk due to extended wait times for secondary care. There is also a general concern regarding workforce resilience and retention across all roles within primary care and estates constraints to delivery. **Impact:** These challenges could result in practices facing serious financial hardship with potential contract hand backs and foreclosure of loans on premises. If GPs are made bankrupt they are unable to hold a medical services contract, therefore the local population could have no contract holder for medical services or premises to operate from, leading to significant instability. This is also impacting on delivery of services with waiting times increasing for patients to see primary care professionals, poor morale and hence higher turnover of staff. There is also a wider risk to the system of increased demand on other services if primary care are unable to deliver core services due to complete saturation or through taking steps to manage down capacity.	**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**	**4x1=4**	⬆
Strategic Risk Owner (Director)	**Helen Goodey, Director of Primary Care and Place**				

Aligned to other system partners risks (include ref no.)	**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	**PC&P 2** There is a general risk that the ICB's requirements of providing Primary Medical Services for practices that are facing resilience challenges (RED 15) **PC&P 9** Current and future GP Training Capacity will be reduced due to challenges with GP educators and estate (RED 16).				
Committee	**Primary Care & Direct Commissioning 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, to identify mitigations and provide resilience funding where appropriate • Resilience and Sustainability of General Practice Sub Group (to the PC strategy group) established • A standard operating procedure (SOP) is being put in place to ensure a fair and consistent approach with good governance • An independent accountant working with the practices and ICB finance team to review the position and put in controls where appropriate • There is a monthly review of practices to assess the issues that have arisen and where additional support may be needed • 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 • ARR underspend process completed to enable PCNs to maximise recruitment. • Primary Care Strategy is in place with associated plans		• Continue to seek clarification for funding for 2024/25 from NHSE • National direction for 2024/25 onwards	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. The resilience and sustainability of General Practice sub group has been established to further develop the ICB response to struggling practices.	• 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	• Financial issues are now the main focus to ensure general practice sustainability. • The introduction of an independent accountant is proving to be key to understanding a practice's financial position • The approach supports budget and cash flow management • The aim is for partners to ensure they are paid appropriately and that clinical models, practice administration and costs are brought with an affordable budget • Benchmarking of salaries and costs is also being undertaken • Awareness training is also being investigated for all partners
	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: BAF7 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 double what it was pre-covid. 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 and seasonal. 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. Follow up patients are also often very delayed for the appointments and largely go unnoticed as they are not reported in any national waiting time target but pose a significant risk of harm especially in specialties such as Ophthalmology or cancer follow ups.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** 
Risk Appetite (include colour)	**Cautious**	**3x4=12**	**4x4=12**	**3x2=6**	
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				

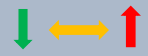
Aligned to other system partners risks (include ref no.)	GHC 3 There is a risk of demand for services beyond planned and commissioned capacity				
Aligned to current ICB Risks	OP&P 5: Risk of failure to comply fully with NHS Constitution standards for planned care waiting times OP&P 7: Risk of services not delivering to commissioned standards or provider failure				
Committee	**Quality Committee / Resources Committee**		**Last Review & Update Date:**	**23 February 2024**	
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 through the Referral Optimisation Group 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. Weekly check and challenge meetings at GHFT to micromanage long waiters in place. • Clinical harm reviews undertaken for all long waits.	• Stratification of waiting list based on other health and socioeconomic factors under development. • Specific plans for improving C&YP access to elective services in development. • Elective recovery plans for Gloucestershire patients treated at out of county NHS providers subject to further development.		• 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. • Elective task and finish group established to support 24/25 planning assumptions and investment prioritisation. • 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 independent sector providers.		• Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.

• Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
1) 24/25 operational plan in development to achieve identified elective targets and initial submission end of Feb 24. Elective task and finish group established to carry out the work at pace. Monitoring progress through Planned Care Delivery Board (ICS level meeting with GHFT represented). 2) Additional capacity investments via ERF currently being developed for prioritisation against available funds. 3) Two new theatres at CGH go live date set for March 24. 4) Additional elective activity planned for 2024/25 (e.g. endoscopy, WLI GLANSO lists as well as insourcing and outsourcing). 5) Roll out of CDC activity (new building now open), 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 24/25 operational planning. 7) 3rd Cath Lab being commissioned for 24/25 8) New FoD community hospital being commissioned with endoscopy facility due to open July 24		1) Operational planning underway in the absence of detailed national planning guidance. High level assumptions being used but a confirmed system ERF target has been communicated as yet. 2) With final ERF target not yet known so prioritisation proceeding on the same basis as last year. Significant high-risk investments require funding which leave less funding available for activity increases. 3) New theatres almost complete and due to open in March. 4) Divisions have identified baseline capacity and efficiency expectations and then remaining activity required to deliver waiting time targets. Investments being prioritised by Elective Task and Finish group. 5) Community Diagnostic centre now open, creating significant additional capacity. 6) ISP contract and activity negotiations underway. 7) Business case and funding implication being finalised and prioritised alongside other elective investments. 8) Working assumption to start using new endoscopy facility for 2 days a week from July 24. Funding implications still to be finalised and prioritised alongside other elective investments.	
	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: BAF 8 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**	**Last Review & Updated:**	**23 February 2024**		
Current Controls (*what do we have in place to mitigate the risk?*)	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

		(how do we know the controls are working?)	
• 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. Project team established to oversee recommissioning of ADHD/ASC pathway • Adult Community Mental Health Transformational programme: Transformation programme nearing completion and process of transferring to BAU in progress. Service specification being drafted for key transformational changes. Short term extension to programme management agreed	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. Shared care arrangements for ADHD prescribing between primary/secondary care.	• 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.	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		The significant work on SEND and across services for children has started to show results, with improving services and greater impact. We are continuing to focus on waiting lists and on appropriate provision. Partnerships with the VCS and with education are delivering excellent results. Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy.	

	• •SEND inspection complete and ICB SEND programme board established. • Work is progressing in this area.	Embedding the community transformation for adult mental health remains a challenge, particularly in the context of significant national policy changes in relation to system partners. Work with police colleagues on a local RCRP implementation model is developing well but remains a work in progress. Data and intelligence challenges remain, particularly in the area of understanding demand changes and modelling future impact.
	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 9 **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)	**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 4 - 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 5- 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 7 - The ICS does not achieve a breakeven position against its Capital Resource Limit				
Committee	**Audit Committee / Resources Committee**		**Last Review & Updated:**	**20 February 2024**	
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	• 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.	• 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	

inflation and wider risks within the system resulting from a slower capital programme		• Annual internal audit reviews on key financial controls	
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.		• 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 on forecast out-turn position being assessed.	
	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		

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** The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high quality care **Due to:** – increasing inflation on capital costs – 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 – High level of backlog maintenance within GHFT (c£72m) **Impact**: – Capital allocation "buys less" as a result of increasing inflation and System may be unable to live within its capital resource limit – Inability to reduce the level of high-risk backlog maintenance, to replace equipment when due or to refurbish facilities across the system in a timely manner leading to down time for unplanned maintenance and reduced productivity across the system –	**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)	**Chief Finance Officer**				
Aligned to other system partners	GHFT: SR10: Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for				

risks (include ref no.)	purpose and provides an environment that colleagues are proud to work in			
Aligned to current ICB Risks	**F&BI 22** - ICB Headquarter Lease Capital Funding Access **F&BI 7** - The ICS does not achieve a breakeven position against its Capital Resource Limit **Dig 1** – ICS Digital Strategy			
Committee	**Audit Committee / Resources Committee**		**Last Review & Updated:**	**26th February 2024**
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 • Monthly review of whole-system financial position by Directors of Finance with reporting into relevant Committee for ICB, GHFT, GHC • 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 • Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed, • EPRR in place, to support any critical infrastructure failures within provider organisations • Mature Provider estates planning forums to manage risk and capital planning oversight • This risk will form part of the ICB infrastructure plan.	• Longer term strategic plan which delivers sustainably for the system.	• Reporting into Board of the ICB and relevant Committee for each organisation. • Monthly capital monitoring is produced 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.		• 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)**		
• ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS • . 5-year capital plan in development as part of the MTFP • Disposals across the system being explored to maximise capital allocations • Developing 'library' of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes		• Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed, • ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS		
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Delivery of in-year breakeven capital financial position			

Pillar 3 Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB					
Emergency Preparedness, Resilience and Response (EPRR) BAF 11	**EPRR:** - Failure to meet the minimum occupational standards for EPRR and Business Continuity. **Due to:** Lack of oversight and resource in the ICB's emergency planning and business continuity team to fulfil the functions and responsibilities of a Category 1 responder. **Impact:** Unable to fulfil our responsibilities as a Category One responder, and effectively lead a robust, effective and coordinated system response to a major incident.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷
Risk Appetite (include colour)	**Zero/Minimal**	**4x3=12**	**4x4=16**	**4x1=4**	↑
Strategic Risk Owner (Director)	**Chief Nursing Officer**				
Aligned to other system partners risks (include ref no.)	**GHFT SR12** Failure to detect and control risks to cyber security (score Red 20) **GHC 8** Cyber There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc (score Red 20)				
Aligned to current ICB Risks	EPRR 2 – EPRR Resourcing				
Committee	**Quality Committee**	**Last Review & Update Date:**	**23 February 2024**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		
• EPRR On-call manager training • EPRR exercises • Oversight of EPRR through the Local Health Resilience Partnership.	• Insufficient internal debriefs have been performed for exercises that the ICB has participated in or that lessons learned have not been embedded,	• Reporting to Quality Committee • NHS England system assurance review and provider assurance process against national standards • BDO Internal Audit Report (November 2023) moderate assurance for design and effectiveness	• BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium recommendations (November 2023).		

	• Lack of progress on the implementation of the cyber security exercise action plan points relating to the joint working and processes required with the cyber and EPRR teams. • Insufficient register of training compliance for Strategic and Tactical Commanders to ensure that the Principles of Health Command training has been completed • Insufficient resources within the EPRR team (the team are currently reviewing capacity and benchmarking against other ICBs)		• NHS System Assurance all but one of the Partners has achieved a standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. One organisation (E-MED PTS) has been assessed regionally as "non-Compliant". ICB itself has seen its overall rating fall from that obtained in 2022 (substantially assured) to a rating in 2023 of "partially assured".
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• We have now updated our On-Call rota system matching skills where possible to compliment those on-call. We have also brought titles in line with EPPR frameworks, with Manager and Senior on call being replaced with Tactical and Strategic leads. • A full programme of training has been set up, with a dedicated EPPR training manager in place. • There is a plan to review the resources of the team initially with some dedicated administrative support and secure some permanent funding for the training post if appropriate. • There are some further long-term discussions to be had with system partners about revisiting the work undertaken that proposed a system wide EPRR Function.		The role of Emergency Accountable Officer has now transferred to the new Executive Nurse and Lead for Quality. MAGIC training for new exec directors has taken place or planned. All on call managers and senior managers have access to a clearly defined work programme which enables all of these staff to achieve and maintain minimum National Occupational Standards. More work needs to be undertaken to ensure all staff take up training opportunities. The ICB, as part of the EPRR work plan for business continuity, is currently undertaking a three-month programme ensuring departments review and update their departmental Business Continuity Management (BCM) plans /Business impact analysis with local departmental walkthrough /discussion of what they would do for a loss or partial loss of service.	

		BCM will be presented at the next face to face staff meeting and the Communications Team will be putting an article in the staff newsletter to highlight this. This subject is addressed in our weekly EPRR Team meetings and also combined in our monthly review meeting with Head of EPRR.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) N/A	

Pillar 3 Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB					
Cyber Security BAF 12	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS **Cause:** Cyber-attacks from organised groups targeting NHS • Malware attacks • Phishing attacks via emails to staff • Password access through data breaches • Inadequate firewall protection and security updates **Impact:** Whole loss of systems and downtime – with inability to recover quickly • Demands for money to recover data (ransomware attacks) • Access to patient records (CHC Trakcare and Liquid Logic and personal data that could be published)	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷
Risk Appetite (include colour)	**ZERO/Minimal**	**5x4=20**	**5x4=20**	**4x2=8**	**NEW**
Strategic Risk Owner (Director)	**Chief Clinical Information Officer**				
Aligned to other system partners risks (include ref no.)	**GHFT SR12** Failure to detect and control risks to cyber security (score Red 20) **GHFT SR13** Inability to maximise digital systems functionality (Score Amber 12) **GHC 8 Cyber** There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc (score Red 20)				
Aligned to current ICB Risks	Dig 2 Cyber Attacks (score Amber 12)				
Committee	**Audit Committee**	**Last Review & Update Date:**	**23 February 2024**		

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**
• Cyber Security action plan in place, reviewed annually and gaps in security and investment identified • Monitoring systems in place and dedicated cyber security team at GHFT • Backup systems and disaster recovery in place and regularly updated • Cyber security delivery workstreams – monitoring safety and access • Investment in cyber tools and software • Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches • Monitoring and reporting via ICS Digital Executives and the ICB Audit Committee; ICS Cyber Operational Group • NHS national monitoring (alerts) and NCSC alerts • Communications and engagement with users on prevention	• Insufficient in-house expertise in cyber security team • Inability to recruit specialist cyber staff because of cost (market forces) • Disaster recovery planning around support systems (out of IT control) not consistently in place • Operating model of cyber-technical & cyber-governance currently not optimal • Volume of cyber-security issues requiring resolution • ICS-wide incident response processes not fully operational	• External audit recently completed by BDO identified no new/unknown risks or issues • External penetration testing conducted annually by GHC and ICB and findings managed • ICB board cyber development session took place in December followed by invitation to complete online training. • Facilitated session with audit committee and digital leads scheduled for 7th March • Annual cyber incident response exercise scheduled for 12th March	• GHFT/CITS penetration test to be scheduled • Action log and schedule arising the external audit report to be published and progress monitored
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Board level awareness of risk and issues • Rationalisation of detection and prevention tooling. • Introduction of targeted monitoring and alerting across key systems and entry points. - Contract monitoring third party suppliers to ensure that there is sufficiently robust data security and protection software and safeguards in place as well as reporting. - Removal of all end-of-life software and hardware.		• The ICB Board Cyber development session in December was positively received. • The next annual cyber incident response exercise is scheduled for 12th March and will act as a barometer to test findings from last year's exercise and the SWASFT cyber incident. • The focus of effort continues on the two red rated risks - risk management and IT asset management	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) N/A		

5x5 Risk Matrix

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

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

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 10

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

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 months report is split into 2 sections, the Integrated Performance Report (Part A) and the Delivery Plan for Recovering Access to Primary Care Update (Part B). **Part A** This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for March 2024. 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 (ICS and ICB M9 report) • 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. There is a supporting metrics document that lists performance on the individual metrics that can be found here. **Part B** In November 2023 the System Delivery Plan for Recovering Access to Primary Care was presented to ICB Board, outlining how Gloucestershire ICB was taking forward the actions outlined in the national Delivery Plan (published by NHSE in May 2023). ICBs are required to bring and update to their public board in October/November 2023 and provide an update in February/March 2024. This report provides an update on progress on the November 2023 System Delivery Plan.						

	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 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. A working group to support the development of the System Delivery Plan for Gloucestershire continuities to meet and 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 were 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. **Next Steps** The ICB will continue to work with practices and PCNs to deliver the required actions for this programme of work. Further discussion with GHFT regarding the relative priority of implementing self-referrals and if/when this could be progressed.

	Data submitted via the Community Services Data Set (CSDS) is being reviewed to identify any data quality issues, to ensure that a full picture of activity is available. Actions that are ongoing include: • Reviewing breakdown of referrals by referral source type in order to identify potential opportunities to increase self-referrals, • Investigating the missing team types in the data we hold as identified by NHSE reports, • Determining if there is a proxy to identify Audiology and Physio self-referrals as not identified in national datasets currently. • Support offers available 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. • Continue to engage with practices regarding transition to optimal telephony and implement the Modern General Practice Model. • Plans are in place to review PCN CAIPs and discuss progress in April 2024, with payments due to PCNs by 31 August 2024. • Primary-Secondary Care Interface Principles document to be finalised, following consultation process. • Gloucestershire Primary Care Activity Survey results to be discussed and actions identified. • 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. • Continue to promote the national resources available regarding Primary Care Access and Pharmacy First and identify if bespoke local videos can be developed.
Key Issues to note	**Part A:** Areas of key exceptions have been included at the front of the Integrated Performance Report. **Part B:** 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)**	**Part A:** 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. **Part B:** This piece of work requires intensive resources in practices, PCNs and the ICB. 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.			
Management of Conflicts of Interest	None			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	X
	Human Resource	X	**Buildings**	X
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** **Part B: Jo White**	**Role Title**	Senior Performance Management Lead Director for People, Culture & Engagement Finance Programme Manager Senior Manager, Quality & Commissioning Programme Director – PMO & ICS Development Deputy Director of Primary Care and Place
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 **Marie Crofts** – Chief Nursing Officer – NHS Gloucestershire ICB **Helen Goodey** – Director of Primary Care and Place *(Part B)*		

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

March 2024

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Integrated Performance Report Contents

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Part A: Integrated Performance Report

March 2024

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Feedback from Committees

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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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	7 March 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Operational Planning (24/25)	**LIMITED**	The Committee discussed the delay to national Operational Planning Guidance and the implications that this was having on 24/25 planning. A review was undertaken of the high level submission made on 29th February 2024 and the activity, performance, workforce and finance submissions made as well as plans for the next submission on 21st March 2024. This included a review of the draft 24/25 capital plan and current revenue position for 24/25. This included review of work to reduce the existing revenue deficit, review of the 24/25 savings schedule and activity underway to determine next steps on non-recurrent schemes/high risk investments.	Work continuing to take place across the system ahead of national planning submissions in March and May 2024.	Submissions to NHS England on 21st March and 2nd May 2024
Performance (In Year 23/24) including Endoscopy	**LIMITED**	Committee received an update on performance for 23/24 and heard about progress being made on elective recovery and ambulance performance. Further discussion was held on endoscopy capacity and performance which continues to be an area of focus as it is a driver of long waits in the system. This also includes surveillance patients previously excluded from national reporting. The Committee heard about waiting list initiatives that are planned to support immediate performance improvement.	Continue to monitor against the recovery plan for Endoscopy services through including reviewing progress against waiting list initiatives that are planned through to March 2024.	Continue to monitor through the Integrated Performance Report.
Finance (In Year 23/24)	**LIMITED**	Committee heard that at Month 10 the year end revenue position was expected to be a £675k deficit which is inclusive of mitigating actions to partly recover the cost of the December and January industrial action. The Committee also received an update on capital expenditure variance with an outturn risk of up to £5.4m relating to IFRS 16 finance leases where national funding is insufficient to cover costs.	Committee will continue to monitor towards the year end position for 2023/24.	Continue to monitor through the Integrated Performance Report.

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

Topic	Committee
None	None

People Committee

Accountable Non-Executive Director	Karen Clements
Meeting Date	8 February 2024

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 24th to 28th Feb **Update**: strike action held in Feb, further ballot planned for future dates	Business continuity planning as per usual arrangements. Await notification of any further dates	April 2024
Band 2/Band 3 Pay Issue	**SIGNIFICANT**	**Update**: Further discussions with regional trades unions representatives on-going. Agreement still needs reached regarding the final elements of the implementation package.	Still awaiting union agreement based on member ballot	April 2024
Inadequate workforce supply and 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.	Work continuing on system wide campaign Be in Gloucestershire. Focus on International recruitment for social care	Early 2024 April 2024
Loss of Workforce Development Funding WFD in 2024/25	**SIGNIFICANT**	NHSE have formally notified there will be no WFD monies in 2024/25. (Historic value has been £310k) These monies support targeted education and support for staff and key infrastructure roles in the People Team. **Update**: business case for key infrastructure roles approved by operational execs. Bid for £30k OD funding submitted via High risk investments process.	Awaiting outcome of high-risk prioritisation process	March 2024
Loss of Continuing Professional Development Funding WFD in 2024/25	**SIGNIFICANT**	Reasonable Indications of further CPD funding for nursing and allied professional staff in 2024/25 will be available (based on 23/24 funding levels)	Awaiting formal confirmation	April 2024 (TBC)

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	15 February 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Patient Safety Incident Response Framework (PSIRF)	**SIGNIFICANT**	The committee ratified GHFT and GHC's PSIRF policies and plans, and has subsequently approved the ICB's policy.	There will be new weekly safety huddles, a quarterly insight and learning group and monthly implementation review meetings. Updates will come back to the Quality Committee six and twelve months time.	August 2024 and March 2025
CQC	**LIMITED**	From April 2024 the Care Quality Commission (CQC) would be commencing Integrated Care System (ICS) assessments, using an update to their standard approach for Trust and Local Authority assessments.	There will ongoing reporting back to the System Quality Group on risks and progress as the evidence base continued to be built.	Ongoing
Fast Track Funding	**LIMITED**	Palliative Care staff had raised concerns about Fast Track Funding and delays, this was also raised at the ICB Public Board and a request was made to examine the End of Life policy, the implementation of the guidance around fast-track funding, and whether the ICB were implementing correct decisions.	The piece of work is in progress and End of Life team were still reviewing the policy and also considering the views of those staff working on the ground.	April 2024
Maternity & Neonatal	**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.	Maternity remain on NHSE Maternity Safety Support Programme. A progress meeting on the Section 29A received from Maternity was expected with the CQC at the end of March 2024 with two actions from the Notice expected to be completed.	March 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	N/A

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- The new Integrated Flow Hub model running at GHFT to assist with joint working and decision making for discharge planning has been successfully piloted with good results seen, in particular the reduction in decision making time for patient discharge. Partners from across the system have set up a co-located work space sited at Gloucester Royal Hospital to improve joint working and take on problem solving of issues affecting system flow. Extension of the pilot is being sought to fully evaluate the model.
- Elective Recovery Performance continues to meet the national target (103% of 19/20 value weighted activity) despite industrial action causing significant numbers of cancellations. The system position for M9- (to December 2023 – latest available validated data) is 105.5%. Despite the industrial action carried out in December and January, activity recovery has been performing well, especially at independent providers.
- The new Community Diagnostic Centre (CDC) at Quayside in Gloucester has opened offering more than 80,000 extra diagnostic appointments each year, allowing patients across Gloucestershire to access potentially lifesaving checks more quickly, without having to go to hospital. A wide range of diagnostic tests including X-Rays, MRI, CT, ultrasound, ECHO and DEXA scanning are either already up and running or will be rolled out in the coming weeks.

Areas of Focus

- In line with national expectations, there is extensive focus on ED performance – in particular to deliver 76% patients seen and discharged or admitted within 4 hours across the system (including the main acute site and MIIUs). Currently in March (to 13th March) system performance is at 72.8% (note: additional capital funding available for top performing and most improved systems in terms of 4-hour performance).
- A recovery plan is in development to address the waiting list for Angiograms at GHFT. Introduction of the third cath lab will significantly reduce the backlog and improve waiting times, and alternatives to support interim recovery are being worked up to be progressed through ERF schemes.
- There continues to be focus on recovery of performance targets for cancer waiting times – in particular waiting list initiatives across Urology, Lower GI and Breast are in place to support recovery against the 28-day and 62-day standards.
- Demand on primary care in Gloucestershire continues to be high, with an additional 42,441 appointments carried out in January 2024 compared to January 2023 (11.4% increase), while registered population rose by 1.1% in the same period.
- Endoscopy performance remains a concern for the system with 63.6% of colonoscopy patients on the waiting list at the end of January waiting over 6 weeks (21.1% of gastroscopy patients and 42.8% of Flexi sig patients also were waiting over 6 weeks). Additional capacity is being supported by NHSE funding and additional local investment, and GHFT are working with productivity specialists to review pathways and procedures.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Investment

- The Business case for piloting a staff housing support service was approved by JCPE, this is a regional collaboration
- The Business case for continued ICS people team was approved
- Business case for two system careers posts was approved by JCPE
- NHSE funded People Promise Manager for GHFT approved (GHC post previously approved and recruited to)

Funding Opportunities

- Submitted bids for Volunteering for Health fund and WorkWell Programmes

Strategy & Planning

- High-level workforce return submitted
- Steering Group Plans on a page for 24/25 drafted
- Workforce section of Joint Forward plan updated

System-wide Development Programmes

- System Leadership conference series agenda drafted and dates proposed (June and Oct) – subject to Exec availability

Long-Term Workforce plan

- Participated in (three) regional workshops (Supply and Retention, Expansion and Apprenticeships and Clinical and Medical reform)

Areas of Focus

Strategy & Planning

- Full draft workforce return (21st March)
- Steering group Plans on a Page to be approved
- Strategies in development: Apprenticeship strategy, Health & Wellbeing strategy and Advanced Practice Strategy.

System-wide Development Programmes

- Systems Thinking masterclass cohort 5 (commencing April 2024), participant list to be finalised.
- Exploring (internal) options for further cohort delivery of system thinking masterclasses.
- Finalised agenda and dates for system leadership conference

International Recruitment

- Commence international recruitment of care workers for eligible providers, establish the pastoral care support arrangements and seek additional expressions of interest.

Programme Delivery

- Ensure agreed programme investments are committed by year end.

Please note: The Quality report is updated bimonthly.

Quality

Quality – Safety, Experience and Effectiveness

Key Achievements

- The system switches over from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) on 1 March. Provider and ICB plans have now been ratified.
- The Patient Transport Advice Centre has worked with Gloucestershire ICB to pilot Amazon Connect technology to improve performance. Initial analysis indicates significant service enhancement including a reduction in avg. call handling time and a 33% increase in calls serviced per agent due to new ways of working.
- We are in the 3rd week of a 4 week trial of the Integrated Flow Hub. At which all system partners work together on things such as; decision to discharge and front door processes. The impact so far has been very positive and it has been recommended via a paper to Exec's to continue the trial over future months.

Areas of Focus

- Analysis of the first People's Panel Survey responses is underway. The first survey focused on: Digital & Information Sharing; Virtual Wards and NHS 111. Total number of responses – 605 (462 from Panellists and 143 from existing self-selecting group).
- MOD have announced another increase to the Beachley Barracks Afghan resettlement site, following the closure of Weeton Barracks. This makes Beachley Barracks the largest site in the country. GICB are working in conjunction with GDOC regarding the NHS legal provision for healthcare.
- The GHFT Standardised Hospital Mortality Indicator (SHMI) has risen to 1.103 in the latest national data publication. This is within control limits but will be a focus for the System Mortality Group.

Finance and Use of Resources

Finance

- The ICS finance position as at month 11 2023/24 is:

	Year To Date (£k) (Overspend)/Underspend	Forecast Outturn (£k) (Overspend)/Underspend
GICB	0	48
GHFT	3,819	(1,490)
GHC	3,324	1,939
Total Surplus/(deficit) versus plan	**7,143**	**498**

- The ICS is forecasting a yearend surplus position of £498k. In year pressures are being managed and there is ongoing work to manage the position and assess the impact on 2024/25.
- The organisational forecast out-turn positions include adjustments arising from the System Risk Share agreement.
- Mitigating actions during the year have included non-recurrent savings and slippage against programmes and budgets, implementation of additional controls and productivity improvements within GHFT and bringing forward plans for other areas. A number of these will impact on 2024/25 leading to improvements in the recurrent run rate in 2024/25.
- Year to date capital expenditure has a variance of £5.9m underspend against budget for the year, relating to early year slippage against schemes. Risk around the confirmation of funding for some National schemes remains. An out-turn risk of £3.7m relating to IFRS16 finance leases was reported in month 11 financial returns. NHSE has subsequently confirmed this will be fully funded. Work is ongoing across the system to mitigate other capital underspend risks.
- Agency costs in month 11 remain below the straight line value of the agency cap for the system, for the fifth consecutive month. Actions continue to further reduce the expenditure within both Trusts, however, Industrial Action in February is one of the factors impacting on spend.

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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Improving Services & Delivering Outcomes

Outcome Measures

- Alongside overarching measures for Life Expectancy, Premature Mortality and Infant Mortality, the outcomes dashboard covers measures aligned to the three pillars of the Integrated Care Partnership:

    1) Health and Wellbeing – focussing on some of the wider determinants of health

    2) Transforming what we do – focussing on indicators aligned with our transformation priorities

    3) Improving Health and Care – focussed on high level indicators across different areas of health and social care services (e.g. elective care, system UEC flow, cancer and mental health)

This dashboard is not exhaustive and there are other areas that stand out as needing additional focus and/or understanding.

- Overall, health outcomes in Gloucestershire are above the national average. 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 below national averages and where, as a result, local people are more likely to depend on the services we provide. The dashboard includes district level data to give an indication of inequalities in outcomes between different parts of the county (which can be hidden if just considering the county averages). The dashboard highlights that there are opportunities for improved secondary prevention, as well as primary prevention. For example, there is variation in the proportion of patients with serious mental illness who take up a physical health check across the county – with lowest coverage seen in Gloucester and Tewkesbury. We can also see that there is a significant difference to the national average in Excess under 75 Mortality rates for adults with serious mental illness – this is higher than average and has been for some time and this is a driver for our mental health CPG.

Improving Services & Delivering Outcomes

Outcome Measures

- Other indicators showing Gloucestershire's position as significantly below the national average include the Gap in the Employment rate between Learning Disability and Overall Employment, the % of recorded blood pressure readings, the % of patients on lipid lowering therapy, and the emergency admission rate. Understanding these areas where we do less well helps to shape our priorities; there are work programmes associated with improving these outcomes, for example blood pressure is the key focus for the Health and Wellbeing Partnership and our Urgent and Emergency Care Transformation Programmes Working as One is seeking to expand alternatives to hospital care and ensure patients are able to access them when appropriate.
- In general, we find Gloucester is the district most likely to be worse than the county average across several of the indicators. For example, although the county compares well to the national picture, the prevalence of obesity in Year 6 aged children varies across the county, with Gloucester seeing a significantly higher proportion of children classed as obese.
- 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

Improving Services & Delivering Outcomes

ICP Dashboard

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

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Overarching	0.1	Life Expectancy	Life expectancy at birth (male)	79.5	80.9	79.7	77.8	80.6	80.6	79.8
	0.2	Life Expectancy	Life expectancy at birth (female)	83.6	84.7	83.5	81.7	83.8	84.5	83.6
	0.3	Premature mortality	Under 75 mortality rate from all causes rate per 100k	326.0	266.1	315.1	406.1	281.7	296.4	315.5
	0.4	Infant mortality	Infant mortality rate, 2020-2022	3.4	1.4	3.2	4.0	4.7	3.8	3.5
Pillar 1: Health and Wellbeing Board	1.1	Physical Activity	% of physically inactive adults	19.0	12.6	20.1	22.2	19.6	18.0	18.8
	1.2	ACEs	% of Children reporting that they 'have someone to help with personal issues'	83.7	85.9	84.1	82.2	85.5	84.0	84.0
	1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm RATE per 100k	187.1	111.2	94.4	225.6	151.5	154.1	162.9
	1.4	Social Isolation & loneliness	% of adults who feel lonely often/always or some of the time	24.5	18.9	18.3	19.8	17.9	22.8	20.4
	1.5	Healthy Weight	% Year 6: Prevalence of obesity, 22-23	17.9	15.7	20.1	26.2	18.4	20.2	20.3
	1.6	Early Years and Best Start in Life	Infant mortality rate, 2020-2022	3.4	1.4	3.2	4.0	4.7	3.8	3.5
	1.7	Housing	% of households which are overcrowded in terms of bedrooms	1.9	1.2	1.8	3.5	1.6	1.4	2.0

ICP Dashboard

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

Improving Services & Delivering Outcomes

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 2: Transforming what we do	2.1	Health equity	Inequality in life expectancy at birth (male), 2018-2020	9	1.1	5.8	13.5	4.7	6.5	7.6
	2.2	Health equity	Inequality in life expectancy at birth (female), 2018-2020	8.4	-1.0	3.8	10.2	2.9	7.4	5.8
	2.3	Health equity	Excess under 75 mortality rate in adults with severe mental illness	N/A	N/A	N/A	N/A	N/A	N/A	580.2
	2.4	Health equity	% School Readiness	69.5	70.7	63.5	65.2	68.1	71.3	67.8
	2.5	Employment exemplar theme	Gap in the employment rate between learning disability and overall employment rate	N/A	N/A	N/A	N/A	N/A	N/A	79.0
	2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage,2023	14.4	14.1	N/A	12.3	12.7	N/A	13.0
	2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+) - %	12.6	6.3	11.3	18.1	8.7	9.3	11.5
	2.8	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations - %	23.7	6.9	21.1	31.5	25.8	15.6	23.3
	2.9	Blood pressure exemplar theme	% of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	64.2	67.1	66.9	61.6	67.9	67.3	65.3
	2.10	Blood pressure exemplar theme	% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	55.0	56.1	56.6	57.7	56.9	52.8	55.9

Improving Services & Delivering Outcomes

ICP Dashboard

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

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 3: Improving Health and Care Services Today	3.1	Improve access/ reduce backlogs	Numbers/breakdown of waiting lists by locality.	17511	10014	8443	21452	13303	4944	75753
	3.2	Improve access to primary care	Primary care: GP headcount per 100k population	82.4	85.8	80.2	81.8	93.4	87.5	84.9
	3.3	Improve mental health support	% SMI register health check uptake	54.5	55.0	61.6	51.0	61.6	50.9	55.2
	3.4	Support Improvements in delivery of UEC	A&E attendances – rate per 1000	23.10	31.40	30.59	28.20	27.67	24.26	31.25
	3.5	Support Improvements in delivery of UEC	Emergency admissions – rate per 1000	21.82	21.69	27.08	24.81	22.61	22.51	25.76
	3.6	Support Improvements in delivery of UEC	Long lengths hospital stay (proxy of availability of out of hospital support).	102	55	66	144	100	17	522
	3.7	Improve access to care: Cancer	% of cancers diagnosed at Stage 1 and 2, 2020	54.0	53.7	54.1	52.6	46.8	54.2	52.4

Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
0.1	Life Expectancy	Life expectancy at birth (male)	2020-2022
0.2	Life Expectancy	Life expectancy at birth (female)	2020-2022
0.3	Premature mortality	Under 75 mortality rate from all causes	2020-2022
0.4	Infant mortality	Infant mortality rate	2020-2022
1.1	Physical Activity	Percentage of physically inactive adults, 2021/22	2021/2022
1.2	Adverse Childhood Experiences	Percentage of Children and Young People reporting that they 'have someone to help with personal issues', 2022	2022
1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm (Directly Standardised Rate)	2021/2022
1.4	Social Isolation & loneliness	Percentage of adults who feel lonely often/always or some of the time	2019/2020
1.5	Healthy Weight	Year 6: Prevalence of obesity	2022-23
1.6	Early Years and Best Start in Life	Infant mortality rate	2020-2022
1.7	Housing	Percentage of households which are overcrowded in terms of bedrooms	2021
2.1	Health equity	Inequality in life expectancy at birth (male), 2018-2020	2018-2020
2.2	Health equity	Inequality in life expectancy at birth (female), 2018-2020	2018-2020
2.3	Health equity	Excess under 75 mortality rate in adults with severe mental illness	2018-2020
2.4	Health equity	School Readiness: percentage of children achieving a good level of development at the end of Reception,	2022/2023
2.5	Employment exemplar theme	Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2021/22
2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage	2023
2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+)	2022
2.8	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations	2022
2.9	Blood pressure exemplar theme	Percentage of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	To September 2023
2.10	Blood pressure exemplar theme	Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	To September 2023

Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
3.1	Improve access to care and reduce backlogs	Numbers/breakdown of waiting lists. WLMDS – *to be replaced with rate*	February 2024
3.2	Improve access to care – primary care	Primary care: GP headcount per 100k population (General Practice Workforce - NHSD) – *note quality concerns have been raised with this metric – exploring with BI and primary care*	February 2024
3.3	Improve mental health support	SMI physical health check uptake	December 2023
3.4	Support Improvements in delivery of Urgent and Emergency Care	A&E attendances - Rate per 1000 population	January 2024
3.5	Support Improvements in delivery of Urgent and Emergency Care	Emergency admissions - Rate per 1000 population	January 2024
3.6	Support Improvements in delivery of Urgent and Emergency Care	Long lengths of hospital stay over 21 days	January 2024
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	January 2024

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- The system has once again responded to further industrial action from Saturday 24 February (7am) to Wednesday 28 February 2024 (11.59pm), centralising services in Gloucestershire Royal Hospital for serious and life-threatening conditions. MIIUs and GP practices have continued to provide UEC services throughout this period, with NHS111 supporting patients in accessing local services where required. With further industrial action expected in the Easter period, the ongoing disruption caused by industrial action is continuing to hamper recovery in UEC services.
- February overall Type 1 ED 4 hour performance was 56.2% (remaining stable to the 56.2% seen in January) and whole system (GHFT and MIIU sites) was 71.7%. March performance to date is currently 72.8%, with the expectation that nationally 76% will be met by all systems in March 2024. We continue to be concerned about high numbers of 12 hour plus waits in the ED department, which comprised 15.3% of all attendances in February 2024. All patients are clinically triaged and prioritised to ensure that urgent cases are seen quickly, and escalation arrangements are in place to ensure patients are reviewed while waiting for treatment or admission.
- Throughout February, the total of patients at GHFT with no criteria to reside has reduced from the challenging position seen following the periods of industrial action. Latest weekly average (w/c 4th March) is 155 (down from over 200 seen at the start of January).
- Gloucestershire Integrated Care System went live with a four-week trial mid February to bring together patient flow colleagues from across partner organisations into the Integrated Flow Hub (IFH), replacing the function of the Transfer of Care Bureau. The IFH is physically located on the Ground Floor of the Courtyard at GRH and is made up of representatives from across the system. The first focus for the IFH was to speed up the decision-making process at the back door of GHFT to facilitate timely discharge for Pathway 1-3 patients. In the first two weeks, the IFH has succeeded in reducing the median time it takes to make a decision post referral from 22.8 hours (pre-trial baseline) to 7.1 hours. The IFH has also increased the % of decision made of the same day as referral from 17% (pre-trial baseline) to 51%. Alongside this, the IFH has been working with the ward MDT teams to streamline the single referral form to ensure only the right information is requested.
- Ambulance response times and handover delays have stabilised, with Category 2 response times at 40.7 minutes on average in February, and time lost handover delay at 90 hours per day.
- Work has continued through winter to promote well-being and appropriate access to services, with public facing campaigns including “Stay Well This Winter”, “Click or Call First” and “No Place Like Home” encouraging people to proactively support their own health, access urgent care via the suitable service and highlighting the benefits of joint working between family members and health and care professionals to get people home from hospital in a timely way. Both the Click or Call First Campaign and the Stay Well This Winter campaign achieved huge reach. Through social media alone the campaigns had around 850,000 impressions across all NHS Gloucestershire social media channels (Facebook, X, Instagram).

Improving Services & Delivering Outcomes

Elective Care

- Following significant disruption to elective recovery by industrial action year to date performance continues to meet our system elective recovery target which has now been revised to 103%. At M10 YTD Flex Gloucestershire ICB commissioned Value Weighted Activity (VWA) is 104.7% of 2019/20 including pathways avoided. Flex data will be updated so this is likely to increase. At M9 YTD Freeze Gloucestershire ICB commissioned VWA is 105.5% of 2019/20 including pathways avoided. The forecast outturn is currently 105.9%. Industrial action taking place in January and February has been factored into this forecast. Without industrial action, the system ERF position is likely to have been in the region of 108%. Although December activity was impacted by industrial action, there was good performance in terms of elective recovery, particularly for activity at independent sector providers.
- In January, the RTT position has recovered slightly, despite industrial action taking place, to 65.3% patients waiting under 18 weeks up from 64.8% in December. Work continues to address long waiters, with >65 weeks dropping to 798 from 814 and >78 week waits reducing to 19 from 33. There were only 4 78 week breaches at GHFT in January (in ENT, Oral Surgery and Cardiology), with the remainder at out of county providers. There was 1 over 104 week waits reported in January – unchanged from December (out of county Trauma and Orthopaedic wait). The overall size of the waiting list continues to be an area of concern.
- Plans are being developed with the aim that 78 week waits are eliminated by the end of March 2024, and that 65 week waits are eliminated by September 2024. This will be supported by additional recovery schemes, improved productivity and continued focus on the theatre utilisation work at GHFT.
- The Head and Neck Service (comprising of ENT, Maxillo-Facial Surgery and Oral Surgery) is under significant pressure as one of the specialties with the longest waits. Analysis has shown that tinnitus is responsible for 19% of referrals to ENT; to reduce demand, Straight-to-test, direct to audiology and signposting to educational material are being explored. In the short term, additional capacity through waiting list initiatives and use of PIDMAS (Patient Initiated Requests to Move Providers) to transfer appropriate patients to Tetbury for aural care is ensuring more patients are seen in a timely manner. Referral optimisation work is ongoing and a workforce development plan is being progressed.
- Angiography remains an area of concern for the system. Elective waits for this service are in excess of 9 months on average and despite a recovery plan in place the waiting list has reduced by only 8.3% since last September with over 500 patients currently waiting. Waiting list initiatives are planned but are challenging to resource and the estate improvements that will assist the recovery of the service are still underway.
- The “centres of excellence” programme “Fit for the Future” is continuing to progress - cath labs, cardiology day case and cardiology beds are being centralised at Gloucestershire Royal Hospital (GRH) this month to help to establish an Image Guided Interventional Surgery (IGIS) hub at GRH and spoke at Cheltenham (which is planned to be operational from 2025). This will mean patients no longer have to travel out of county for image guided surgery.

Improving Services & Delivering Outcomes

Cancer

- Following an improvement in December, there has been a further dip in 28 Day Faster Diagnosis performance in January, with the overall performance dropping to 69.7% (patients receiving a diagnosis or all clear within 28 days of referral). Lower GI, Skin and Urology are driving this deterioration, but good recovery has been seen in the Breast specialty, which achieved 84.2% in January following additional investment in waiting list initiatives throughout the latter part of 2023.
- Endoscopy backlog and capacity is impacting the early part of the pathway leading to a high percentage of patients breaching 2ww and putting pressure on 28 days performance due to late diagnostics. A system wide task and finish group for endoscopy is supporting detailed capacity and demand reviews as well as action across community hospital provision. A recovery plan is being developed to run during 24/25 and 25/26 which will focus on reduction of backlog and prevention of new patients joining the backlog. This is expected to deliver an improvement in 28 day performance.
- The Teledermatology pilot (medical illustration staff review all referrals and either approve images from primary care or provide imaging of lesions where needed ensuring 100% of referrals can undergo virtual triage based on images) will be extended throughout 24/25 to focus on streamlining triage pathways to redirect referrals directly to surgery, max fax and ENT saving further outpatient appointments and releasing resource for treatment and OPA.
- 62 day back log is below trajectory, with current performance at 257 against a 170 trajectory which is unlikely to be achieved at the ed of March 2024 – the majority are patients waiting in the Urology specialty. Industrial action has put pressure on some pathways – while cancellations for cancer treatments and outpatient appointments were avoided, once dates were announced activity was not booked in many areas thus reducing overall capacity during the affected periods. GHFT are continuing to explore waiting list initiatives to support performance, and a harm review is carried out on all patients post 104 days to ensure risks are reduced wherever possible. Overall compliance against the 62 day treatment target was 60.1% in January – a decrease on the December position which was expected as focus continues to be on treating the backlog of patients.
- Referrals for patients with non-specific symptoms have been increasing but remain under trajectory – YTD (April-January) has seen 332 referrals against a target of 547. Expansion of the service is expected throughout 24/25 due to increased awareness and education across the county, in addition to the roll out of GRAIL (GRAIL pilot will provide approx. 23,000 blood tests across Gloucestershire to identify early stage cancer in people with no symptoms).
- TLHC is currently scheduled to go live in GICS with Inner City Gloucester PCN in April 2024 but due to ongoing challenges with the new PACs at GHFT, In Health have not been able to link the clinical systems as required to implement TLHC in GICS. This may cause a delay in the roll out.

Improving Services & Delivering Outcomes

Primary Care and Dental

- Demand on primary care has continued to increase, with 413,281 appointments delivered in January by GP practices across Gloucestershire.
- Use of Faecal Immunoprecipitation Testing (FIT) in primary care is ahead of trajectory to reach the 80% compliance target by March 2024 – January 2024 data shows 81% of referrals are being accompanied by a positive FIT result ≥10µg/g. This is leading performance in the SWAG Cancer Alliance.
- "First Dental Steps" has now launched, led by the health visiting team. This provides access to oral health packs; toothbrush, toothpaste and specific drinking cups that are being universally distributed at 9-12 months baby check appointments in Gloucestershire. Language and learning, safety, diet and behaviour are included as part of the review, together with oral health advice and the provision of the dental pack.
- Additional dental capacity continues to be expanded, with an additional 186 stabilisation appointments and 39 urgent appointments a week now commissioned as from the 1st February 2024 and further capacity due to come on board with additional providers. Patients are being identified from urgent care appointments accessed via NHS 111 who do not currently have a dental home for accessing the ongoing treatment they require to achieve more stability with their dental needs. For patients the initial access point is NHS 111.
- 67% schools out of the 172 identified have agreed to undertaking the Supervised Toothbrushing programme with At Home Dental support. The minimum target uptake rate has been achieved, however ongoing work will continue to increase the participation count. 63 schools have begun carrying out the 2-3 year programme, with the toothbrush packs having been delivered and training carried out to the schools, along with Oral Health talks and Q&A sessions for parents being delivered in person. 13 schools have declined the offer, which is higher than the regional average of decline rates, mainly due to insufficient capacity within the schools to carry out the programme within the current school timetables. The Gloucestershire County Council Public Health team will be working with At Home Dental to understand this further and support schools with further discussions and considerations for embedding the programme.
- Pharmacy First has now launched nationally, with a national media campaign beginning on 19th February 2024 across various social media platforms, posters and streamed TV with target audience of 18-40 year olds. The Pharmacy First service builds on the NHS Community Pharmacist Consultation Service which has run since October 2019. The consultation service enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply with the Pharmacy Frist expansion enabling community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways. The Community pharmacy teams are responding to this new service delivery within existing workload and workforce challenges, and all 105 community pharmacy teams in Gloucestershire have signed up to deliver the service. The ICB is supporting colleagues from general practice, primary care networks and NHS111/DoS to build effective, sustainable relationships and local support that will enable us to realise the full benefits of this service.

Improving Services & Delivering Outcomes

Diagnostics

- The number of patients on the diagnostic test waiting list has grown to the highest number since 2019 in January 2024, at 14,865. Of these, 3404 had been waiting more than 6 weeks at the end of the month (22.9%). This deterioration in performance was expected, due to changes in reporting of surveillance patients for endoscopy and audiology patients at GHFT – while these patients may not have been included in national reporting previously, they have been visible to GHFT and are being booked in date order alongside other patients on the active list.
- Endoscopy performance remains a concern for the system with 63.6% of colonoscopy patients on the waiting list at the end of January waiting over 6 weeks (21.1% of gastroscopy patients and 42.8% of Flexi sig patients also were waiting over 6 weeks). GHFT are now reviewing the demand and capacity analysis carried out and are planning to review productivity in collaboration with 'Four Eyes'. NHSE have awarded GHFT £500,000 to clear backlogs which is supporting additional activity planned into 24/25. GHFT are working through the recommendations from the demand and capacity modelling and the NHSE support visit carried out in December, including strengthening leadership and developing a long term strategy.
- The community direct access contract with Inhealth (for GPs) will cease on 31st March 2024 – this activity will be covered by GHFT as an interim measure while a long term solution is scoped. Winfield Hospital will take on some additional activity (surveillance patients from Inhealth) and are expanding their endoscopy offer so may also be able to provide a transfer opportunity for patients waiting at GHFT.
- National focus on diagnostic performance is to address any 13+ week waits for diagnostic tests – in January 2024, there were 1582 breaches over 13 weeks, predominantly across the four endoscopy modalities (Colonoscopy, gastroscopy, flexi sigmoidoscopy and cystoscopy). Peripheral Neurophys also had a number of patients breaching 13 weeks due to a combination of workforce challenges (including staff sickness and vacancy). The service has a recovery plan in place and is reviewing their workforce plan.
- The new £15m facility at Quayside in Gloucester has now opened its doors and will offer more than 80,000 extra diagnostic appointments each year, allowing patients across Gloucestershire to access potentially lifesaving checks more quickly, without having to go to hospital. A wide range of diagnostic tests including X-Rays, MRI, CT, ultrasound, ECHO and DEXA scanning are either already up and running or will be rolled out in the coming weeks. While the new facility provides enhanced diagnostic services, patients will still be able to have X-Rays and other imaging procedures carried out at existing hospital sites, including Gloucestershire Royal Hospital, Cheltenham General Hospital, and community hospitals, where appropriate.
- Cellular pathology turn around times (TAT) have significantly improved following focussed work on faster pathways, with January 2024 seeing GHFT report a 67% compliance with a 3 day TAT (up from an average of 20% in early 2023) and 94% within 7 days.

Improving Services & Delivering Outcomes

Mental Health

- During 23/24, Gloucestershire has met planned commitments around community access for serious mental illness with the latest reported figures nationally at 5740 people accessing services against a target of 4805 (December 2023). Moving into 24/25, the national expectation is for ICSs to be reporting access to transformed community services. PCNs will self-declare when all the requirements for transformed services have been met, allowing access to be reported via the MHMDS. Currently, only activity provided by organisations submitting data to the MHMDS is captured – meaning there is a risk that smaller voluntary sector organisations and community groups will not be reflected in access figures spite providing activity locally. For patients, there is a risk over continuity of care due to a lack of joined up clinical systems: resolving this will improve reporting accuracy against the national targets for service access and improve the experience for patients and staff. The mental health commissioning team are working with partners on a plan to begin to address this.
- Improving Access to Psychological Therapies (IAPT) access has increase, at 1326 in January – missing the planned level by only two referrals. The recovery rate for IAPT has improved after failing to meet the 50% standard in November – in December performance was 51.1% of patients reaching recovery and in January this was 50.9%. For 24/25 operational targets are set to focus on service quality, with completed treatments and reliable recovery the focus of planning trajectories.
- There were 5 Out of Area placement days recorded in January, bringing the total YTD to 373. The annual target is 800. This is the lowest volume of out of are placement days reported since May 2023, reflecting the focus on ensuring local provision wherever possible.
- Eating disorders – the proportion of patients assessed within target has improved significantly in 23/24 to date. The January position (latest validated data) shows that for adults, 87.5% received assessment within target and 82.6% began treatment within 16 weeks. The team is currently working through the backlog of routine adult referrals with a plan to complete this by the end of March. The CYP service has achieved 95% of referrals beginning urgent treatment within a week in January (meeting the national target), and 70% of routine referrals beginning treatment within 4 weeks. Capacity in the service is an ongoing challenge, with 20% of adolescent patients and 12% of adult patients requiring more than 20 sessions for their treatment. Additional support from VCS organisations (BEAT, TiC+ and ORRI) has continued with high levels of uptake assisting a significant reduction in the back log of patients waiting for treatment. Currently 36 patients are waiting on the adolescent waiting list.
- Perinatal mental health access continues to be ahead of trajectory against operational planning targets with 74 women accessing services in January. YTD access has already exceeded the annual target of 672. January waiting time performance was 98.5% (patients seen within 6 weeks of referral).

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

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(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Recruitment and Retention

- System wide discussion on Higher Development Award, meetings with providers held, prior to selecting a provider(s) to pilot the award with.
- Social care app for as part of their international recruits has been configured with user testing with a group of international recruits planned for March 2024.
- Pilot ward for team e-rostering at GHFT selected, rules agreed and proposed 'go-live' date set for March

Innovation

- The proposal for a Staff housing hub has been approved. The aim of the Housing Hub pilot (2 years) is to put in place additional support for new and existing employees, specifically relating to sourcing of initial and longer-term accommodation to aid onboarding, engagement and staff retention. This will also include expansion and promotion of Homeshare and Homestay schemes, thus having wider benefits to the population.

28

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Our People (Workforce)

Our People Strategy: Focussed Pillars

Education Training and Development

- Evaluating We Want You pilot (ends June 2024), and planning priorities for transitioning into a "business as usual" service, using two new careers posts (funded via Section 256)
- NHS cadets aimed at 14-18 year olds from under-represented communities to enter a career in health and care, launched Jan 2024.
- Multiply functional skills training for those over 19 without a math qualification. Looking to train 500 numeracy champions across the county. More info on how to sign up: Become a Numeracy Champion – Multiply | National Numeracy
- System-wide Coaching Conference planned for April 2024

- **Apprenticeship and T-Level**
  - Successful national apprenticeship week in February with organisations hosting apprenticeship awards, undertaking podcasts and other promotional events and webinars to publicise T-Levels and apprenticeships
  - Looking to expand T-Level provision in response to college expansion in numbers moving forwards, particularly looking into primary and social care placements as well as other non-clinical T-Level opportunities.
  - ICS apprenticeship strategy out for final review

- **Care Leavers Covenant**
  - Funded by the Department of Education, the Care Leavers Covenant aims to provide additional support for those leaving the care system as they face significant challenges getting well paid rewarding work.
  - The NHS is a part of the Universal Family Programme, which seeks to support care leavers into NHS careers through work experience, training programmes, internships, apprenticeships and professional roles.
  - After connecting with organisations across Gloucestershire who already offer support for care leavers, we have formed a Care Leavers Covenant Working Group.
  - We are working closely with GCC and their 'Step Forwards' ICS initiative to build bespoke work experience opportunities:
  - 4 young care leavers have been identified for an initial pilot

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, meetings have been held with partner organisations to inform this, including one with Gloucestershire Constabulary, who would like greater co-operation and collaboration on health and well-being issues.
- The Well-Being Line funding has now been approved for a further 12 months to March 2025, a longer-term strategy for the service needs to be discussed and agreed across system partners.
- Suicide prevention (and postvention) is a focus area for collaboration across the system, GHFT are finalising a policy and associated support materials, which can form the basis of a system-wide approach.
- System-wide 'early starter conversation' content has been drafted, this is 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 supports staff retention as a significant minority (NHS 20%) of staff leave their roles within the first year of employment. A pilot group has been selected for this (Independent Social Care Staff) and a date for the first pilot session set for May 2024.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

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

- The System-wide Leadership programmes have been mapped and proposal for greater collaboration for a system-wide leadership development programme is being considered based on existing programme and any identified gaps.
- A Leadership Conference Series is being planned, with representation from each of the system partners on the Health and Well-being Board. The aim of these events will be to establish connections and strengthen relationships between leaders across the partnership.
- Three regional (NHSE) workforce planning workshops have been held, with system participation, focused on Supply and Retention, Expansion and Apprenticeships and Clinical and Medical reform.
- System-wide EDI priorities for 24/25 have been proposed as:
  - Obtaining better insights from EDI data
  - Anti-discrimination
  - Inclusive Recruitment and Promotion Practices (debiasing recruitment and promotion practices)

31

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NHS

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Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

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Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- There has been no communication from the NHSE SW Commissioning Hub to the Clinical and Quality Directorate since the last report. We have received no notification of any immediate quality concerns regarding POD services and the quarter 3 POD services quality report has not yet been received.

Urgent and Emergency Care – Working As One

- Trials continue to iterate and work through the areas identified as having largest impact in their area . The hospital flow work continues to advance its roll-out plan and is upping the engagement with hospital leadership to make sure everyone is on board and supporting the roll-out. The ICB are working closely with GHFT around how to align Working As One work with any other outcomes from the Clinical Vision of Flow work, and in preparation for the Perfect First Week . The ICB teams are working through the last stages of ensuring data feeds for the benefits tracking are in place and validated .

Community and Mental Health

- Following CQC concerns regarding the standards of care at Berkeley House, a period of enhanced surveillance continues. The CQC inspection report for Berkeley House was published on the 1st March. The Trust continue to meet with CQC regularly and good progress has been made with the completion and implementation of the Trust's action plan following inspection. The Trust is now moving to a phase of embedding and testing actions. Discharge plans for residents of Berkeley House are progressing and a new interim manager has commenced post.
- Chestnut Ward received a CQC Mental Health Act inspection last week. No major concerns were expressed on the day. Pressure continues concerning mental health inpatient beds with the Trust trying to avoid out of area bed placement.
- A Healthwatch report regarding Wotton Lawn Hospital is due to be published imminently.

3

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Quality – Safety, Experience and Effectiveness

Assurance

Migrant Health

- GICB continue to work with the MOD to support health provision for TSFA (Transitional Service Family Accommodation) & RSOM (Reception, Staging and Onward Movement) sites. Beachley Barracks is not the largest combined site in the country supporting Entitled Persons (EP's) of all ages with health screening and access to healthcare.
- A contract is now in place with GDOC to support provision, the site can accommodate around 1000 EP's some of which have complex health needs.

Maternity

- CQC section 29A action plan is in place. Good progress is being made by the Trust to address the main issues which include lack of timely Safeguarding training and backlog of reported incidents. Maternity remain on NHSE Maternity Safety & Support Programme with Maternity Improvement Advisor's for both midwifery & Obstetrics.
- GHT & LMNS are working collaboratively on an Integrated Single Maternity and Neonatal action plan which will support prioritisation and transformation.
- Monthly Perinatal Quality & Safety oversight meetings led by the LMNS to ensure oversight and progress against action plans. Maternity Incentive schemes submitted, with full self-assessed compliance against all Safety Actions, to NHSR. Midwifery staffing and Ultrasound scan capacity remain on risk register. Scan capacity gap analysis underway. Midwifery staffing improving slowly.
- Quarterly Maternity and Neonatal Voices Partnership (User led) meetings with System partners, reviewing themes from feedback, complaints & incidents and developing co-produced action for organisations to feed into a systemwide 'you said we listened" feedback.
- Following the BBC Panorama programme, the Chief Nursing Officer (SRO) has met with colleagues at GHFT, including the Chief Executive Officer, and is establishing a short-term Quality Improvement Group (QIG) chaired by the SRO to ensure a focus on top priorities agreed by the group, which will include the MNVP rep.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Serious Incidents

- As the system switches over to the Patient Safety Incident response Framework (PSIRF) on 1 March, these will be the last reported Serious Incidents under the Serious Incident framework 2015.

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.

- There were two Never Events reported in January. Both related to wrong site anaesthetic block at GHFT. Both patients has been discharged and are not receiving on-going care. The Trust is subsequently revisiting the work previously undertaken on surgical Never Events.

Learn from Patient Safety Events (LFPSE)

- GHC have now switched over to the LFPSE service and are no longer reporting to the soon to be closed National Reporting and Learning System (NRLS). GHFT hope to switch in early April.
- NHS England have now launched the first version a new tool that will eventually enable the ICB to look at whole system data. While the first version is limited, it will be taken to the new System Safety and Leaning Group, implemented as part of PSIRF.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

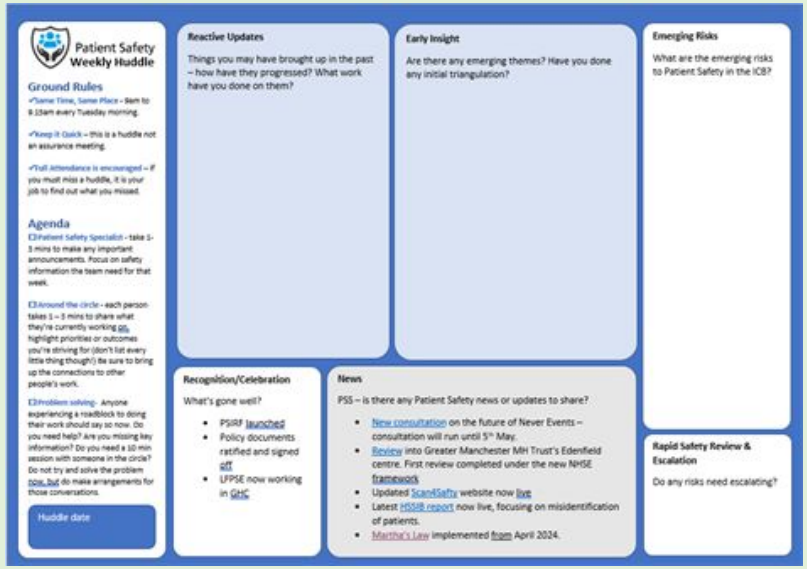
Safety

Patient Safety Incident Response Framework (PSIRF)

- The majority of NHS services provided in Gloucestershire, along with the ICB switched off the Serious Incident Framework 2015 and transitioned to the new PSIRF on 1st March.
- Under PSIRF, 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.
- This includes:
    - Collaborating in the development, agreement, maintenance and review of patient safety incident response policy and plans.
    - Overseeing the effectiveness of systems to achieve improvement following patient safety incidents.
    - Supporting the co-ordination of cross-system learning responses.
    - Sharing insights and information across organisations and services to improve safety.

ICB PSIRF Plan and Safety and Learning Group

- As part of the switch from SIs to PSIRF the ICB will formally instigate a quarterly Integrated System Safety & Learning Group.
- From 5th March will also start holding weekly 'Safety and Insights Huddles' based on 'sign up safety huddle methodology. As part of this we will also be developing a process for Rapid Safety Reviews.
- We will be testing this approach in early March.



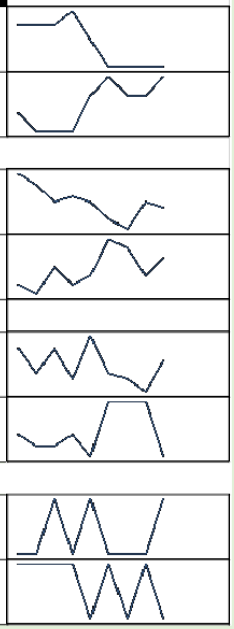
Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April – December 2023

		Apr-23 Provider	May-23 Provider	Jun-23 Provider	Jul-23 Provider	Aug-23 Provider	Sep-23 Provider	Oct-23 Provider	Nov-23 Provider	Dec-23 Provider	Jan-24 Provider	Feb-24 Provider	Mar-24 Provider
GHT Inpatients	% Positive	93%	93%	93%	94%	92%	90%	90%	90%	90%			
	% Negative	4%	3%	3%	3%	5%	6%	5%	5%	6%			
GHT A&E	% Positive	83%	81%	78%	79%	78%	75%	73%	78%	77%			
	% Negative	12%	11%	14%	12%	13%	17%	16%	13%	15%			
GHC Mental Health	% Positive	87%	83%	87%	82%	89%	83%	82%	80%	85%			
	% Negative	7%	6%	6%	7%	5%	10%	10%	10%	5%			
GHC Community	% Positive	94%	94%	95%	94%	95%	94%	94%	94%	95%			
	% Negative	3%	3%	3%	3%	2%	3%	2%	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.

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Quality – Safety, Experience and Effectiveness

Effectiveness

System Clinical Effectiveness Group

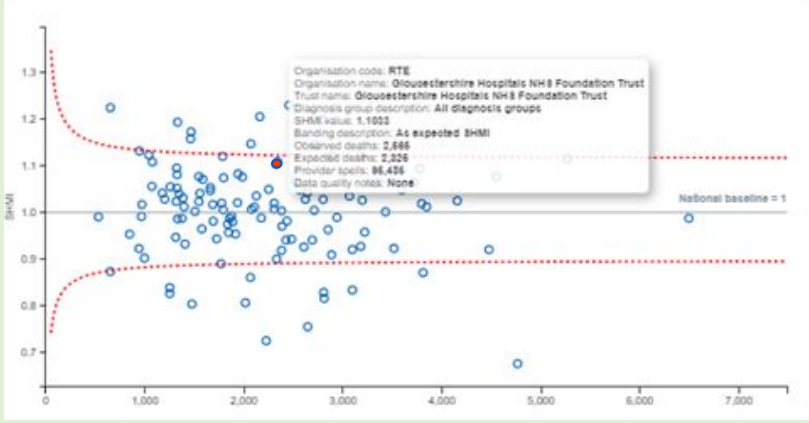
- The System Clinical Effectiveness Group (SCEG) has now reformatted it's agenda and will now focus on:
  - Regulator and National Updates
  - Prioritization and Improvement
  - Assurance and Outcomes
  - CPGs
- It is the intention of the group to improve the links between the SCEG and CPGs
- The first meeting where the new approach will be used will be held on 11th March.

System Mortality Group (SMG)

- Due to the change in Chief Medical Officer, the SMG has not met since November. However the next meeting is planned for 20th March where we will discuss:
  - The next South West Epidemiological Population Assessment of Mortality
  - PCN mortality data
  - Mortality data sources
  - Standardised Hospital Mortality Indicator (see below)

SHMI

- After a long period of reduction in GHNHSFT's Standardised Hospital Mortality Indicator (SHMI), we have seen a rise in the most recently published data to 1.1033.
- The national baseline is 1.
- The funnel plot opposite shows that the Trust is still within expected levels but is approaching the upper control limit.



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ICS Finance Report

Month 11

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Finance and Use of Resources

Financial Overview & Key Risks

- The year end forecast out-turn is a £498k surplus versus plan.
- The 2023/24 YTD revenue position is a £7,143k surplus versus plan for the system. This includes the impact of the receipt of funding to cover year to date industrial action, as well as the benefits associated with a number of identified underspends plus some additional income. The underlying position remains challenging and a high level of savings and a number of non recurrent financial savings and income, are included in the revenue forecasts.
- Financial challenges across the system in 2023/24 include pay costs, including a pay award pressure for GMS services, within GHFT,, PFI inflationary indexation charges within GHFT, ICB prescribing cost increases and continuing health care package increases. A number of these pressures are recurrent and will continue into 2024/25 and have been taken into account in 2024/25 financial planning.
- The GHFT YTD position is currently a surplus against plan of £3,819k. However, the position will worsen over month 12 due to £5m non-delivery of Financial Sustainability schemes causing an adverse variance to plan and costs relating to urgent care escalation, which will deteriorate the run rate.
- Savings plans are forecasting full delivery by year end for GHC and the ICB, however GHFT is forecasting a £6.0m underperformance. This relates primarily to a shortfall against the UEC target. Savings delivery includes a number of non-recurrent savings schemes to help offset slippage in the delivery recurrent schemes. Whilst the 2023/24 financial position overall is absorbing the under delivery, this slippage in the recurrent efficiencies has resulted in an increased financial challenge in 2024/25.
- The year to date capital expenditure is £5.9m behind plan due to slippage across a number of schemes. Scheme expenditure is forecast to underspend by £4.7m by the year end, attributable to slippage against Nationally funded projects. When submitting the month 11 financial returns a forecast overspend against the IFRS16 capital allocation was reported. NHSE has subsequently advised the IFRS16 allocation will be increased to fully fund the forecast overspend. Work is ongoing across the system to look at mitigations in respect of system capital allocation and other net CDEL underspends.

Finance and Use of Resources

Financial Overview & Key Risks

Key Financial Issues

- The GHFT year to date position to date includes the growing impact of actions within their financial recovery plan. These include:
  - Productivity within theatres programme
  - Outpatient productivity programme: in development
  - Additional control measures, especially relating to workforce controls
  - Holding year to date underspends within budgets across the system
  - Bringing forward savings where possible; this is has made a minimal impact in 23/24, however, should reduce the recurrent expenditure into 24/25
- They system has implemented a System triple lock process for any revenue investments
- 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. Additional workforce controls were implemented from early autumn and are showing an impact on staffing numbers including reductions in agency staff in particular.
- The impact of GHC workforce controls have led to an ongoing reduction in agency spend and this is now below the 23/24 target of 3.7%. The GHFT agency expenditure is also reducing, albeit from a higher base position, however, the February industrial action has had an adverse impact. Each organisation is maintaining workforce systems and controls including changes to processes to bring substantive staff into post quicker, standard operating procedures for agency use plus increases in lead in times to enable better planning of bank and agency use. E-rostering for nursing is in place within both organisations with cross system working ongoing.
- Both GHFT and GHC are now focusing on achieving the lower agency target of 3.2% required as part of the 2024/25 financial planning exercise. Both organisations are aiming to minimise, and ultimately eradicate, off Framework agency usage.

Finance and Use of Resources

Financial Overview & Key Risks

- The System ERF plan is dependent on delivery of elective activity as per the plan. The national target has now been reduced by 4% to 103% to enable systems to cover the cost of year to date industrial action. ERF forecasts for 2023/24 are currently under review and subject to a more cautious approach following recent reductions in activity performed by two Independent Sector providers, and the adverse impact further industrial action in January and February. As a result, the expectation is for activity performance to report a reduced forecast outturn position.
- The system continues to develop a medium term plan following on from the Joint Forward Plan with an underpinning medium term financial plan. The more detailed financial planning exercise for 2024/25 is progressing. A full 2024/25 system financial plan is scheduled to be submitted to NHSE on 21st March 2024. The focus within current financial planning 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.

Finance and Use of Resources

Elective Recovery Fund – Monthly Analysis

		April	May	June	July	August	September	October	November	December	January	February	March
Daycase	Plan	3,914,330	4,501,069	5,028,807	4,604,028	4,473,582	4,697,548	4,688,765	5,152,195	3,970,582	5,024,455	4,919,284	4,657,391
		103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%
	Actual	4,142,997	4,967,275	5,003,351	4,758,616	5,001,976	4,968,323	5,041,557	5,434,250	4,538,541	5,059,781		
		109.0%	113.7%	102.5%	106.5%	115.2%	108.9%	110.7%	108.6%	117.7%	103.7%		
Ordinary Admissions	Plan	3,471,884	4,159,717	4,058,871	4,057,142	4,568,542	4,035,398	4,686,083	4,790,338	3,541,755	3,927,528	4,266,579	4,247,887
		103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%
	Actual	3,318,791	3,663,879	3,988,858	3,800,584	3,433,348	3,266,695	3,902,394	4,121,629	3,389,347	3,303,903		
		98.5%	90.7%	101.2%	96.5%	77.4%	83.4%	85.8%	88.6%	98.6%	86.6%		
Outpatient Attendances	Plan	2,859,077	3,182,719	3,575,068	3,227,214	3,128,736	3,393,327	3,614,362	3,704,566	2,835,780	3,750,121	3,465,307	3,285,441
		103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%
	Actual	2,974,542	3,461,382	3,593,085	3,405,803	3,430,512	3,505,957	3,860,831	3,971,249	3,004,401	3,640,997		
		107.2%	112.0%	103.5%	108.7%	112.9%	106.4%	110.0%	110.4%	109.1%	102.9%		
Outpatient Procedures	Plan	1,480,803	1,565,800	1,788,801	1,667,295	1,589,302	1,580,663	1,750,976	1,810,966	1,461,667	1,851,566	1,751,072	1,657,348
		103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%
	Actual	1,380,277	1,498,073	1,650,749	1,630,862	1,578,339	1,554,073	1,728,466	1,804,877	1,403,310	1,759,576		
		96.0%	98.5%	95.0%	100.7%	102.3%	101.3%	101.7%	102.7%	98.9%	97.9%		
TOTAL GLOUCESTERSHIRE SYSTEM	Plan	11,779,080	13,474,687	14,515,719	13,634,552	13,843,992	13,787,302	14,831,223	15,540,035	11,877,916	14,622,079	14,481,651	13,928,137
		103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%
	Actual	11,816,606	13,590,609	14,236,043	13,595,865	13,444,176	13,295,049	14,533,248	15,332,005	12,335,599	13,870,441		
		103.3%	103.9%	101.0%	102.7%	100.0%	99.3%	100.9%	101.6%	107.0%	97.7%		
	incl.Pathways	107.1%	107.9%	105.1%	106.7%	103.5%	102.7%	103.9%	104.3%	109.5%	97.8%		

- The target for Gloucestershire System remains at **103%** taking into account year to date Industrial Action.
- At M10 YTD Flex Gloucestershire ICB commissioned VWA is 104.7% of 2019/20 including pathways avoided.
- At M9 YTD Freeze Gloucestershire ICB commissioned VWA is 105.5% of 2019/20 including pathways avoided.
- Year to date (M1-9) industrial action accounts for a known 6,389 cancellations equating to c.£2.9m elective activity lost (based on average tariff).
- 2023/24 full year forecasts for ERF performance are currently under review taking into account the M10 and M11 industrial action, a number of changes with the independent sector and the impact of recent urgent care escalation.
- The System's likely YTD position, had there been no industrial action is 108%
- Independent Sector providers are continuing to deliver YTD higher activity volumes (134.7%) than GHFT (98.4%) and OOC NHS Providers (91.7%).

Finance and Use of Resources

Finance and Use of Resources - Dashboard

Statement of Net Income & Expenditure Position (£'000)							
Month 11 2023/24 - February	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	(1,929)	1,890	3,819	↑	0	(1,490)	(1,490) ↓
Gloucestershire Health and Care NHS Foundation Trust	23	3,347	3,324	↑	0	1,939	1,939 ↑
Gloucestershire Integrated Care Board	0	(0)	(0)	→	0	48	48 ↑
System Surplus/(Deficit)	**(1,906)**	**5,237**	**7,143**	↑	**0**	**498**	**498** ↑

Efficiency Programme (£'000)									
Month 11 2023/24 - February	Month 11 Efficiency Plan	Month 11 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	31,046	26,347	(4,699)	↓	34,721	28,714	(6,007)	↓	83%	AMBER - Medium Risk
Gloucestershire Health and Care NHS Foundation Trust	9,251	8,412	(839)	↓	9,883	9,883	(0)	→	100%	GREEN - Low Risk
Gloucestershire Integrated Care Board	12,037	12,340	303	↑	13,128	13,598	470	↑	104%	GREEN - Low Risk
Total	**52,334**	**47,098**	**(5,236)**	↓	**57,732**	**52,195**	**(5,537)**		**90%**	**AMBER - Medium Risk**

Other Metrics					
Month 11 2023/24 - February	GHFT	GHC	GICB		ICS
Better Payment Pratice Code (total paid within 30 days or due date by value)	91%	99%	100%		98%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	(7,882)	(679)	78		(8,483)
Cash status	Amber	Green	Green		Green

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

Cash status green – above plan

45

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 actual	M9 actual	M10 actual	M11 plan	M12 plan
Gloucestershire Hospitals NHS Foundation Trust	2,248	2,248	1,750	2,018	2,272	2,862	1,733	2,235	3,869	2,780	2,333	2,367
Gloucestershire Health and Care NHS Foundation Trust	1,786	1,786	631	631	309	534	723	1,550	9	0	453	1,471
Gloucestershire Integrated Care Board	1,096	1,096	1,096	1,096	1,096	1,096	1,093	1,093	1,094	1,091	1,393	1,258
System Total	**5,130**	**5,130**	**3,477**	**3,745**	**3,677**	**4,492**	**3,549**	**4,878**	**4,972**	**3,871**	**4,179**	**5,096**

- Savings and efficiencies totalling £57.7m are planned across the system in 2023/24.
- As at month 11 reporting, the year to date delivery is £5,236k behind plan, across the system. The risk ratings for each organisation's full year delivery forecast are:
  - **GHC: Low –** The Trust continues to identify recurring savings, and has delivered a further £54k in month 11. Non recurring savings are fully identified. The Trust has identified that £324k of recurring savings are at risk of non delivery in 23/24 but work continues to identify any further savings opportunities.
  - **GHFT: Medium –** £26.3m of savings have been delivered (£17.5m recurrent, £8.9m non-recurrent). GHFT is forecasting delivery of £28.7m. The highest risk items in the original planned position driving the gap of £6.0M are the UEC programme (£4m) and the system stretch target (£1.4M). The total value of amber rated schemes within the forecast is £0.3m, with the remainder RAG rated Green.
  - **ICB: Low –** the savings programme amounts to £13.128m for FY 2023/24. The programme has been risk assessed and is anticipated to deliver to plan the total GICB programme for 2023/24. There is slippage in the UEC programme and CHC/placements programmes, offset by over delivery on Primary Care medicines optimisation and other non-recurrent savings.

Finance and Use of Resources

Capital: Organisational Positions, Challenges and Opportunities

Capital Expenditure (£'000)						
Month 11 2023/24 - February	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
	15PLANYTD	15ACTYTD		15PLANCY	15FOTCY	
System Capital Allocation						
Gloucestershire Hospitals NHS Foundation Trust	22,334	23,774	1,440	26,174	26,174	0
Gloucestershire Health and Care NHS Foundation Trust	11,254	10,631	(623)	11,491	10,943	(548)
Gloucestershire Integrated Care Board	1,089	581	(508)	1,110	1,188	78
Total System Capital Allocation	**34,677**	**34,986**	**309**	**38,775**	**38,305**	**(470)**
	15PLANYTD	15ACTYTD		15PLANCY	15FOTCY	
Other Net CDEL sources						
Gloucestershire Hospitals NHS Foundation Trust	20,343	10,162	(10,181)	21,314	13,432	(7,882)
Gloucestershire Health and Care NHS Foundation Trust	1,511	100	(1,411)	1,841	1,710	(131)
Total System CDEL (NHS)	**56,531**	**45,248**	**(11,283)**	**61,930**	**53,447**	**(8,483)**
	15PLANYTD	15ACTYTD		15PLANCY	15FOTCY	
IFRS16 Lease Capital						
Gloucestershire Hospitals NHS Foundation Trust	1,091	6,853	5,762	1,478	5,431	3,953
Gloucestershire Health and Care NHS Foundation Trust	710	78	(632)	1,168	983	(185)
Gloucestershire Integrated Care Board	2,371	2,586	216	2,586	2,561	(25)
Total System Capital including IFRS16 Leases (NHS)	**60,703**	**54,765**	**(5,938)**	**67,162**	**62,422**	**(4,740)**

Note: GHFT plan figures at system level have been updated to reflect changes in GHFT's allocation.

Within the ICS system capital allocation, capital expenditure is £309k overspent year to date as at month 11 of 2023/24. The year end forecast is for system capital allocation expenditure to underspend by £470k. Work is ongoing to bring underspending projects back to budget before year end.

GHFT is internally reporting a forecast capital variance of £3.9m below CDEL versus plan. This is driven by a £7.9m underspend against the national programme, less an IFRS16 overspend of £4.0m.

System capital allocation is forecast to be on budget.

The £4.0m overspend against IFRS16 is now forecast to be mitigated across the region via the allocation of IFRS16 contingency as at month 12.

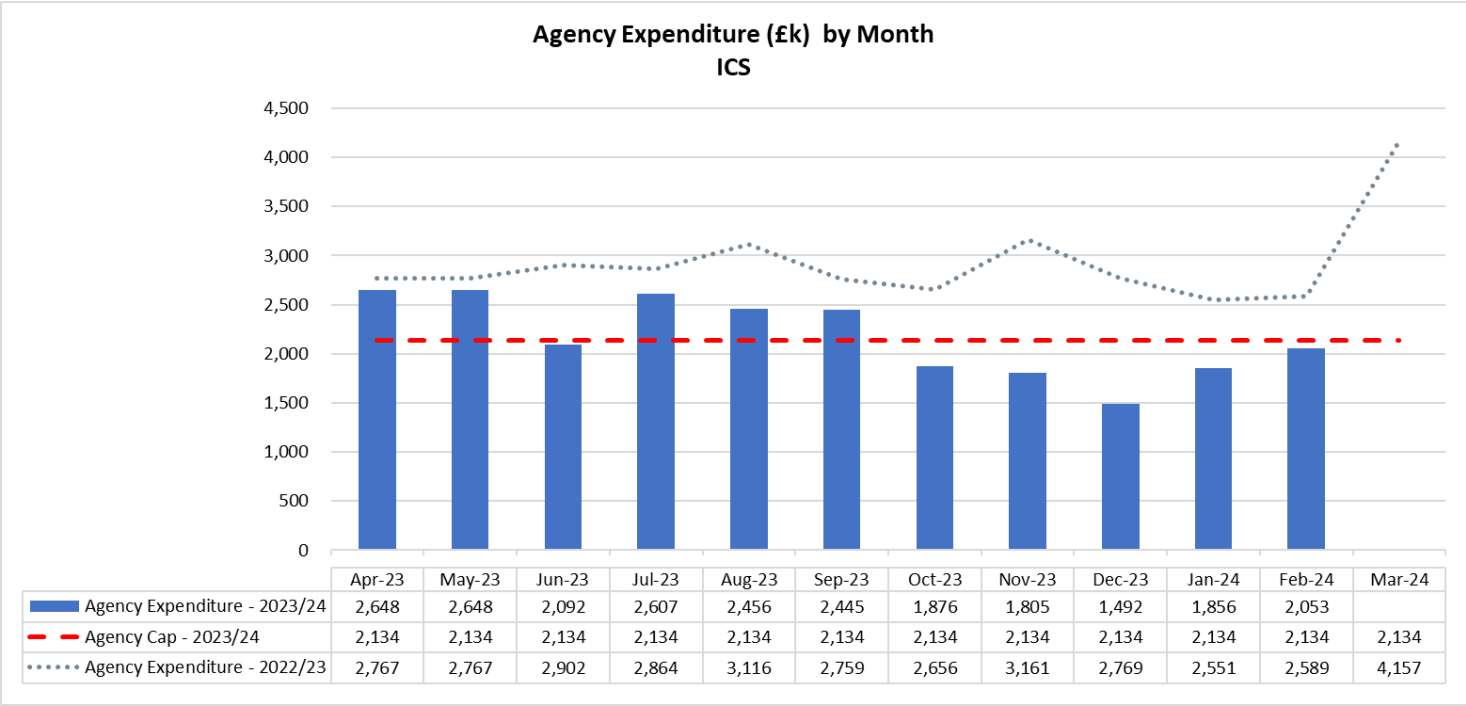
The £7.9m underspend against national programme is largely driven by underspends movements for; (1) the 5th Orthopaedic Theatre project, (2) an underspend against the CDC lease capital allocation.

GHC capital spend continues to progress well. GHC system allocation is forecast to be underspent by £548k at year end. Spend on several maintenance and IT schemes is committed and expenditure is starting to catch up with plan. GHC remains committed to implementing mitigating actions to recover its system capital allocation shortfall before year end.

The Lexham Lodge asset sale is still anticipated to be concluded towards the end of March. GHC is no longer proceeding with its full Clinical System Project and has lowered its expenditure forecast, and agreed with the National Digitisation Programme it will not receive the associated funding.

Finance and Use of Resources

Agency Expenditure vs NHSE Cap



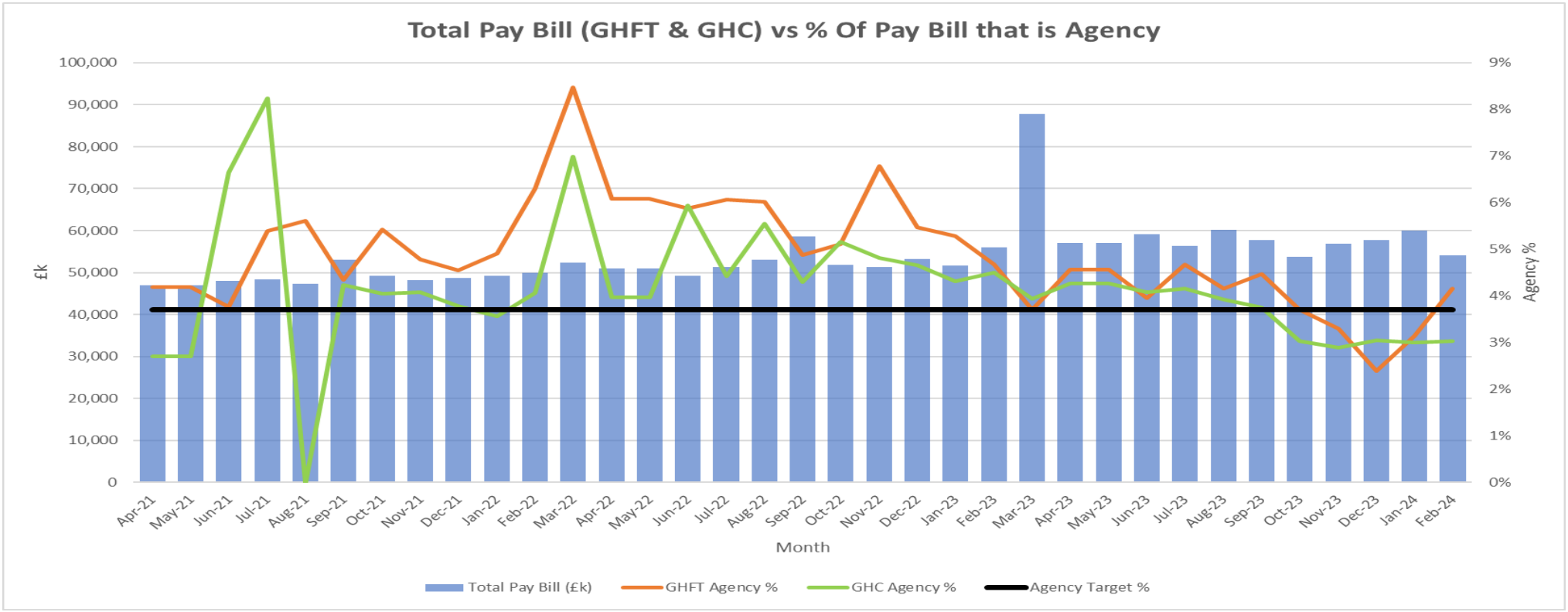
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456	2,445	1,876	1,805	1,492	1,856	2,053	
Agency Cap - 2023/24	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134
Agency Expenditure - 2022/23	2,767	2,767	2,902	2,864	3,116	2,759	2,656	3,161	2,769	2,551	2,589	4,157

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 11, the rate of agency expenditure continues to be below the straight line trend of the agency cap, although agency spend has increased slightly through Q4. The forecast against the cap includes a number of assumptions around the impact of actions underway or planned. The forecast remains prudent ahead of winter pressures.
- GHFT reported an increase in agency expenditure in months 10 and 11 as a result of operational pressures and higher levels of enhanced nursing care.

Finance and Use of Resources

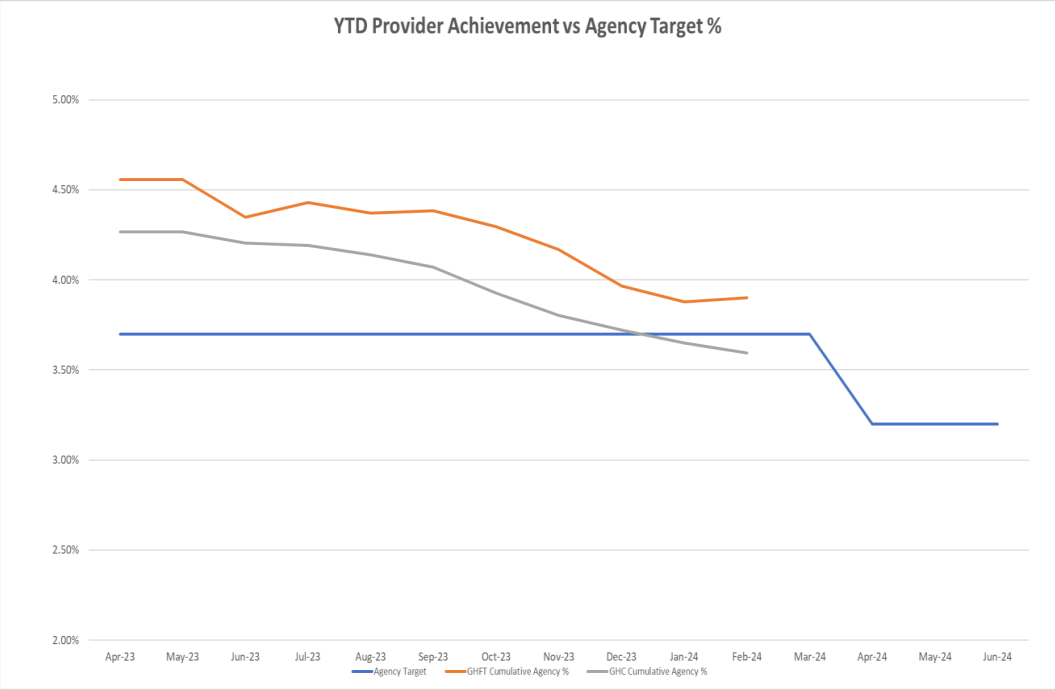
Agency Spend vs Total Pay Bill



	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	Nov-23	Dec-23	Jan-24	Feb-24
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	£ 1,616	£ 1,818	£ 1,747	£ 1,744	£ 1,350	£ 1,304	£ 969	£ 1,323	£ 1,515
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	£ 501	£ 523	£ 533	£ 538
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	£ 2,364	£ 2,544	£ 2,456	£ 2,446	£ 1,876	£ 1,805	£ 1,492	£ 1,856	£ 2,053

Finance and Use of Resources

Agency Usage vs Target



- GHFT and GHC agency spend as a proportion of all staff costs are shown vs the 3.7% target (which will become 3.2% from April ’24).
- There is a clear downward trend for both , with GHC now achieving the 3.7% target. GHFT have seen a slight increase in agency usage through February.

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ICB Finance Report

Month 11

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Finance and Use of Resources

Financial Overview and Key Risks

Overview

- The ICB forecast outturn position is a £49k surplus. The position reflects the dental underspend, updated prescribing and CHC forecasts, non recurrent slippage in other specific allocations (e.g. SDF) plus all anticipated allocations. Continued work is underway to identify mitigating actions to continue to manage the position, as previously agreed, holding non recurrent underspends against programmes and budgets and also identifying any recurrent underspends which will help the underlying financial position.
- The ICB month 11 YTD position is showing a breakeven position against the plan. The position reflects the prescribing cost pressure (£5.4m) and a growing cost pressure relating to Continuing Health Care (£4.9m) and Children's Services (£0.9m). These are offset by an underspends in independent sector (£1.2m), primary care Pharmacy, Optometry, Dental budgets (£3.9m) and other non recurrent slippage. In addition to these pressures there remain other, smaller pressures and risks within the financial position that are being managed.
- Prescribing data for 9 months is showing an ongoing upward trend in spend compared to last year (7.39% increase compared to same period last year, 2022/23 had 8.5% growth in overall costs compared to 2021/22). Key drivers in prescribing costs include continuous glucose monitoring devices (due to NICE guidance), growth in diabetes drugs and in direct-acting oral anticoagulants (DOACs) as diagnosis increases. It is expected that the cost of DOACs will reduce in the second half of the year as a result of the introduction of generic Apixaban and associated lower cost, the ICB will continue to benefit from the national DOAC rebate for Edoxaban. It is anticipated that NCSO will remain a pressure in 23/24.
- The Delegated Pharmacy, Optometry, Dental budgets are showing a £3.9m underspend. The underspend is due to contractual under delivery.
- The Continuing Health Care budget is showing a variance of £4.9m adverse to the year to date budget. This is driven primarily by activity growth in CHC residential and domiciliary care and Funded Nursing Care and reflects an increasing trend in the number and cost of packages.
- The discharge to assess beds budget is showing a year to date overspend of £1.4m due to slippage in the savings plan. The programme of work within urgent and emergency care to move people to the correct patient pathway on discharge is in place and the Home First service staffing is increasing thus leading to greater capacity within the Home First pathway, leading to delivery of the savings recurrently.

Finance and Use of Resources

Financial Overview and Key Risks

Overview (cont.)

- The Integrated Community Equipment Service is showing a year to date overspend of £0.7m; this is due to a number of factors including demand. The mitigations include procurement savings and improved return and recycle performance, however, these may not impact in this financial year due to delays in the restructuring programme.
- The savings programme amounts to £13.128m for the 2023/24 financial year. There is slippage in the UEC programme and CHC/placements programmes. Non recurrent savings have been identified to mitigate any shortfalls with the program forecasted to deliver £13.598m (103%).
- The ICB and System plan is dependent on delivery of the elective activity as per the plan; the associated Elective Recovery fund is £26.67m which includes £1m secondary care dental ERF. Due to ongoing industrial action, the national target has been reduced by a further 2% to enable systems to cover the cost of industrial action in that period. The revised target for Gloucestershire System is 103% taking into account Industrial Action from months 1-7. At M9 YTD Gloucestershire ICB commissioned activity is 104.7% of 2019/20 including pathways avoided. ERF forecasts for 2023/24 are currently under review and subject to a more cautious approach following recent reductions in activity performed by two Independent Sector providers, and the adverse impact further industrial action in January and February. As a result, the expectation is for activity performance to report a reduced forecast outturn position.
- The Mental Health Investment Standard (MHIS) for 23/24 is £106m and is forecast to be met.

Key Financial Risks

- Additional high cost placements, particularly children's services and learning disabilities remain key financial risks for the ICB.
- Continuing Care, especially CHC Residential Care is a risk as both increases in activity and complexity for packages of care are being seen and the forecast is being updated with revised information including some scenario modelling

Finance and Use of Resources

ICB Allocation: M11

- The ICB's confirmed allocation as at 29 February 2024 is £1,348m.

Description	Recurrent	Non Rec	Total Allocation
M10 Balance Brought Forward	**1,255,531**	**84,314**	**1,339,845**
DOAC Rebate Q2 23/24		375	375
Dental New Patient Premium 23/24		59	59
PCARP reimbursement 2023-24		127	127
PCT Independent prescribing set up & evaluation fees M11		2	2
PCT Supporting Mentors Month 11		19	19
PCT GP Fellowships Month 11		280	280
ARRS Central Allocation M11		4,168	4,168
DWP Workwell - year 1 funding - (1.6)		89	89
DWP Talking Therapies - (1.6)		1	1
Mental Health Inpatient Quality Transformation (1.4)		24	24
WT&E Exemplars - Cohort 2 (Phase2). GHNHSFT		12	12
MH AFC Uplift M11		1	1
MH DDRB Uplift M11		1	1
Month 11 Industrial Action		2,827	2,827
Microsoft License final adjustment 23/24 GHNHSFT		(6)	(6)
TOTAL IN-YEAR ALLOCATION 23/24 @ M11	**1,255,531**	**92,293**	**1,347,824**

Finance and Use of Resources

ICB Statement of Comprehensive Income: In-Year Position

Statement of Comprehensive Income (£'000)							
Month 11 2023/24 - February	M11 Plan	M11 Actual Position	Year to Date Variance to Plan Favourable / (Adverse)		Full-Year Plan	Forecast Outturn Actual Position	Forecast Outturn Variance to Plan Favourable / (Adverse)
Acute Services	581,965	581,915	49		634,476	634,297	179
Mental Health Services	123,538	123,367	170		134,624	135,009	(385)
Community Health Services	107,549	109,106	(1,557)		117,416	118,279	(863)
Continuing Care Services	61,220	66,136	(4,916)		67,039	72,589	(5,550)
Primary Care Services	175,577	176,590	(1,013)		192,031	194,497	(2,466)
Delegated Primary Care Commissioning	111,954	112,793	(839)		122,484	123,304	(820)
Other Commissioned Services	34,917	35,096	(179)		37,968	38,197	(229)
Programme Reserve & Contingency	23,740	16,280	7,460		26,544	17,435	9,109
Other Programme Services	1,389	1,621	(232)		1,440	1,698	(257)
Total Commissioning Services	**1,221,848**	**1,222,905**	**(1,058)**		**1,334,022**	**1,335,305**	**(1,283)**
Running Costs	12,652	11,594	1,058		13,802	12,471	1,331
TOTAL NET EXPENDITURE	**1,234,500**	**1,234,500**	**(0)**		**1,347,824**	**1,347,776**	**48**
ALLOCATION	**1,234,500**	**1,234,500**	**0**		**1,347,824**	**1,347,824**	**0**
Outside of Envelope	**0**	**0**	**0**		**0**	**0**	**0**
Underspend / (Deficit)	**0**	**(0)**	**(0)**		**0**	**48**	**48**

Finance and Use of Resources

ICB Savings and Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB) 2023/24 EFFICIENCIES PROGRAMME - AS AT MONTH 11									
PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FULL YEAR OUTTURN EFFICIENCY PLAN £'000	FORECAST OUTTURN EFFICIENCY (YTD ACTUALS + FORECAST REMAINING MONTHS) £'000	FORECAST OUTTURN VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN AS % OF TARGET	HIGH LEVEL IN-YEAR RISK RATING
PRIMARY CARE MEDICATION OPTIMISATION	Primary Care Medicines Optimisation	2,739	4,459	1,720	2,988	4,742	1,754	158.70%	GREEN - Low Risk
	Home Oxygen	138	138	0	150	150	0	100.00%	GREEN - Low Risk
PRIMARY CARE MEDICATION OPTIMISATION - TOTALS		2,877	4,597	1,720	3,138	4,892	1,754	155.90%	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Continuing Healthcare / Joint Placements - All Age	1,418	944	(474)	1,547	1,000	(547)	64.64%	RED - High Risk
CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS		1,418	944	(474)	1,547	1,000	(547)	64.64%	
URGENT EMERGENCY CARE (UEC)	Discharge to Assess Beds (UEC Efficiencies)	2,841	1,716	(1,125)	3,100	2,120	(980)	68.39%	RED - High Risk
URGENT EMERGENCY CARE (UEC) - TOTALS		2,841	1,716	(1,125)	3,100	2,120	(980)	68.39%	
OTHER	ICB Recurrent and Non-Recurrent Efficiencies (E.g. 1.1% Efficieny, Running Costs and Additional Efficiencies)	4,901	5,083	182	5,343	5,586	243	104.55%	GREEN - Low Risk
OTHER - TOTALS		4,901	5,083	182	5,343	5,586	243	104.55%	
2023/24 ICB SAVINGS PROGRAMME - TOTALS		12,037	12,340	303	13,128	13,598	470	103.58%	AMBER - Medium Risk

Finance and Use of Resources

ICB Savings and Efficiencies: Overview

Summary

- Gloucestershire Integrated Care Board (GICB) has a savings programme amounting to £13.128m (1.038% of the total revenue allocation) for the 2023/24 financial year; this is based on GICB controllable spend. The programme has been risk assessed as at Month 11 and £13.598m forecast savings are reported (103%); this reflects additional medicines optimisation savings offset by under delivery within Continuing Health Care & Placements and Discharge to Assess areas of savings.
- Month 11 position reports additional savings compared to month 10 (£13.128m). This position includes £1.754m additional Primary Care Medicines Optimisation forecast savings delivery, £2.12m Discharge to Assess savings delivery (£0.98m below plan) and £1m Continuing Health Care & Placements savings (£0.547m below plan). The most significant risks to ICB overall level of savings delivery continue to be savings in relation to Discharge to Assess savings delivery and Continuing Health Care & Placements.

- **Medicines Optimisation (£3.138m requirement)** - At Month 11 the ICB has received ePact data for nine months of 2023/24. Forecast savings of £4.7m are reported (£3.8m reported at Month 10). Additional savings are now included at month 11. With regard to practice variation , savings are now being reported with further related savings expected in 2024/25.
- **Continuing Healthcare (CHC) and Placements (£1.547m requirement)** – At month 11, £1.0m forecast savings delivery continues to be reported. There are significant challenges in increasing adult continuing care, fast-track and CHC & LD review assessments. Social care assessment support to deliver increased care package reviews presents a significant risk to the programme.
- **Urgent Emergency Care (£3.1m requirement)** –Reduction of commissioned discharge assessment beds is being delivered through the intermediate care pillar of the urgent care transformation programme to ensure management of patient flow. The programme has successfully decommissioned a level of block commissioned beds and also reduced use of spot purchased discharge beds. At month 11 forecast savings delivery of £2.12m (£2.13m reported at month 10) with the recurrent £3.1m benefits delivered during 2024/25 (i.e. £0.98m under-delivery within 2023/24).
- **ICB Recurrent and Non-Recurrent Efficiencies (£5.343m requirement)** – The planned £5.343m programme area is focused on transactional efficiencies and these have been fully delivered at the start of the financial year. Additional savings of £0.2m are also reported.

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Part B: Primary Care Access Recovery Plan (PCARP) Progress Update

March 2024

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Introduction

In May 2023, the Delivery Plan for Recovering Access to Primary Care (PCARP) was published by NHSE, outlining the requirement for ICBs to develop system-level access improvement plans ('System Delivery Plan').

As required by NHSE, ICBs reported to ICB Board in November 2023, and ICBs are required to report progress again in March 2024.

This document will provide an update on progress against the national actions and local system delivery plan.

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59

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.

Empower Patients

To manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.

Implement Modern General Practice Access

To tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

Build Capacity

To deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.

Cut Bureaucracy

And reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

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Empowering Patients

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. Helping the public do more for themselves, making information and easy-to-use tools available by:

• Improving information and NHS App functionality • Increasing self-directed care where clinically appropriate • Expanding community pharmacy services.

Improving information and NHS App functionality

Ensure directly bookable appointments are available online following bookable online appointment guidance - There is no available data that identifies the number of bookable appointments are available at practice level. We are using the POMI data as a baseline to identify practices with low booking rates. Work is ongoing to support practices.

Offer secure NHS App messaging to patients where practices have the technology to do so in place - Accurx has released functionality that will send bulk messages and Floreys to patients with an active NHS APP account. There is a three hour window for the patient to acknowledge the message, after which time the notification will be resent via SMS. Practices should promote the NHS APP and encourage patients to activate the notification setting. Two-way messaging is on the road map for the NHS APP but not currently available.

Repeat Prescription Ordering: The national aim is for 90% of repeat ordering to be through online services. We have asked NHSE to clarify what data is being captured. There are new promotional materials for practices to promote online ordering of repeat medication.

patients who have an online account

Patients enabled for **online repeat prescriptions ordering**:

- **Gloucestershire: 50.8%**
- South West: 50.3%
- Nationally: 50.4%

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61

Self-Referrals

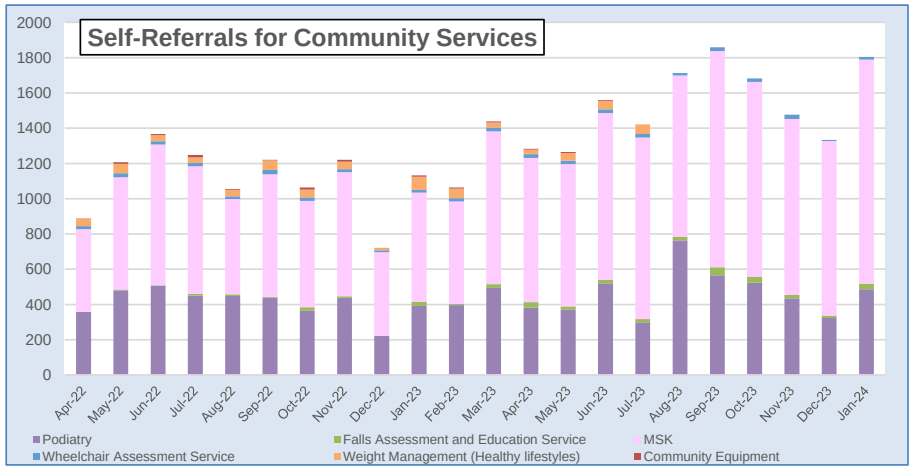
The national ambition is to have self-referrals routes established for the 7 services listed below and increase self-referral activity in these areas by 50% .

Total self-referrals have increased by 44%

	Community Musculoskeletal	Audiology (incl. hearing aid provision	Weight Management Services	Community Podiatry	Wheelchair services	Community Equipment Services	Falls Response Services
% increase against 22/23 baseline (data as of Jan 24)	61% ^	Service not in place yet, expected Q4 23/24	3% ^ *(Data as at July 23)*	14% ^	4% ^	-12% v *(Data as at June 23)*	195% ^

Progress and Next Steps:

- Further discussion with GHFT regarding the relative priority of implementing self-referrals and if/when this could be progressed.
- A monitoring dashboard has been developed to track self-referral activity across the 7 service areas and track progress against the national target of increasing self-referrals by 50%.
- As part of this process data submitted via the Community Services Data Set (CSDS) is being reviewed to identify any data quality issues, to ensure that a full picture of activity is available. Actions that are ongoing include:
  1. Reviewing breakdown of referrals by referral source type in order to identify potential opportunities to increase self-referrals,
  2. Review gaps in current data to ensure that referral source data is consistently available and all self-referrals are being accurately captured
  3. Determining if there is a proxy to identify Audiology and Physio self-referrals as not identified in national datasets currently.



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Self-Referrals

The national ambition is to have self-referrals routes established for the 7 services listed below and increase self-referral activity in these areas by 50% .

Audiology: In Gloucestershire this is the only service that is currently not accessible via self-referral routes

- Whilst the service is not open to self-referrals for new patients, existing patients who reach the end of their 5 year pathway and need to be reassessed and fitted with new hearing aids can contact the service directly to book their appointments rather than being referred via the GP.
- Clarification is being sought from NHSE regarding whether this activity should be considered 'self-referral' as it is understood that other areas in the South West are declaring that they are partially compliant with the requirement based on similar arrangements.
- Concerns have been raised at a local, regional, and national level about the potential for self-referral in audiology to significantly increase referral demand. NHSE are gathering evidence from areas that have already adopted self-referrals to understand the scale of this issue and inform ongoing discussions.
- Due to the concerns above and competing pressures on the audiology service, notably delivering the national paediatric hearing services improvement programme and supporting elective recovery in ENT any consideration of the audiology service moving to a self-referral model is currently on hold.

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Expanding Community Pharmacy Services

Roll out of Pharmacy First, Expansion of Blood pressure check service and oral contraceptives, IT system connectivity

Community Pharmacy PCN Leads have been identified

Pharmacy First Service Launched 31st January 2024; reducing pressures on General Practice and increasing patient access to assessment, advice and appropriate treatments by making pharmacies first contact for minor illness (see table for 7 clinical pathways).

Introduction of contraception initiation (in addition to ongoing supply for women as part of the pharmacy contraception service).

Expansion of Blood pressure check service supporting the identification of people with undiagnosed hypertension at risk of heart attack and stroke, better utilising skill-mix to support delivery of clinical services.

Community Pharmacy PCN Leads to build collaborative relationships between local pharmacy teams and their member practices to support increased clinical activity.

Antimicrobial Resistance (AMR) processes have been reviewed nationally and locally. Antimicrobial use is being monitored nationally.

Workforce challenges exist across pharmacist and pharmacy technician roles across both general practice and community pharmacy teams with work underway to increase the pipeline and skill development to deliver the services described above.

NHS Community Pharmacy Independent Prescribing Pathfinder Programme aims to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating IP for patients in primary care. GICB were awarded funding for 3 pharmacy sites to test and learn from involvement in this national programme with a local hypertension treatment pathway building on existing service.

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64

General Practice Improvement Programme

The ICB Primary Care Team have continued to promote the GPIP offers available to General Practice and we have seen an increase in interest and uptake:

- 3 practices ^ — Intensive practice support offer
- 14 practices ^ — Intermediate practice support offer
- 3 PCNS (19 practices) ^ — PCN level support offer

Support Level Framework (SLF)

The ICB have engaged with PCNs to discuss completing the SLF with their practices to develop actions to be implemented within practices and across the PCN:

- 5 PCNs (20 practices) ^ — PCN Led SLF
- 36 practices ^ — NHSE Led SLF (via GPIP)

The remaining few practices that haven't engaged in GPIP yet are being contacted by the ICB to take part in an SLF conversation.

PCN Feedback regarding GPIP

"Good experience of the intensive programme…consultant was an ex-practice manager so very understanding and flexible for the PCN to adapt the programme… A lot of involvement required for the modules, but was worthwhile."

PCN Feedback regarding SLF

"Identified themes across the network and planning to change some process to standardise across the network"

#2 No. of PCN taking part in the Digital & Transformation Lead training

Care Navigation

ICB are continuing to promote the national Care Navigation & local offer to practices/PCNs. Below shows current progress:

- 38 ^ primary care staff engaged with **national care navigation training**
- 14 ^ Practices **undergoing implementation** with **local care navigation**
- 26 ^ Practices **completed implementation** with **local care navigation**

The five components of NHS IMPACT have been considered and embedding an approach of continuous improvement.

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65

Modern General Practice Access

The approach, which NHSE are calling Modern General Practice Access has three components:

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

Better Digital Telephony

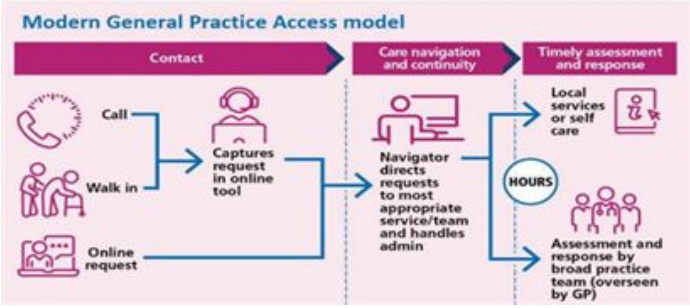
12
Phase 1 'critical list'

- 12 Practices (previously 15) are now identified as on the phase 1 'critical list' needing to move from analogue to digital telephony.
- This has reduced due to practices implementing digital telephony independently. The 12 practices will move over to digital telephony by 31st March 2024.

16
Phase 2 'cohort a'

- In November 23 NHSE confirmed additional support for practices that are using digital telephony but lower functionality than national standards.
- 16 Practices have been identified as Phase 2 'cohort a.'

Both phases have received funding from NHSE to support the telephony changes.



Faster navigation, assessment, and response

- Practices and PCNs have been advised of the mapping to qualify for the ACC-08 IIF indicator for two week appointments. NHSE have advised that 4 exception codes for these appointments are now available, however, they will not be counted in 23/24.
- All PCNs CAIP reported plans to review and comply with GPAD mapping guidance. This will be reviewed with CAIP updates due in April to ensure all practices are continuing to be compliant.
- Practices understand the contractual requirement of outcome at first point of contact.
- Primary care team work with practices to monitor diversion to 111.

Practice Websites

One practice has been the pilot site for the move to Footfall foundation site which meets the new criteria set out by NHSE. Practices have been invited to book their go live date for the transfer.

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Practices requested to move to Foundation Footfall (anticipated by May 24 – subject to supplier availability)

Register with a GP Surgery Online

- There has been an increase of practices currently enrolled for the service from 29 to 32 (48.4%).
- The NHSE target for end of March 2024 is 60% enrolment. Practices that are not currently enrolled have been contacted and offered support.

Digital Tools

- Silicon Footfall websites & Accurx for online patient facing services and Ardens for data quality, have been offered to all practices and they have the choice to adopt the products procured by the ICB.
- Digital strategies are in the process of being reviewed so inline with national digital ambitions.

The ICB Digital and Primary Care team are scheduling meetings to support practices in identifying issues relating to all the digital elements of PCARP. Practices are being prioritised using GPAD, POMI and NHS 111 data to identify areas of greatest support needs.

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66

Primary – Secondary Care Interface

One of the four core areas of PCARP focuses on cutting bureaucracy to help relieve workload pressures experienced by general practice teams, freeing them up to focus on patient care. An integral part of this is **improving the primary-secondary care interface**.

***GP and Consultant Specialist Advice survey*:** Revealed a very clear sense of frustration amongst primary and secondary care clinicians with how interactions at the interface between primary and secondary care are working, and the need for focused work on the themes of culture, communication, and clinical process to improve the situation.

Primary-Secondary Care Interface Principles document: A Primary-Secondary Care Interface Principles document has been drafted and is currently going through a consultation process before being signed off and put in place. The document has been circulated and discussed with the Medical Council, LMC and PCN Clinical Directors for their input and feedback. Further work is needed to gather feedback from secondary care clinicians and managers before the principles can be finalised.

Building relationships: A time limited primary and secondary care interface working group is being established to drive improvement, with a particular focus on building relationships across the interface. In addition to this a GP and consultant networking event is being considered to bring people together and help create a shared understanding of the pressures and issues across the system.

Improving communication: Work is underway to understand and improve mechanisms for GPs to raise issues with secondary care, with an initial focus on developing an effective and consistent process for expediating appointments through the Elective Care Hub. Consideration is also being given to the value of introducing a primary care liaison officer.

Gloucestershire Primary Care Activity Survey

GPs have been sharing anecdotal evidence particularly regarding holding patients whilst they wait for secondary care appts or other services.

Secondary care activity survey in primary care - Commissioned by the ICB in Q3 of 2023

GPs requested to log every GP encounter for a minimum of 1 week, Jan-Feb 24

Survey aimed to answer: *"what is the estimated proportion of GP encounters which is related to transfer of work for secondary to primary care?"*

Results will be shared in due course.

The Primary-Secondary Care Interface is a priority in Gloucestershire to support with the transfer of work.

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67

Communications

The national plan commits to a national campaign with three components to increase public understanding of the changes to primary care services, the benefits they bring, and how and what services they can access

Focus of communications is currently on Pharmacy first since launch in January 23 (table describes recent/upcoming actions)

Social media posts are scheduled to be shared

National comms resources for PCARP have been shared with practices via the weekly primary care bulletin, in December 2023

Discussions have taken place regarding production of bespoke local videos

Comms Plan - Upcoming Actions	Date
Inform practices of Pharmacy First launch via primary care bulletin	30 January 2024
Reactive statement for enquiries following national launch of Pharmacy First on 31 January	31 January 2024
Localised media release with local data, case studies and spokespeople	19 February 2024
Briefing for local community stakeholders	19 February 2024
Sharing links to NHSE Pharmacy First resources (to download) with practices via primary care bulletin: • Poster to display in waiting rooms • Video for waiting room TV screens • Copy for practice websites • Social media posts and graphics for practices	Late Feb
Share NHSE campaign resources across NHS Gloucestershire social media channels (Facebook, X, Instagram)	From 19 February 2024
Update NHS Gloucestershire website: home page carousel	From 19 February 2024
Update NHS Gloucestershire staff via staff briefing and intranet	1 February 2024 and mid-February 2024

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Risks to Delivery

Risk Area	Risk Description	Score (Lik.*Imp.)	Mitigations
Modern General Practice Access - Telephony	Digital infrastructure challenges with implementing Cloud Based Telephony within the FOD practices (5 practices).	12(3*4)	The ICB Digital Team are working on a solution engaging with National Digital Team.
GPAD	Data not accurately recording appointment mapping data, thus likely showing a reduced performance for ACC-08. Risk to PCNs being paid through IIF indicator.	9(3*3)	Raised with national and regional NHSE. ACC-08 indicator has been removed from IIF from 24/25.
General Practice Improvement Programme	Lack of engagement from remaining few practices which have yet to sign up to GPIP	12(3*4)	The ICB communicating with these practices to discuss the offers available and how the ICB are able to support. Smaller needs assessment may be all that is required.
Expanding Community Pharmacy Services	Workforce challenges exist across pharmacist and pharmacy technician roles across both general practice and community pharmacy teams	12(3*4)	Work is underway to increase the pipeline and skill development to deliver the services described on slide 4. Work ongoing to support relationship between GP practices and CPs with Community Pharmacy PCN Leads that have been funded to develop effective and sustainable relationships with GP Practice and Pharmacy teams until end March 24.
Primary Care / Secondary Care Interface	**Interface principles**: the necessary systems and processes may not be in place with providers to enable them to achieve the principles	12(4*4)	Making sure the principles are both correct and achievable is part of the engagement process.

Finance

Funding Stream	Gloucestershire allocation	Anticipated spend by 31st March 24	Comments
IIF National Capacity and Access **Support** Payment	£1.81m	£1.81m	Paid to PCNs, proportionally to their Adjusted Population, in 12 equal payments over the 23/24 financial year. This is 'unconditional' funding. For the period 1 April 23 to 31 March 24 this is calculated as £2.765*PCN's Adjusted Population as of 1 January 2023.
IIF Local Capacity and Access **Improvement** Payment	£789k	£0k – *to be paid by 31st August*	To be paid by 31 August 2024, based on commissioners assessment of PCN Capacity and Access Improvement Plans achievement. The maximum a PCN could achieve is £1.185 multiplied by the PCN's Adjusted Population as of 1 January 2023. This equates to ~£56,000/PCN/year.
Transition Cover & Transformation Funding ~Average £13,500 per practice in 23/24 and 24/25	£473k per year (30% (£142k) received to date)	£473k	Available to provide additional capacity to help smooth the transition to the new Modern General Practice Access model
Primary Care Service/System Development Funding (SDF)	£2.4m (this covers numerous programmes of work)	£2.4m	SDF funding, covers numerous programmes of work and has all been committed and planned to be spent by the end of the financial year.
Digital telephony - phase 1	£432k	£432k	Unknown cost associated with infrastructure challenges in FOD practices switching to CBT
Digital telephony - phase 2 (cohort a)	£448k	£448k	Funding has all been spent
Online consultation, messaging and appointment booking tools (~93p per patient)	£635k (~93p per patient)	£236k	Used to fund Silicon footfall Website & Accurx – fixed costs Digital team in discussion with SCW procurement regarding remaining spend options.

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Primary Care Access Recovery Plan (PCARP)

Progress Update

March 2024

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Introduction

In May 2023, the Delivery Plan for Recovering Access to Primary Care (PCARP) was published by NHSE, outlining the requirement for ICBs to develop system-level access improvement plans ('System Delivery Plan').

As required by NHSE, ICBs reported to ICB Board in November 2023, and ICBs are required to report progress again in March 2024.

This document will provide an update on progress against the national actions and local system delivery plan.

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.

Empower Patients

To manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.

Implement Modern General Practice Access

To tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

Build Capacity

To deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.

Cut Bureaucracy

And reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

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Empowering Patients

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. Helping the public do more for themselves, making information and easy-to-use tools available by:

• Improving information and NHS App functionality • Increasing self-directed care where clinically appropriate • Expanding community pharmacy services.

Improving information and NHS App functionality

Ensure directly bookable appointments are available online following bookable online appointment guidance - There is no available data that identifies the number of bookable appointments are available at practice level. We are using the POMI data as a baseline to identify practices with low booking rates. Work is ongoing to support practices.

Offer secure NHS App messaging to patients where practices have the technology to do so in place - Accurx has released functionality that will send bulk messages and Floreys to patients with an active NHS APP account. There is a three hour window for the patient to acknowledge the message, after which time the notification will be resent via SMS. Practices should promote the NHS APP and encourage patients to activate the notification setting. Two-way messaging is on the road map for the NHS APP but not currently available.

Repeat Prescription Ordering: The national aim is for 90% of repeat ordering to be through online services. We have asked NHSE to clarify what data is being captured. There are new promotional materials for practices to promote online ordering of repeat medication.

patients who have an online account

Patients enabled for **online appointment booking/cancellation**:

- **Gloucestershire: 42.9%**
- South West: 43.2%
- Nationally: 45.3%

Patients enabled for **online repeat prescriptions ordering**:

- **Gloucestershire: 50.8%**
- South West: 50.3%
- Nationally: 50.4%

Self-referrals

The national ambition is to have self-referrals routes established for the 7 services listed below and increase self-referral activity in these areas by 50% .

Total self-referrals have increased by 44%

	Community Musculoskeletal	Audiology (incl. hearing aid provision	Weight Management Services	Community Podiatry	Wheelchair services	Community Equipment Services	Falls Response Services
% increase against 22/23 baseline (data as of Jan 24)	61% ^	Service not in place yet, expected Q4 23/24	3% ^ *(Data as at July 23)*	14% ^	4% ^	-12% v *(Data as at June 23)*	195% ^

Progress and Next Steps:

- Further discussion with GHFT regarding the relative priority of implementing self-referrals and if/when this could be progressed.
- A monitoring dashboard has been developed to track self-referral activity across the 7 service areas and track progress against the national target of increasing self-referrals by 50%.
- As part of this process data submitted via the Community Services Data Set (CSDS) is being reviewed to identify any data quality issues, to ensure that a full picture of activity is available. Actions that are ongoing include:
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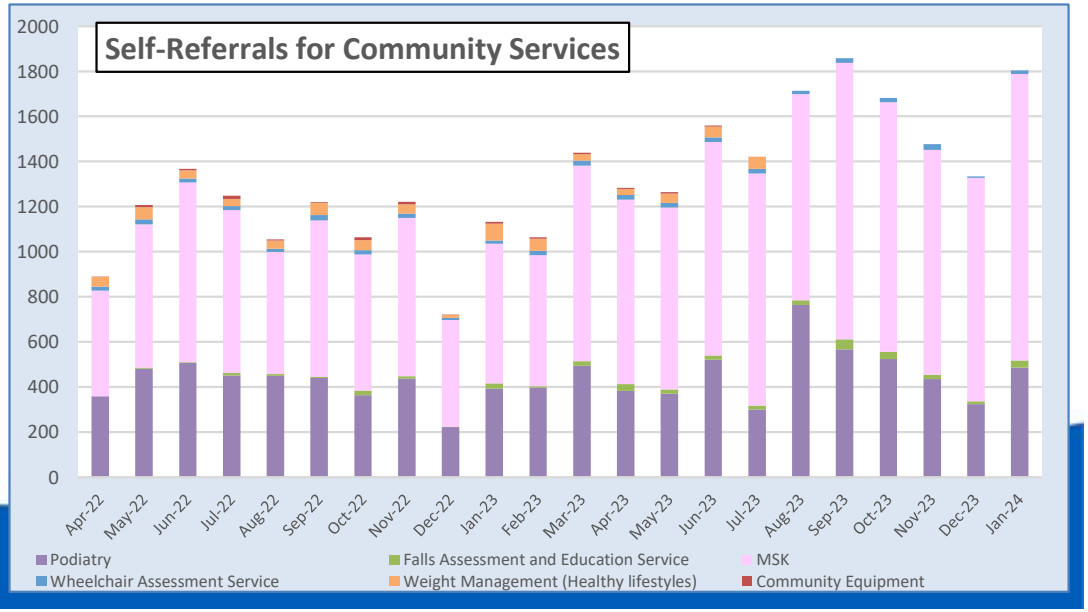

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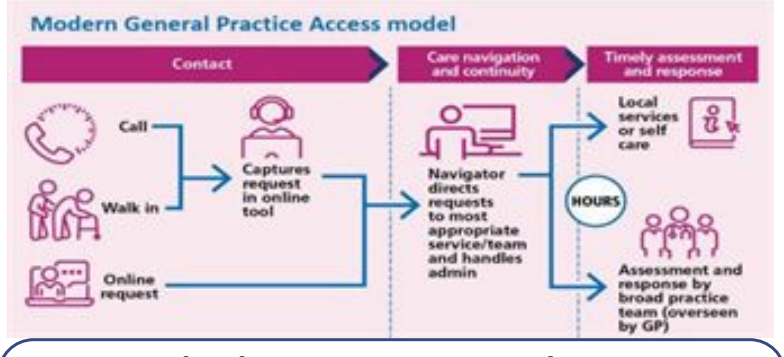

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Risks to Delivery

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Modern General Practice Access - Telephony	Digital infrastructure challenges with implementing Cloud Based Telephony within the FOD practices (5 practices).	12(3*4)	The ICB Digital Team are working on a solution engaging with National Digital Team.
GPAD	Data not accurately recording appointment mapping data, thus likely showing a reduced performance for ACC-08. Risk to PCNs being paid through IIF indicator.	9(3*3)	Raised with national and regional NHSE. ACC-08 indicator has been removed from IIF from 24/25.
General Practice Improvement Programme	Lack of engagement from remaining few practices which have yet to sign up to GPIP	12(3*4)	The ICB communicating with these practices to discuss the offers available and how the ICB are able to support. Smaller needs assessment may be all that is required.
Expanding Community Pharmacy Services	Workforce challenges exist across pharmacist and pharmacy technician roles across both general practice and community pharmacy teams	12(3*4)	Work is underway to increase the pipeline and skill development to deliver the services described on slide 4. Work ongoing to support relationship between GP practices and CPs with Community Pharmacy PCN Leads that have been funded to develop effective and sustainable relationships with GP Practice and Pharmacy teams until end March 24.
Primary Care / Secondary Care Interface	**Interface principles**: the necessary systems and processes may not be in place with providers to enable them to achieve the principles	12(4*4)	Making sure the principles are both correct and achievable is part of the engagement process.

Finance

Funding Stream	Gloucestershire allocation	Anticipated spend by 31st March 24	Comments
IIF National Capacity and Access **Support** Payment	£1.81m	£1.81m	Paid to PCNs, proportionally to their Adjusted Population, in 12 equal payments over the 23/24 financial year. This is 'unconditional' funding. For the period 1 April 23 to 31 March 24 this is calculated as £2.765*PCN's Adjusted Population as of 1 January 2023.
IIF Local Capacity and Access **Improvement** Payment	£789k	£0k – *to be paid by 31st August*	To be paid by 31 August 2024, based on commissioners assessment of PCN Capacity and Access Improvement Plans achievement. The maximum a PCN could achieve is £1.185 multiplied by the PCN's Adjusted Population as of 1 January 2023. This equates to ~£56,000/PCN/year.
Transition Cover & Transformation Funding ~Average £13,500 per practice in 23/24 and 24/25	£473k per year (30% (£142k) received to date)	£473k	Available to provide additional capacity to help smooth the transition to the new Modern General Practice Access model
Primary Care Service/System Development Funding (SDF)	£2.4m (this covers numerous programmes of work)	£2.4m	SDF funding, covers numerous programmes of work and has all been committed and planned to be spent by the end of the financial year.
Digital telephony - phase 1	£432k	£432k	Unknown cost associated with infrastructure challenges in FOD practices switching to CBT
Digital telephony - phase 2 (cohort a)	£448k	£448k	Funding has all been spent
Online consultation, messaging and appointment booking tools (~93p per patient)	£635k (~93p per patient)	£236k	Used to fund Silicon footfall Website & Accurx – fixed costs Digital team in discussion with SCW procurement regarding remaining spend options.

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**ICB Progress Report – Public Sector Equality Duty and our response to the Equality Delivery System**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting							
	ICB Internal	**Date**			**System Partner**	**Date**	
					EDS Task and Finish Group	16/03/23	
Executive Summary	Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework designed to assist organisations in assessing their performance and identifying future improvement actions. The PSED includes a requirement that the ICB will publish equality information about both the communities we serve and the staff we employ. It also requires ICBs to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The report sets out or response to these requirements and evidences the process we have undertaken to review our performance against the EDS framework and the eleven outcome areas spread across three Domains: • *Commissioned or provided services* • *Workforce health and well-being* • *Inclusive leadership.* We are required to undertake a self-assessment of our performance and independently verify our position with stakeholders and staff. As a result of this process, we have also identified a range of improvement actions which are described in the report and will form a programme of work for the coming year.						

<table>
<tr><td>Key Issues to note</td><td colspan="4">We have worked collaboratively with GHFT and GHC on Domain 1 and the outcome areas relating to Commissioned and Provided services

Whilst we have identified some good practice and an overall improvement on last year’s performance, the are some areas where we are still developing and embedding equality objectives and reporting.

The three equality objectives that were previously identified need to be refined and an action plan developed which identifies measurable objectives and mechanisms to continually monitor our delivery against these. This will enable us to more easily evaluate the areas of improvement identified and to ensure alignment with Operational Plan priorities.</td></tr>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The Equality and Human Rights Commission (EHRC) have recently reviewed all ICBs relating to the PSED. There is a deadline for the annual publication of equality information (31st March 2024). The review identified good practice, but also suggested areas where we could improve. This included more specific equality objectives, publishing on our website more granular equality information such as the protected characteristics of our Core 20 population, more case studies and equality impact assessments.

This process is also part of the System Oversight Framework for ICBs and NHS provider organisations and so failure to comply with these requirements would mean that we are potentially unable to show are commitment to addressing:
• equality of access;
• experience across the services we provide and commission; and
• how we treat our staff.

Risk rating 3x 2 – Low</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">There are no conflicts of interest identified through this process.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>X</td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">There are no additional costs associated with carrying out this annual assessment.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">It is statutory obligation for public sector to evidence how they are meeting the Public Sector Equality Duty.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">The outputs of this process highlights the potential gaps in service provision and experience for both patients and staff and areas where improvements can be made to address health inequalities.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">As above.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">Not applicable.</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">We have utilised information from patient and staff surveys as part of the evidence base to inform our response. The Working with People & Communities Advisory Group (WPACG) and Maternity and Neonatal Voices Partnership (MNVP) have worked with us to review the information and to independently assess our performance. The Staff Partnership Forum has reviewed and assessed Domain 2: Workforce health and well-being</td></tr>
</table>

Recommendation	**The Board is requested to:** **Note the up-to-date position of Gloucestershire's population against the 9 protected characteristics.** **i) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group, Maternity Voices and Neonatal Partnership and the ICB's Staff Partnership Forum.** **ii) Note and approve the improvement actions set out in Sections 5 & 8.** **iii) Note that information about the profile of our local population and the EDS assessment will be published on our website on 31st March 2024.**		
Authors	**Tracey Cox** **Christina Gradowski** **Caroline Smith**	**Role Title**	**Director People, Culture & Engagement** **Associate Director of Corporate Affairs** **Senior Manager, Engagement & Inclusion**
Sponsoring Director (if not author)	**Tracey Cox, Director People, Culture & Engagement**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
EHRC	The Equality and Human Rights Commission
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
MNVP	Maternity and Neonatal Voices Partnership
PSED	Public Sector Equality Duty
VCSE	Voluntary, Community and Social Enterprise
WPACG	Working with People & Communities Advisory Group

ICB Progress Report – Public Sector Equality Duty and the Equality Delivery System

Contents

Appendix 1: Link to Infographic showing an overview of the Gloucestershire population

Appendix 2: *Membership of Working with People & Communities Advisory Group*

Appendix 3: *EDS Reporting Framework 2023-24*

1 Purpose of the Document

Integrated Care Boards have a vital role in tackling inequalities in access to and outcomes from health and social care services. Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework and toolkit that is designed to assist organisations in assessing their performance and identifying future improvement actions. This paper reports on our progress against both the PSED and the revised EDS toolkit issued in 2022.

2 Public Sector Equality Duty & Equality Delivery System Toolkit

2.1 PSED Duty

The PSED is designed to support ICBs and other bodies to think about equality across our work programme, to identify the major challenges and to agree the actions we will take to tackle them.

The PSED consists of a general duty and specific duties. The general duty requires ICBs to think about how they can prevent discrimination, advance equality and foster good relations. This applies to the services that are provided and commissioned and to the employment of staff. The PSED requires a thorough consideration of the needs of people with each protected characteristics and is therefore different to the focus of the health inequalities duty which includes a focus on geographical inequalities and other non-protected characteristic inequalities.

The specific duty requires the ICB to be transparent about our work on equality and to show how we are meeting the requirements of the general duty. Each year we must publish equality information that demonstrates how we are thinking about equality across the services we provide and commission and the employment of staff.

ICBs should also have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The Equality and Human Rights Commission (EHRC) monitor the performance of ICBs and require the annual publication of equality information (31st March 2024).

2.2 Equality Delivery System Toolkit

The NHS Equality Delivery System is an accountable improvement tool for NHS Organisations in England. Updated EDS Technical Guidance was published August 2022. This is the third version, commissioned by NHS England and supported by the Equality Diversity Council and is a simplified version of EDS2. The EDS comprises eleven outcomes spread across three Domains:

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

Outcomes are evaluated, scored, and rated using available evidence and are designed to provide assurance or point to the need for improvement.

EDS ratings and Score Guidance are in place to assess each outcome area with the overall assessment approach based on the following: -

Undeveloped activity – organisations score 0 for each outcome	Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped
Developing activity – organisations score 1 for each outcome	Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score 2 for each outcome	Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score 3 for each outcome	Those who score 33, adding all outcome scores in all domains, are rated Excelling

Completion of the EDS, and the creation of interventions and action plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach and the 23/24 Operational Planning Guidance. NHS organisations are expected to start to adopt a system approach to application of the EDS framework where possible.

3 Overview of Gloucestershire's Equality Information

As per last year, the 2021 Census data information provides us with more accurate and up to date information about the profile of our local population. The infographic at Appendix 1 shows our position across the nine protected characteristics.

4 Our Approach to EDS for 2023/24

Across Gloucestershire we have agreed that we will collaborate on a review of *Commissioned and Provided* services for the 2023/24 review and each organisation would review its own progress on *Workforce health and wellbeing and Inclusive Leadership.*

We have collated evidence to support a review of the requirements against the 3 Domains and 11 outcome areas and have engaged with both staff networks, the Working with People & Communities Advisory Group (WPACG) and the Maternity and Neonatal Voices Partnership to review the information and to independently assess our performance. The membership of the WPAGAG is available at Appendix 2.

The next section shows our evidence and assessment against the framework. Whilst we have identified some good practice and an overall improvement on last year's performance, there are some areas where we are still developing and embedding equality objectives, data and reporting.

5 Overview of Outcomes

5.1 Domain 1: Commissioned or Provided services

This year we have agreed across Gloucestershire to revisit our progress on Cancer Services and Translation & Interpretation Services (which we reviewed last year) and to look at Maternity Services. For each service area we were required to test four outcomes:

- 1A: Patients (service users) have required levels of access to the service
- 1B: Individual patients (service user's) health needs are met
- 1C: When patients (service users) use the service, they are free from harm
- 1D: Patients (service users) report positive experiences of the service

What we did
We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The evidence has been discussed with the ICB Working with People and Communities Advisory Group and Maternity and Neonatal Voices Partnership representatives, who gave valuable insight into our self-assessment and made recommendations regarding ratings for each of the four outcomes. The following summarises the findings for each section. The full assessment is included in Appendix 3.
What we found
Outcome 1A: Patients (service users) have required levels of access to the service **Cancer services:** There is good provision of cancer services across primary care, acute and community services. A place-based population health approach is being taken through Integrated Locality Partnership and Primary Care Networks. Our Integrated Care Strategy focuses on understanding our communities and achieving equity through a range of targeted improvement for those living in our most deprived areas of the county. There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Analysis by some protected characteristics remains challenging due to the incompleteness of data. The Gloucestershire ICS Cancer Programme oversees much of the work to increase early diagnosis rates and ensure identification of, and reduction in, inequalities

Translation and Interpretation (T&I) Services: Each NHS organisation in One Gloucestershire commissions Translation & Interpretation (T&I) Services, which are available to patients' attending appointments in Primary Care, Acute and Community Services.

We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners. This will enable:

- Continuity of interpreter (where preferred)
- Improved access to services
- Collection of robust feedback from people in our communities
- Improved staff training

Our work with Gloucestershire Deaf Association has provided a better understanding of the number of British Sign Language users accessing health care in the county**.**

We are working with voluntary sector partners to raise awareness of the Accessible Information Standard (2016) and develop mechanisms to ensure compliance across our system.

Maternity Services:

The Local Maternity and Neonatal System (LMNS) Board has regular oversight of and monitors the national local maternity services dashboard. This brings together information from different data sources to track, benchmark and improve the quality of maternity services in Gloucestershire.

Maternity services, including Delivery Suite, Birthing Units, Community Midwives and Perinatal Mental Health Services are delivered in a number of locations in Gloucestershire.

Our data shows that 21.3% of maternity bookings are for women from ethnic minority communities. This is higher than the ethnic minority population in Gloucestershire, which according to the 2021 Census is 17.7%, for women of child-bearing age. 23.9% of all bookings are from women who live in the most deprived areas (IMD Deciles 1&2) of Gloucestershire. 14.7% of these women are booked with the Continuity of Carer team/pathway.

Outcome 1B: Individual patients (service user's) health needs are met

Cancer Services: System-wide work to deliver the Cancer Operational Planning guidance 2023/24 has contributed to local action, including:

- Faster diagnosis and operational improvement; e.g. Targeted focus on inequalities in prostate cancer aimed at increasing engagement in men over 45 from a black ethnic background, with family history of prostate cancer.
- Early Diagnosis: NHS Cancer Screening - Working to identify the population groups with low screening uptake locally e.g. Actively developing opportunities to improve screening uptake in women from South Asian communities and in areas of deprivation.
- Improving access to screening for people with Learning Disabilities and Autism by having a dedicated cancer screening support nurse.

- Primary Care Direct Enhanced Service and Quality Improvement Projects respond to local needs and challenges.

Translation and Interpretation (T&I) Services: Access to the T&I services available across One Gloucestershire services 24/7, 365 days.

- Policies and procedures in place to ensure staff are able to access T&I support.
- Reasonable adjustments made e.g. longer appointments, mobility, support for hearing and sight impairments.
- New service specification for spoken language will:
  - support requests for continuity of interpreter across organisations
  - enable service improvement (re T&I) based on feedback from patients
- Accessible Information Standard: Working in partnership with VCS organisations to support awareness raising of communication needs for people with a disability, sensory or cognitive impairment.

Maternity Services:

The Local Maternity and Neonatal System (LMNS) has developed an Equity and Equality action plan, in collaboration with the Maternity and Neonatal Voices Partnership (MNVP). This 5-year plan sets out initiatives which include:

- 2 Midwifery Continuity of Carer (MCoC) teams have been established to provide support in areas of high deprivation and ethnic minority communities.
- A Perinatal Emotional Health and Wellbeing pilot funded by the ICB and delivered by The Nelson Trust supports women with low/moderate perinatal mental health needs, and can support with issues around accommodation, drug and alcohol misuse and domestic abuse.
- Perinatal Equity and Equality Action Plan developed with a focus on mothers from more deprived areas and ethnic minorities, young mothers and Traveller communities
- A young mums' support group is delivered by Forest Voluntary Action Forum (FVAF), who has identified the needs of the young people and encourages social inclusion, helps build confidence, learn new skills and increase parenting social circles.

Outcome 1C: When patients (service users) use the service, they are free from harm

Cancer Services: Gloucestershire residents are able to access reasonably high quality, safe healthcare. The Care Quality Commission has rated both main providers as ‘Good’. In Primary Care settings, residents can also access good quality GP services, most of which are rated as either ‘Good’ or ‘Outstanding’.

- System Safety Group established to oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level.
- Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy.

- Embedded through Professional Registration, Staff training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour.

Translation & Interpretation Services:

- Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients.
- DATIX reporting reviewed and actioned.
- Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement.
- One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety.

Maternity Services:

- Local Maternity and Neonatal System receive regular updates on quality and safety, including the quarterly Perinatal Quality Surveillance and Safety Report.
- Maternity and Neonatal safety champions in post and meet bi-monthly, undertaking walkabouts of key areas of focus. They provide visible leadership and promote safe, personalised care, share learning and best practice from national research, local investigations and initiatives.
- DATIX reporting – a daily review of all incidents rated moderate harm+ takes place to ensure we are responding to any potential safety concerns in a timely way. In addition, the introduction of hot and cold de-brief post incident to support staff health and wellbeing
- We have strengthened the quality and safety reporting both internally and externally to support an increase in learning from our incidents and patient feedback.

Outcome 1D: Patients (service users) report positive experiences of the service

Cancer Services: Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities.

- Patient experience information gathered through engagement is reported back to service leads and system partners.
- Patient Experience data is gathered, monitored and acted upon:
  - National cancer survey – high levels of satisfaction reported, although limited analysis by protected characteristics possible due to small numbers involved
  - Patient experience data gathered via Friends and Family Test (FFT) – demographic data capture extended to provide greater breakdown of ethnicity; disability; carer

- Working closely with ICB Insights Manager to build relationships with local communities and groups, including plans for engagement work and cultural competency training for staff supporting events.
- Targeted campaigns include:
  - Prostate cancer risk and awareness event with the African Caribbean Community.
  - Breast Cancer Awareness Events utilising the Information Bus to target deprived communities, ethnic minority communities (prevalence of late-stage diagnosis), the homeless community and the LGBT+ community.
  - Bartongate Children's Centre event - female Afghani refugees, with support from GARAS.
  - All Nations Health and Wellbeing event attended by Prostate and Breast Nurses.
  - General awareness, risks and prevention with Nepalese soldiers

Translation & Interpretation Services:

- We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners. This will enable:
  - Continuity of interpreter (where preferred)
  - Improved access to services
  - Collection of robust feedback from people in our communities
  - Opportunity to promote service to local communities
  - Improved staff training
- Gloucestershire Health and Care NHSFT are in the process of introducing a QR code, so that when an appointment has taken place, the Deaf client will receive a text so they can send back some feedback.
- Working with Inclusion Gloucestershire, Gloucestershire Hospitals NHSFT have reviewed patient information leaflets and agreed which should be translated into Easy Read. Information to support patients in Shared Decision Making has been included on the back of each leaflet.

Our assessment rating:

There is a range of scores across the different services, but when combined they equate to the following:

Outcome 1A – Achieving activity = Score 2

Outcome 1B – Achieving activity = Score 2

Outcome 1C – Achieving activity = Score 2

Outcome 1D – Achieving activity = Score 2

Overall Rating for Domain 1: Commissioned or Provided services is Achieving Activity (score 8 out of possible 12)

Improvement Actions: -

- Further data analysis is underway for cancer services to improve identification of variation and link further datasets to improve data quality.
- Work to provide consistency and clarity of the maternity offer for labour and delivery.
- Further improvements are made to equality data recording, in order to achieve consistency.
- Establish mechanisms for gathering patient experience of translation and interpretation services and explore innovation in improving access and visibility of the service.
- Review compliance with the Accessible Information Standard providing and evaluating the impact of additional training and support for staff.

5.2 Domain 2: Workforce health and wellbeing (ICB employed staff)

The 4 outcomes areas for review of our approach in this area are as follows:

- 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source
- 2D: Staff recommend the organisation as a place to work and receive treatment

What we did

We reviewed the data and statistics we have on our workforce profile including a breakdown of staff according to gender, ethnicity, age and disability. We reviewed the range of health and wellbeing initiatives and projects that the ICB has supported over the past year to assess how staff are supported to manage their health conditions such as obesity, diabetes, asthma, COPD and mental health conditions.

The staff survey results for 2022 were assessed as well as more recently the staff survey results relating to 2023. The range of activities and resources produced was listed in a presentation (and domain 3 document) and shared with the ICB Staff Partnership Forum on 29th February 2024 for their feedback and input..

What we found

Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions

The ICB has supported a range of health and wellbeing projects and initiatives over the year (2023-2024) including: **Staff health checks (MOTs); Blood Pressure Checks; Women's Health Day; MSK session; Promote hybrid working and office furniture grant; Health & Wellbeing policies; Reasonable Adjustments** policy, Health Passport and Guidance was developed in 2023; **Intranet resources** and blogs cover Women's Health, Alcohol and Drugs, Mental Health

Staff Survey H&WB Results 2023

In the 2023 survey, a number of the People Promise element scores relating to the theme of *safe and healthy* cannot be benchmarked due to data issues but we scored above the ICB average and improved on last year's position on staff reporting that burnout was not an issue. More staff completed the staff survey than the previous year with 77% of staff employed by the ICB responding to the survey compared to 74% in 2022.

For the forthcoming year 2024 we have identified the following H&WB themes

Managers supporting staff with H&WB

- 2023, 87% of staff can approach immediate manager to talk openly about flexible working compared to 88% in 2022; slight deterioration in score.
- 2023, 84% of staff reported that their immediate manager takes a positive interest in my health & well-being; compared to 86% in 2022; deterioration in score.

Organisation supporting staff with H&WB 2023, 78% of staff confirmed that the organisation takes positive action on health and well-being; compared to 83% in 2022; deterioration in score.

MSK 2023, 79% of staff have in the last 12 months not experienced musculoskeletal (MSK) problems as a result of work activities; compared to 82% in 2022.

Reasonable adjustments 2023, 83% of staff reported that the organisation made reasonable adjustment(s) to enable them to carry out work; compared to 93% in 2022 a significant deterioration in score.

Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

- The ICB has updated its policies on Harassment and Bullying. Managers training on Harassment and Bullying was provided in 2022 by the CSU HR Team.
- Training provided to all staff on building a culture of conscious inclusion; sessions were designed for managers 8A and above and for staff in bands 7 and below. The Commissioning Support Unit ED&I specialists delivered the training throughout 2023. Feedback and evaluation on the training has been received.
- ICB has a Whistleblowing and Freedom to Speak Up Policy with an induction session on FTSU as well as slots at the Staff Meeting. There are now two FTSU Guardians who are trained at the ICB and a lead NED for FTSU.
- The ICB introduced a Zero Tolerance of Abuse of NHS Staff Policy in 2023 with reporting forms and a dedicated incidence box.
- ***The ICB offers Restorative supervision*** for clinical staff at the ICB either group or 1:1 available from Professional Nurse Advocate's (PNA).
- ***The ICB is a signatory to the Sexual Safety in Healthcare Organisational Charter*** Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help

achieve this. NHS Gloucestershire ICB Board agreed on the 10 principles and actions to achieve this, at its September 2023 board meeting.

- A compassionate leadership workshop was held with senior managers in March 2023 and a compassionate leadership intranet page has been produced with a range of resources for staff.

Outcome 2C. Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source

The ICB has a range of resources and procedures in place to support staff including:

- Flexible working policy to help staff achieve a work-life balance.
- Leave and Other Leave policies including Disability Leave.
- Additional Leave procedures and process whereby staff can purchase additional leave for 2023-24 57 staff have exercised this choice with 70 staff taking additional leave in 2023-24 financial year.
- Training delivered on Building a Culture of Conscious Inclusion.

Staff Survey

- In 2023 68% of staff *feel safe to speak up about anything that concerns me in this organisation* which is better than the national average for ICBs of 60%, However in 2022 it was 76.6% equivalent to the 'Best'

Outcome 2D: Staff recommend the organisation as a place to work and receive treatment

- In 2023 57% of Glos ICB staff reported *If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.* This is above the national average 48% but has significantly decreased from 2021 with 71% of ICB staff reporting favourably on this question.
- However, 77% of Gloucestershire ICB staff reported that the care of patients / service users is my organisation's top priority in 2023 compared to the national average of 67%.
- Gloucestershire ICB has positive scores in relation to recommending the ICB as a place to work compared to the national average. However there has been a dip in scores between 2021 and 2022 and a further dip in 2023 to 75%. but still compares well to the national average which is 52%.

Our assessment rating:

Outcome 2A – Achieving activity = Score 2
Outcome 2B – Developing activity = Score 1
Outcome 2C – Developing activity = Score 1.5
Outcome 2D – Developing activity = Score 1.5

Overall Rating for Domain 2: Workforce health and wellbeing (ICB employed staff) Score 6 out of possible 12.
Improvement Actions: -
• Further work will be undertaken on wellbeing initiatives that are targeted to protected characteristics; a special session on domestic abuse and supporting staff by GDASS will be organised for Spring 2024. • A H&WB survey will be sent out to staff to gather ideas to improve staff health while at work in Q1 of 2024 with a focus on protected characteristics. • Further FTSU sessions will be organised during 2024. • FTSU mandatory training via a national e-learning module will be made available to staff in June 2024 • ICB will be undertaking further work to tackle bullying and harassment from patients, service users, their family, staff and managers, with a coordinated approach across the ICS and internal focus groups to understand the issues in more depth. • A focus on creating a health workplace culture with particular emphasis on understanding stress experienced by our staff, improving Musculo-skeletal health.

5.3 Domain 3: Inclusive Leadership

The 3 outcomes areas for review of Inclusive Leadership are as follows:

- 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
- 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
- 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

What we did
Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. 1. Looked at organisational level and system wide approaches to support senior leaders understanding of equality and health inequalities 2. Collated an evidence file. 3. Reported on key system initiatives in place and provided an overview of these to the Working with People and Communities Advisory Group in March 2024

Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.

1. We undertook a desk top review of a number of meetings which have taken place since March 2023 to see how frequently the Board Members were discussing inequalities and issues relating to equality, diversity and inclusion. Meetings reviewed:
   - Integrated Care Board Meetings (Public)
   - ICS Strategic Executive (Closed)

Outcome 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

We reviewed how well the ICB is using relevant tools such as the following:

1. Workforce Race Equality Standards (WRES)
2. Workforce Disability Standards (WDES)
3. Impact Assessments
4. Gender Pay Gap Reporting
5. Accessible Information Standards
6. Patient and Carer Race Equality Framework (Mental health)

What we found

For Outcome 3A:

EDI Objectives for all Board members

- In line with the national EDI improvement plan all ICB Board members will have an EDI objective by March 2024.

Training & Support for Staff

1. We have run a 2nd cohort of the Reciprocal mentoring programme - matching staff from a range of services and with different protected characteristics with Senior Managers to become co-mentees for a 6-month period

- Cohort 1: 22 pairs, including 13 Executives & Non-Executive Directors
- Cohort 2: 17 pairs, including 6 Executive & Non-Executive Directors

2. We have run a 2nd Cohort of the Inclusive Allies programme:

107 staff from Public sector organisations across Gloucestershire participated in the 2nd Inclusive allies programme during 2023

3. Training for ICB employed staff

We commissioned cultural awareness training for ICB staff (72% of staff completed the training). Providers across the system has also run specific EDI training for their staff.

For Outcome 3B:

Board, Strategy & Committee meetings:

1. We continue to ensure that health inequalities are regularly discussed at ICB Board meetings – a recent desk top review of agendas and meeting papers showed that there are frequent discussions on health inequalities.
    - *2 specific topic items and 15 separate references to EDI/Inequalities as part of the non-standard Board items across Public and Confidential sessions*
    - *5 Patient Stories (every meeting apart from extraordinary Board).*
    - *Health Inequalities clearly referenced in Board Assurance Framework*
2. A dedicated EDI development session for Board members took place in October 2023

3. The People Committee recently reviewed the Workforce Race Equality Standards which illustrate the different experience of staff from Black and Minority ethnic backgrounds in relation to discrimination, bullying and harassment as well as the representation and disparity ratio between staff at different grades. This is an area for further focus in 2024/25.

For Outcome 3C: -

Tools to Support Staff across the system:

- GCC colleagues have launched the Prevention & health Inequalities hub. The hub is an online compendium of information, resources, and practical tools to help people to better understand and take action to improve health equity in their areas of work. It includes tools such as :-
    - Health Equality Assessment Tool (HEAT)
    - Health Equity Audit (HEA)
    - Health Impact Assessment (HIA)
    - The Hub can be found here: www.gloucestershire.gov.uk/PHI-Hub

We will continue to promote the hub and its resources to support staff across the system in taking appropriate action to manage health inequalities as part of our work programmes.

- The ICB Board considered a draft Inequalities Framework at its February ICB development session. An outcomes framework and health Inequalities dashboard are in development and will be shared with the Board in due course.

Our assessment rating:

Given the ICB is a relatively new statutory body, and we are continuing to develop our approach, both ICB assessors and WP&ACAG members proposed the following ratings:

Outcome 3A – Developing activity = Score 1.5

Outcome 3B – Developing activity = Score 1.5

Outcome 3C – Developing activity = Score 2

Overall Rating for Domain 3: *Inclusive Leadership (Activity Score 5 out of possible 9)*
Future Improvement Actions: -
• System wide action planning on WRES results with a focus on recruitment, data and anti-discrimination. • Further review of equality objectives in 2024 linked to roll out of the Inequalities Framework • Improve the visibility on our website of equality information such as the protected characteristics of our Core 20 population, more case studies and equality impact assessments.

6 Our Overall Assessment & Rating

Organisations are required to provide an overall rating, created by adding all outcome scores together. Our position is:

Domain 1 Commissioned & provided services = 8
Domain 2 Staff health and wellbeing = 6
Domain 3 Inclusive Leadership = 5

This gives an overall score of 19 (compared to 14 in 2022/23). Those who score between 8 and 21, adding all outcome scores in all domains, are rated as Developing.

7 Equality Objectives

In line with the Public Sector Equality Duty requirements we are required to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. Equality objectives agreed in 2023 are:

7.1 To develop the quality and range of equality and health inequalities data as part of our clinical programmes of work to improve our understanding of the impact of inequalities and the opportunities to take improvement actions.

7.2 To deliver our programme of work in the Core 20 Plus5 clinical priority areas.

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

8 Future Issues to Consider

The Equality and Human Rights Council (EHRC), working collaboratively with NHS England and the Care Quality Commission has been reviewing how every ICB is meeting its PSED obligations. They will use this information to target support and share information on best practice.

Our initial feedback from the EHRC:

- recognises good practice in our work with local communities of interest;
- recommend we refine our Equality Objectives to create more specific and measurable objectives and develop an action plan to monitor and evaluate progress towards meeting these objectives.
- encourages us to demonstrate detailed understanding of our population and their health needs, through published data sets and Equality Impact Assessments.
- suggests in line with good practice, we continue to publicly report our workforce data, including plans to address inequity identified through the Workforce Race Equality Standard, Workforce Disability Standard and gender pay gap.

9 Recommendations

ICB members are asked to:

i) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group, Maternity and Neonatal Voices Partnership and the ICB's Staff Partnership Forum

ii) Note and approve the improvement actions set out in sections 5 & 8.

iii) Note that information about the profile of our local population and the EDS assessment will be published on our website on 31st March 2024.

Appendix 1: **Infographic showing an overview of the Gloucestershire population**

Understanding our local population : NHS Gloucestershire ICB (nhsglos.nhs.uk)

Appendix 2: Membership of Working with People & Communities Advisory Group

The proposed 'lay' membership should be up to 12 individuals including the Chair. The WWPAC AG members should include individuals with recent and relevant experience of health and care services in Gloucestershire and have a mix of characteristics and interests:

- Chair (Jenny Hepworth, NHS Gloucestershire ICB Lay Champion)
- John Lane - Healthwatch Gloucestershire
- Vicci-Livingston-Thompson – Inclusion Gloucestershire
- Rupert Walters – 4orty2 – Black Business Network
- Jennifer Skillen – Expert by Experience
- Pat Eagle – Foundation Trust Public Governor
- Jan Marriott – Trust Non-Executive Director/Partnership Board Co-Chair
- Riki Moody – Gloucestershire Care Home Providers Association
- Matt Lennard / Gill Parker – VCS Alliance
- Emma Mawby – LGBT+ Partnership
- Becky Parish and Caroline Smith - NHS Gloucestershire ICB Engagement/Insight/Equality and Diversity Leads

Appendix 3

NHS Gloucestershire

NHS Equality Delivery System
EDS Reporting 2023/24

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	**NHS Gloucestershire ICB**	**Organisation Board Sponsor/Lead**
		Tracey Cox, Director People, Culture & Engagement
Name of Integrated Care System	NHS Gloucestershire Integrated Care System	

EDS Lead	Tracey Cox		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	March 2024		**Individual organisation**	Domain 2 & 3: NHS Gloucestershire ICB
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	Domain 1: Gloucestershire Health & Care NHSFT Gloucestershire Hospitals NHSFT NHS Gloucestershire ICB

Date completed	18/03/2024	**Month and year published**	March 2024
Date authorised		**Revision date**	March 2025

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The three service areas are Cancer Services, Translation & Interpretation Services and Maternity Services (including Perinatal Mental Health). These were selected based on work that is underway to tackle health inequalities, patient experience data and local community insight.

The evidence for Cancer Services and Translation and interpretation has been discussed with the ICB Working with People and Communities Advisory Group. The evidence relating to Maternity Services was discussed with the Maternity and Neonatal Voices Partnership (MNVP). Both discussions gave valuable insight into our self-assessment and made recommendations regarding ratings for each of the four outcomes. Services were individually assessed, and scores combined to arrive at the overall rating.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Cancer services:** There is good provision of cancer services across primary care, acute and community services. A place-based population health approach is being taken through Integrated Locality Partnership and Primary Care Networks. Our Integrated Care Strategy focuses on understanding our communities and achieving equity: • There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Analysis by some protected characteristics remains challenging due to the incompleteness of data. • Targeted improvements for those living in our most deprived areas (CORE20Plus5 – 5 clinical priorities one of which is Cancer) • There is a focus on improving access to care and reducing backlogs in waiting times (COVID19 recovery).	2	Cancer Clinical Programme Board Macmillan Next Steps Joint Service Lead

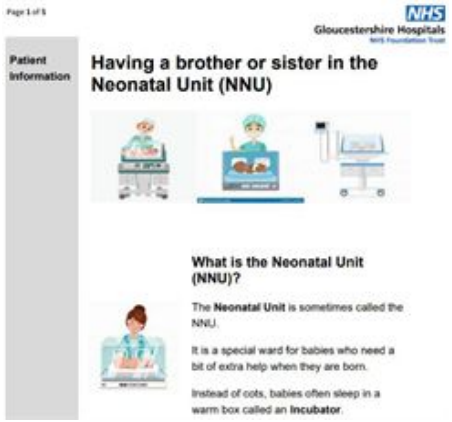
		The Gloucestershire ICS Cancer Programme oversees much of the work to increase early diagnosis rates and ensure identification of, and reduction in, inequalities: • Early diagnosis variation is associated with deprivation • Patients from the most deprived groups appear under-represented in Cancer Waits data. • Patients in the most deprived areas of Gloucestershire are more likely to wait longer than 2 weeks to be seen when referred with suspected cancer. • Cross-system data project to enable more detailed review of variation in early diagnosis. Programmes focus on ensuring timely presentation, faster diagnosis and operational improvement. Collaboration across the system, personalisation and effective two-way communication with communities aims to reduce barriers to equity. Non-Specific Symptoms (NSS) pathway launched as a pilot in 2022 has now been rolled out to all GP practices in Gloucestershire. Work is commencing to improve access to lung, pancreatic and colorectal cancer screening and treatment, and to reduce DNAs and late diagnosis in groups who experience health inequalities. There are plans in place to provide increased diagnostic capacity via both the Community Diagnostic Centre (CDC) and endoscopy business plans to meet the requirements for urgent suspected cancer. Priority diagnostic capacity for urgent suspected cancer is provided via both the CDC and releasing existing capacity as other activity is moved to the CDC. Committed approach to ensure timed pathways and pathway improvements are delivered across system. The key actions include: • Service Improvement Lead appointed with specific focus on Best Practice Timed Pathways (BPTP) improvement; focus on four priority pathways (prostate, lower GI, skin and breast).		

		• Pathway trackers to manage patients through the pathway have been appointed across the service to improve patient flow and data validation. • Promotion of GP decision tool and targeted education to help direct use of appropriate diagnostics. • Telederm pilot expected to enable achievement of timing milestones for skin cancer pathway. Macmillan Next Steps - specialist cancer rehabilitation programme provides accessible support for adults living across the county. **Translation and Interpretation (T&I) Services:** Each NHS organisation in One Gloucestershire commissions Translation & Interpretation (T&I) Services, which are available to patients' attending appointments in Primary Care, Acute and Community Services. We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners. This will enable: • Continuity of interpreter (where preferred) • Improved access to services • Collection of robust feedback from people in our communities • Improved staff training Our work with Gloucestershire Deaf Association has provided a better understanding of the number of British Sign Language users accessing health care in the county**.** We are working with voluntary sector partners to raise awareness of the Accessible Information Standard (2016) and develop mechanisms to ensure compliance across our system.	2	Equality Leads/Contract holders across each organisation

		Maternity Services The Local Maternity and Neonatal System (LMNS) Board has regular oversight of and monitors the national local maternity services dashboard. This brings together information from different data sources to track, benchmark and improve the quality of maternity services in Gloucestershire. • Maternity services, including Delivery Suite, Birthing Units, Community Midwives and Perinatal Mental Health Services are delivered in a number of locations in Gloucestershire • Current data shows the number of maternity bookings in Gloucestershire (2023/24 year to date) stands at just under 5,400. • 12.3% of all bookings are for women whose ethnicity is recorded as Black/Asian/Mixed. When combined with those whose ethnicity is recorded as White Other/White Irish/Other, this figure rises to 21.3% This is higher than the ethnic minority population in Gloucestershire, which according to the 2021 Census is 12.3%. We understand this difference is likely to be due to an increase in immigration since the 2021 Census, and note the rate from the Census data is an average across all age groups. If reviewing Census data for women of childbearing age (those aged 15-45 years), the rate of those from an ethnic minority is 17.7%, which is closer to our 'booking' rate. • The 'ethnicity at booking' data is recorded in our maternity and neonatal dashboard and is reviewed at the monthly LMNS Perinatal Quality and Safety workstream meetings. • 23.9% of all bookings are from women who live in the most deprived areas (IMD Deciles 1&2) of Gloucestershire. 14.7% of these women are booked with the Continuity of Carer team/pathway. The LMNS ensures that services are delivered in a way that meets the needs of people in the community. For example, the Birth Anxiety and Trauma Service (part of the Perinatal Mental Health team) and Perinatal Pelvic Health Service deliver aspects of their services within community settings. Continuity of Carer teams are based in geographical areas which were identified in an	2	Local Maternity and Neonatal System (LMNS Board)

		earlier needs analysis as being those where deprivation was highest, and/or had a high proportion of ethnic minority women and birthing people: • We carried out a maternity and neonatal 'Equity and Equality' population needs analysis in 2022, which consisted of an in-depth review of maternity and neonatal risk factors and outcomes. This identified key groups for whom risk factors and outcomes were poorest. This included those from ethnic minority communities, young mums, travellers, and those from the most deprived areas of the county - and we consequently identified a number of wards as priority areas for us. • Our Workforce Race Equality Standard data also indicated that staff from an ethnic minority community, working in the Women's and Children's division at Gloucestershire Hospitals Trust (GHFT), experienced race inequalities at work. This suggest there is scope for learning and improvement across the maternity pathway to support both our service users and staff. • The LMNS has established an EDI Workstream which has attendance from staff across the system, including representatives from health visiting, maternity, Public Health, the county council, Maternity and Neonatal Voices Partnership, Communications and Engagement. The workstream oversees maternity and neonatal deliverables (as directed by NHS England), as well as a number of other projects which identify inequality within our system and develop action plans to reduce these. • Gloucestershire Maternity and Neonatal Voices Partnership continually engages with women and birthing people, through face-to-face individual and group meetings, and through surveys, to ask for their feedback on the services. This feedback is shared with the LMNS through the Maternity Experience workstream, and actions are agreed on to make improvements. • Tackling Tobacco Dependency (TTD) offers support to pregnant women in Gloucestershire. All pregnant women are assessed at their first antenatal appointment (carbon monoxide assessment) to identify smokers and refer them to the Healthy Lifestyles Service (HLS) where they will be		

		offered a full programme of support. In 22/23, 93.6% of pregnant women received a CO test against a target of 95%.
		• Perinatal Mental Health Service offers:
		  – support in venues which are easily accessible through public transport and the Team base is centrally located close to the train and bus stations. Home visits are offered, based on the service user needs.
		  – Communication needs are assessed, recorded and acted upon.
		  – Service users offered a choice of appointments: Face to Face, virtual (via Attend Anywhere) or telephone is available, and we give service users the options to choose. Remote appointments are avoided when English is not the service user's first language.
		  – Carers/partners are invited to attend appointments, with consent from the service user.
		• Perinatal Emotional Health and Wellbeing pilot supports women with low/moderate perinatal mental health needs, and can support with issues around accommodation, drug and alcohol misuse and domestic abuse.
		• The 1001 days programme is targeted at expectant women and their families to improve/maintain healthier lifestyles including smoking cessation during pregnancy and up to the child's second birthday. It includes targeted engagement and communication with those from protected characteristic and inclusion groups to promote the programme. In 2022/23 81% of women that set a quit date were smokefree at 4 weeks.
		Access to information:
		• Expansion of patient information available in Easy Read as translated and reviewed by Inclusion Gloucestershire. Including the translation of ICON information
		• Information available on website to support LGBT+ users of maternity services
				Kim Tiffney, Perinatal Mental Health Team, Glos Health & Care NHSFT
				
				Head of Patient Experience, Glos Hospitals NHSFT

		• Information available on website in English and most commonly requested languages to support vaccinations in pregnancy: Arabic, Chinese; Polish; Punjabi; Romanian; Somali • Information available in easy read for children with siblings in the neonatal unit; both in printed and online formats.  Gloucestershire Hospitals NHS Patient Information **Having a brother or sister in the Neonatal Unit (NNU)** **What is the Neonatal Unit (NNU)?** The **Neonatal Unit** is sometimes called the NNU. It is a special ward for babies who need a bit of extra help when they are born. Instead of cots, babies often sleep in a warm box called an **incubator**. • A dedicated maternity playlist on YouTube Maternity - YouTube including tours of the departments, what to expect with certain procedures including caesarean section and induction of labour, support to tackle tobacco dependency and how to book in with the service. We have subtitling on the majority of the videos available and have translated some into other languages		

				
	1B: Individual patients (service users) health needs are met	**Cancer Services:** System-wide work to deliver the Cancer Operational Planning guidance 2022/23 has contributed to local action, including: • Faster diagnosis and operational improvement; e.g. Targeted focus on inequalities in prostate cancer aimed at increasing engagement in men over 45 from a black ethnic background, with family history of prostate cancer. • Early Diagnosis: Effective Primary Care Pathways. – Supporting Primary Care Networks (PCNs) to deliver the cancer early diagnosis DES requirements with a focus on improving early diagnosis in areas with high deprivation through improving their referral practice. – Updated information data packs provided to PCNs to support with Early Diagnosis of their population. • Early Diagnosis: NHS Cancer Screening – Working to identify the population groups with low screening uptake locally e.g. Actively developing opportunities to improve screening uptake in women from South Asian communities and in areas of deprivation.	2	Cancer Clinical Programme Board

		– Improving access to screening for people with Learning Disabilities and Autism by having a dedicated cancer screening support nurse. In addition to the Primary Care DES, PCN Quality Improvement Projects respond to local challenges, e.g: • **Inner City Glos PCN** – Cervical Screening: Addressing Health Literacy and Language Barriers. 52 languages spoken in the practice population. • **Cheltenham Central PCN** - Holistic/Health Inequalities Focused Cancer Early Diagnosis Health Education and Empowerment for Men and Women utilising Social Prescriber Support • **Hadwen & Quedgeley PCN** - Mens Health Awareness on Early Cancer Diagnosis • **Stroud Cotswolds PCN** - Best practice in use of direct access CT scans for early cancer diagnosis and early detection and screening. Support for difficult to access groups such as people with Learning Difficulties and refugees. **Macmillan Next Steps** - The service uses a multidisciplinary team to meet the needs of individuals through: • Use of MYCAW wellbeing tool - MYCaW® is an individualised questionnaire designed for evaluating holistic and personalised approaches to support people.		Primary Care Networks Macmillan Next Steps Joint Service Lead
		Translation and Interpretation (T&I) Services: Access to the T&I services available across One Gloucestershire services 24/7, 365 days. • Policies and procedures in place to ensure staff are able to access T&I support. • Reasonable adjustments made e.g. longer appointments, mobility, support for hearing and sight impairments. • Resources and leaflets about services translated and available on request. • Service users have the right to express their needs, requirements, opinions and views using their preferred language or communication style	2	Equality Leads/Contract holders across each organisation

		• Options for appointments include Face to Face, virtual (via Attend Anywhere) or telephone, including BSL language are provided
		• Translation of the appointment's letters are provided in preferred communication style or language.
		• New service specification for spoken language will:
		  – support requests for continuity of interpreter across organisations
		  – enable service improvement (re T&I) based on feedback from patients
		Accessible Information Standard: Working in partnership with VCS organisations to support awareness raising of communication needs for people with a disability, sensory or cognitive impairment.
		Maternity Services
		Our needs analysis identified groups and communities where outcomes were poorer, and also made recommendations about further work and areas of focus in order to reduce these health inequalities. This led to the development of our LMNS Equity and Equality action plan, in collaboration with the Maternity and Neonatal Voices Partnership (MNVP). This co-produced 5-year plan includes:
		• 2 Midwifery Continuity of Carer (MCoC) teams have been established to provide support in areas of high deprivation and ethnic minority communities.
		• A Quality Improvement project to develop and deliver an in-house maternity Treating Tobacco Dependency programme. The project will target pregnant women who smoke living in areas where smoking rates are highest particularly those living in Gloucester (CORE20); young mothers and those from more deprived neighbourhoods. Three Specialist Maternity Support Workers work as tobacco treatment and dependency advisors targeting pregnant women in these areas and specifically those who do not currently engage with the county wide community Stop Smoking service.
		• A Perinatal Emotional Health and Wellbeing pilot funded by the ICB and delivered by The Nelson Trust supports women with low/moderate
			1.5	LMNS Board; LMNS Equity Workstream; MNVP

		perinatal mental health needs, and can support with issues around accommodation, drug and alcohol misuse and domestic abuse. • Improving Perinatal Mental Health and access to these services, including in South Asian women and young mums. The South Asian women's group is currently being scoped, in a change to the previous provision. • Perinatal Equity and Equality Action Plan developed with a focus on mothers from more deprived areas and ethnic minorities, young mothers and Traveller communities • A young mums' support group is delivered by Forest Voluntary Action Forum (FVAF), who has identified the needs of the young people and encourages social inclusion, helps build confidence, learn new skills and increase parenting social circles. • A Quality Improvement project for an Infant Feeding app, 'Anya', to support those in areas where breastfeeding rates are lower (Gloucester and the Forest of Dean). This project will be evaluated in collaboration with the West of England Health Innovation Network • Improving access to translation and interpreting services with development of lanyards and pocket-sized information cards to support clinical staff to access interpreters easily. • Cultural competency training and Black Maternity Matters anti-racist training delivered to staff across the LMNS including a bespoke senior leaders' programme. This programme supports quality improvement to improve experiences for black and Asian women accessing maternity and neonatal services eg. silk bonnets available on delivery suite for women with texturized hair. • A Quality Improvement project to review current antenatal pathway and scan capacity to ensure it meets the additional needs of women from specific ethnic minority communities. This work has included a review of the use of interpreters within antenatal settings. • Audit undertaken on the documentation of communication needs of women. Audit also identified uptake of interpreting services within the antenatal, intrapartum and postpartum periods. Recommendations		

		relating to better recording of women's needs and improve availability of interpreters have been identified and improvement work is being developed in response. This includes work to increase the recording of ethnic group to meet the 95% compliance target. • Joint maternity and neonatal reviews of all admissions to the neonatal unit of babies equal to or greater than 37 weeks (ATAIN) to identify whether separation could have been avoided. • Improved access of the transitional care unit to support families of babies cared for in NICO. Further work is being planned to: • Improve access to antenatal education through online education, translated into a number of different languages, to support those unable to access other antenatal education provision • Data analysis for those who book 'late' (after 12 weeks of pregnancy) to see if any work can be done to reduce this rate Perinatal Mental Health Service: • Offers an individual initial assessment and person-centred care plan based on individual needs and delivered collaboratively with them. • Each service user is allocated a lead Health Care Professional who is responsible for care plan. • Care is supported through Multi-disciplinary Team meetings, caseload review meetings with lead Health Care Professional, reflective sessions, and safeguarding supervision sessions. • Clinicians work closely with other agencies/voluntary sectors and maintain good communication to ensure that safe and good quality of care is provided and to maintain the continuity of care.		Kim Tiffney, Perinatal Mental Health Team, Glos Health & Care NHSFT

	1C: When patients (service users) use the service, they are free from harm	**Cancer Services:** Gloucestershire residents are able to access high quality, safe healthcare. The Care Quality Commission has rated both main providers as 'Good'. In Primary Care settings, residents can also access good quality GP services, most of which are rated as either 'Good' or 'Outstanding'. • ***System Safety Group** established to**:*** – *Oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level;* – *Help the system by being proactive;* – *Include digital safety;* – *Inspire safety culture across the ICS;* • Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy. • Embedded through Professional Registration, Staff mandatory training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour. **Translation & Interpretation Services:** • Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients. • DATIX reporting reviewed and actioned. • Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement. • One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety. • Translation & Interpretation Delivery Group will have oversight of the re-procured service, providing more scrutiny of the service.	2 2	ICS System Safety Group

		Maternity Services: • Local Maternity and Neonatal System receive regular updates on quality and safety, including the quarterly Perinatal Quality Surveillance and Safety Report. This report provides detailed information on emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. It reflects actions in line with Ockenden Report and progress made in response to any identified concerns at provider level. • Maternity and Neonatal safety champions in post and meet bi-monthly, undertaking walkabouts of key areas of focus. They provide visible leadership and promote safe, personalised care, share learning and best practice from national research, local investigations and initiatives. • DATIX reporting – a daily review of all incidents rated moderate harm+ takes place to ensure we are responding to any potential safety concerns in a timely way. In addition, the introduction of hot and cold de-brief post incident to support staff health and wellbeing • Twice weekly MDT meeting to review incidents. • We have strengthened the quality and safety reporting both internally and externally to support an increase in learning from our incidents and patient feedback	1.5	Clinical Quality Assurance Group Local Maternity and Neonatal System Board

NHS Gloucestershire Hospitals NHS Foundation Trust

Level 3 Safeguarding

	Band 2 and 3		Band 5		Band 6 and above		Junior Drs	Consultants	
	New starters	Current	New Starters	Current	New Starters	Current	New Starters	New Starters	Current
Component 1 Complete level 1 and 2 eLearning (for anyone needing Level 3, this is a once-only in your career)	During induction	Complete every 3 years	During induction	Complete ASAP if not completed within induction	During induction	Complete ASAP if not completed in Induction	Within first 3 months	During induction	Complete as soon as possible if not completed
Component 2 GSCP Interagency day (Level 3) (this is a once-only during employment at GHT)	n/a	n/a	During induction	Within next 3 months if not completed during induction	During induction	Complete Interagency day if not already completed	Within first 3 months	During induction	If not completed during induction
Component 3 GSCP module library (for midwives this is 4 hours of modules yearly)	n/a	n/a	4 hours within 3 months of starting in post	Complete 4 hours of GCSP modules	4 hours within 3 months of starting in post	If all other components completed, please complete 4 hours of GSCP modules every year	8 hours within Initial 3 months	Complete 8 hours of modules of your choice from the GSCP site within the first year	Complete 4 hours each year from the GSCP site
Component 4 Maternity day	n/a	n/a	1 hour	1 hour completed before uplift to Band 6	1 hour	n/a	n/a	n/a	n/a
Component 5 Reflection (complete self-declaration when completed)	n/a	n/a	3 hours	3 hours prior to uplift to Band 6	3 hours	n/a	n/a	n/a	n/a
Total Hours/Year			16 hours	16 hours	16 hours	12-16 hours over 3 years	16 hours during 4-12 months	16 hours	12-16 hours over 3 years

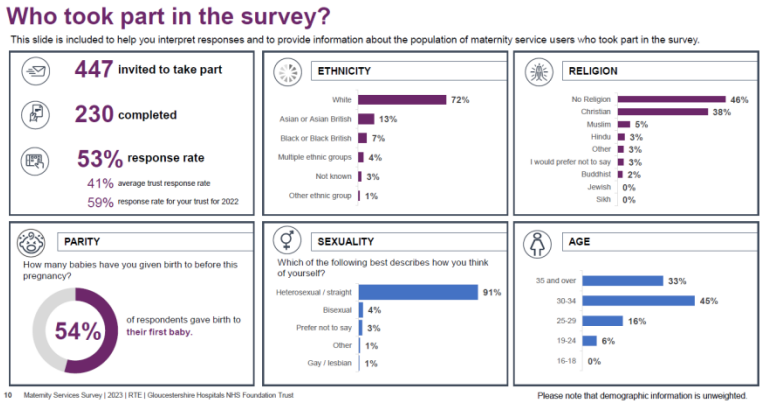
- We have enhanced our safeguarding children training.
- We have a dedicated ‘high risk’ midwife.
- Increase staffing both midwifery and obstetric.
- Named midwife – safeguarding expanding the vulnerable women’s offer for young mums under the age of 18, to include 18-20 year olds.
- Widened access routes and more structured approach to the Debrief Pathway for women who experience Birth Trauma.
- As part of the Black Maternity Matters collaborative (a co-produced project to improve the care of Black women in the Southwest Region), Gloucestershire LMNS are taking part in an anti-racism, quality improvement education and training programme examining a range of topics including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women.
- The LMNS has funded Cultural Competency and Awareness training which was rolled out to approximately 120 staff across the LMNS, the majority of whom were from maternity services at GHFT.

		• Training films are being developed in collaboration with Maternity and Neonatal Voices Partnership for mandatory training to be rolled out to professionals systemwide in 2023/24, to raise awareness of vulnerable pregnant women and services available to support women and professionals. • One Gloucestershire statutory partners are working together to have one provider for Interpreting and Translating services across the ICS. As part of their Health Inequalities Fellowship, a midwife at GHFT has created a visible quick guide to booking an interpreter and increased awareness and uptake of the service. • GHFT are celebrating Black History Month with events dedicated to showcasing the work of pioneering black women in health care. These include screenings and discussions about the importance of Black History Month, Allyship and being an anti-racist organisation. • All qualifying HSIB/ MNSI and NHS Resolution's EN scheme reportable cases have been reported with all families receiving a letter informing them of any investigations in line with Regulation 20 of the Health and Social Care Act 2008 in respect to duty of candour. • Perinatal Mental Health: – Informed consent to share and treatment obtained from service users. – Regular safeguarding supervision sessions – Risks assessments carried out prior to appointments and expected to update regularly and whenever there is a change in presentation or risks. – Follow information governance and trust incident report. • Complaints and Serious incidents are recorded and analysed.		Kim Tiffney, Perinatal Mental Health Team, Glos Health & Care NHSFT

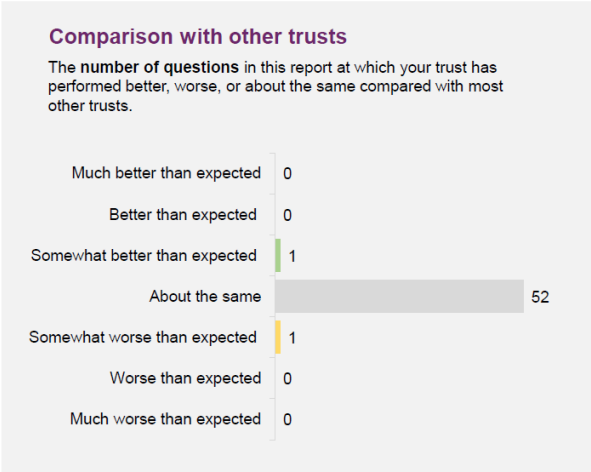
	1D: Patients (service users) report positive experiences of the service	**Cancer Services:** Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities. • Patient experience information gathered through engagement is reported back to service leads and system partners. • Patient Experience data is gathered, monitored and acted upon: - National cancer survey – high levels of satisfaction reported, although limited analysis by protected characteristics possible due to small numbers involved - Patient experience data gathered via Friends and Family Test (FFT) – demographic data capture extended to provide greater breakdown of ethnicity; disability; carer - Programme evaluation/wellbeing measures (PROMs) gathered via Macmillan Next Steps • Working closely with ICB Insights Manager to build relationships with local communities and groups, including plans for engagement work and cultural competency training for staff supporting events. • Public awareness campaigns involving the Cancer Patient reference group and local charities such as Maggies, Focus, Charlies and Macmillan. Aims to reduce stigma and fear about Cancer and encourage informal opportunistic conversations in a safe space. • Targeted campaigns include: – Prostate cancer risk and awareness event with the African Caribbean Community. – Breast Cancer Awareness Events utilising the Information Bus with support from nurses, screeners, Macmillan Next Steps, Macmillan Information Hub and the Community Outreach Worker in Gloucester City. The events targeted deprived communities, ethnic minority communities (prevalence of late-stage diagnosis), the homeless community and the LGBT+ community. – Friendship Café event for the Asian women's group.	2	Cancer Clinical Programme Board Macmillan Next Steps Joint Service Lead Patient engagement and experience leads

		– Bartongate Children's Centre event - female Afghani refugees, with support from GARAS. – All Nations Health and Wellbeing event attended by Prostate and Breast Nurses. – General awareness, risks and prevention with Nepalese soldiers – Patient Participation Group Network -highlighting focus of work to support earlier diagnosis across the county. **Translation & Interpretation Services:** • We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners. This will enable: – Continuity of interpreter (where preferred) – Improved access to services – Collection of robust feedback from people in our communities – Opportunity to promote service to local communities – Improved staff training • Negative feedback from Clinical Teams is collated by Contract leads and discussed at regular contract meetings, but this is predominately about the process/difficulties associated with securing the interpreter or specific language, rather than patient experience of the service. • Gloucestershire Health and Care NHSFT are in the process of introducing a QR code, so that when an appointment has taken place, the Deaf client will receive a text so they can send back some feedback. • Working with Inclusion Gloucestershire, Gloucestershire Hospitals NHSFT have reviewed patient information leaflets and agreed which should be translated into Easy Read. Information to support patients in Shared Decision Making has been included on the back of each leaflet.	1	Equality Leads/Contract holders across each organisation

		Maternity Services: • As part of the Local Maternity and Neonatal System (LMNS) Equity and Equality action plan and in collaboration with the Maternity and Neonatal Voices Partnership (MNVP), engagement is being carried out with women, communities, and organisations with a view to coproducing interventions, e.g a working group has been set up in the Forest of Dean focussing on the requirements of Romanian women. Roadshows are planned in Cheltenham and Tewkesbury aimed at Health Visitors and Midwives to understand challenges around maternity care and suggested solutions. • Introduction of Maternity and Neonatal Experience Group created to ensure that experience data (including FFT, National Surveys, PALS) is reviewed and responded to. MNVP are members of this group. This group reports to Maternity Delivery Group and up to Quality and Performance Committee, a sub-committee of Trust Board • Feedback received via the MNVP is regularly reported to LMNS Board. • All national surveys, FFT and PALS insight is reported monthly to Quality Delivery Group, through to Quality and Performance Committee through to Trust Board by exception. • National Maternity Survey 2023 data gives us information about who, based on demographic data.	2	LMNS Board; Head of Patient Experience, GHNHSFT; Maternity and Neonatal Experience Group



- Gloucestershire scored ‘about the same’ as other Trusts nationally in all sections of the survey. The breakdown against question is below



- The FFT data for maternity services through 22/23 and the overall Trust score is below

Care type		Q1	Q2	Q3	Q4	2022/23 Total
Maternity	Total Responses	213	209	228	263	913
	Positive score	83.6%	88.1%	88.2%	87.4%	86.9%
Trust	Total Responses	18,118	19,536	16,346	23,992	77,992
	Positive score	87.7%	89.2%	88.5%	92.4%	89.7%

- Patient stories are shared at Trust Board and these have included both maternity and neonatal stories.
- Introduction of a dedicated survey to understand the experiences of those accessing our Early Pregnancy Assessment Unit
- Introduction of telephone relay service for those women, birthing people and partners to make contact with our PALS team when English is not their first language.

Perinatal Mental Health:

- Friends and family test feedback regularly reviewed and reported.
- Feedback for group interventions is sought and evaluated.
- Core 10 Outcome measures are used. (Likely changing to Dialogue in line with Transformation of wider mental health services in the Trust.
- Positive feedback to clinicians is reported on Datix compliments.
- The service runs an Experts by Experience Meeting bi-monthly to seek opinion and opportunities for improvement.

Kim Tiffney, Perinatal Mental Health Team, Glos Health & Care NHSFT

Domain 1: Commissioned or provided services overall rating	8	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• The ICB has supported a range of health and wellbeing projects and initiatives over the year (2023-2024) including: • Staff health checks (MOTs) available to all ICB staff and widely promoted via the staff bulletin, wellbeing day and weekly emails. The health checks include an assessment of blood pressure, cholesterol, HbA1c (diabetes check) BMI, and a discussion with healthy lifestyle coach. Approximately 100 health checks were carried out in 2022-23 financial year and further 12 health checks during 2023-24 financial year. There is some funding left to offer this service to new starters in 2024. • Blood Pressure Checks are available to ICB staff and other NHS staff from January 2024 at Gloucester Cathedral. The ICB has been publicising that clinicians are offering blood pressure checks and talking to people about simple changes they can make to lead healthier lifestyles BP checks at Gloucester Cathedral : Intranet – NHS Gloucestershire (nhsglos.nhs.uk). • Women's Health Day was arranged on World Menopause Day 18th October 2023, providing free sessions on nutrition, exercise – Pilates and cardiovascular exercise and the Menopause information session was led by Consultant Gynaecologist Dr Vellayan (GHFT). • MSK session – a physiotherapy session was arranged for staff on 10th January 2024 to address the staff feedback obtained via the staff survey. The session concentrated on raising awareness of MSK's/Ageing Well and the management of conditions; the ICB publicises how staff can self-refer to the Glos Physiotherapy service and includes information such as How can I help myself if I have pain? (gloshospitals.nhs.uk)	2	Christina Gradowski Associate Director of Corporate Affairs

		• Promote hybrid working and office furniture grant; in the Autumn of 2023 the ICB moved office premises to Shire Hall allowing the ICB to further promote its hybrid working approach, office furniture grant scheme and workplace set up in Shire Hall. All these interventions are designed to help staff manage work and home life better and support them when working in predominantly sedentary jobs. There has been information in the Staff Briefings on MSK conditions, DSE assessments via Robert Hall and ergonomic chairs, hand rests and mouses as well as standing up desks in Shire Hall. There have been health and wellbeing sessions on improving staff mobility during the working day – guidance for those who Chair and organise meetings to ensure there are proper comfort breaks during long meetings and promoting walking at lunchtime and around the offices (see Staff Handbook). • Health & Wellbeing policies have been developed including the Drugs and Alcohol Policy, Physical Activity Policy and Menopause Policy with a range of resources available and communicated to staff via the weekly staff briefings that are emailed out to all ICB staff. • Reasonable Adjustments policy, Health Passport and Guidance was developed in 2023. As part of the Reasonable Adjustments policy it was recognised that those staff members with disabilities / long term conditions may need additional time off work to attend specialist appointments and meetings for equipment, treatment and or benefits; therefore disability leave of up to 5 days in a 12 month period was introduced to allow staff that time. • **Intranet resources** and blogs cover Women's Health, Alcohol and Drugs, Mental Health including ○ Susan's wellbeing blog: join me for Dry January : Intranet – NHS Gloucestershire (nhsglos.nhs.uk)		

		○ Women's Health : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) ○ Zero Suicide Alliance (ZSA) ○ Mental health support for staff : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) • **Publicity and training** was provided to managers to understand the Flexible Working policy and how to manage staff sickness Line Manager training: supporting attendance and managing absence : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) • **Managers training on Health and Wellbeing** was delivered by Susan Doran in 2023 and was designed to help line managers become more aware and skilled in dealing with staff health and wellbeing issues. Several sessions were organised during the past 12 months. • **Time To Talk** Wellbeing Champions were briefed to raise the Time to Talk initiative at their Team meetings during February and March with links to resources provided, and to consider staff who live alone and work from home who may experience loneliness and isolation. • **Wellbeing Newsletters** were produced on a range of topics including Stress, Mental Health, MSK, diet and exercise and financial wellbeing amongst many other topics; these topics are now being embedded in the weekly Staff Briefing sent out on Friday via email. • **Healthy Eating** is a topic covered in a variety of newsletters and staff briefing articles over the last 4 years. Diet and Nutrition is highlighted in articles on Cancer, Diabetes, weight management. Other topics include eating seasonally available foods, which included the provision of fruit or lunches. Further topics have included, Salt Awareness Week, Eating Disorders and the importance of a varied and balance diet for gut health – the		

		microbiome at the full Staff meeting in January 2024. Information on healthy eating is available on the staff intranet. Health and Wellbeing : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) • **The 'Healthy Eating, Smart Meeting'** guidance has been developed as a statement of intent and is available on the staff intranet. This information was incorporated into the Staff Handbook in 2023 with clear instructions on ordering healthy and sustainable lunches for ICB meetings p35 Staff Induction and Handbook : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) The ICB has trained 15 staff as Mental Health First Aiders • The ICB is accredited as a Disability Confident Employer and Mindful Employer. • The ICB Appraisal process includes a discussion during the appraisal of staff health and wellbeing and signposting to resources. • Publicity about pension seminars to staff has been communicated specifically targeted at the older workforce in preparation for retirement. A retirement session was held with CHC staff in September 2023 to highlight the new pension rules on partial retirement and retire and return. • The ICB specifically employs a Health and Wellbeing Consultant to work 2 days a week to develop and promote wellbeing policies, resources and communications. • **Staff Survey H&WB Results 2023 compared to 2022** In 2023 more of our staff completed the staff survey than the previous year with 77% of staff employed by the ICB responding to the survey compared to 74% in 2022. It should be noted in the		

		following section detailing results from the staff survey, where scores are below 10 they are not reported due to data protection. In last year's report we detailed a range of staff survey results on wellbeing and identified themes from the findings. A key theme was staff burnout a range of actions were taken seeking to address this. Below shows some mixed results with comparable results to 2022 and improvements in 2023. **Staff Burnout comparison 2023 to 2022** • 2023, 88% of staff satisfied with opportunities for flexible working patterns compared to 85% in 2022; improvement in this score. • 2023, 76% of staff reported that the organisation is committed to helping balance work and home life; same score in 2022 – 76%. • 2023, 63% of staff have in last 12 months, not felt unwell due to work related stress, compared to 67% in 2022; improvement in this score. • 2023, 33% of staff never/rarely find work emotionally exhausting; compared to 32% in 2022; slight improvement in this score. In 2023 the five areas with the most improved scores from the previous year is represented in the table below		

Most improved scores	Org 2023	Org 2022
q14d. Last experience of harassment/bullying/abuse reported	52%	42%
q12b. Never/rarely feel burnt out because of work	44%	39%
q4d. Satisfied with opportunities for flexible working patterns	88%	85%
q12e. Never/rarely worn out at the end of work	29%	26%
q4c. Satisfied with level of pay	52%	49%

For the forthcoming year 2024 we have identified the following H&WB themes

Managers supporting staff with H&WB

- 2023, 87% of staff can approach immediate manager to talk openly about flexible working compared to 88% in 2022; slight deterioration in score.
- 2023, 84% of staff reported that their immediate manager takes a positive interest in my health & well-being; compared to 86% in 2022; deterioration in score.

Organisation supporting staff with H&WB 2023, 78% of staff confirmed that the organisation takes positive action on health and well-being; compared to 83% in 2022; deterioration in score.

		MSK 2023, 79% of staff have in the last 12 months not experienced musculoskeletal (MSK) problems as a result of work activities; compared to 82% in 2022. ***Reasonable adjustments*** 2023, 83% of staff reported that the organisation made reasonable adjustment(s) to enable them to carry out work; compared to 93% in 2022 a significant deterioration in score. **Gloucestershire Healthy Workplace Award** This is a local award which recognises employers commitment to the health and wellbeing of its employees. The ICB was awarded the Healthy Workplace Award Level 1 in 2021 and the Advanced Award in 2022.		
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• The ICB has updated its policies on Harassment and Bullying. • Managers training on Harassment and Bullying was provided in 2022 by the CSU HR Team. • Training provided to all staff on building a culture of conscious inclusion; sessions were designed for managers 8A and above and for staff in bands 7 and below. The Commissioning Support Unit ED&I specialists delivered the training throughout 2023. Feedback and evaluation on the training has been received. • ICB has a Whistleblowing and Freedom to Speak Up Policy with an induction session on FTSU as well as slots at the Staff Meeting. There are now two FTSU Guardians who are trained at the ICB and a lead NED for FTSU. • The ICB introduced a Zero Tolerance of Abuse of NHS Staff Policy in 2023 with reporting forms and a dedicated incidence box.	1	Christina Gradowski Associate Director of Corporate Affairs

		• ***The ICB offers Restorative supervision*** for clinical staff at the ICB either group or 1:1 available from Professional Nurse Advocate's (PNA). • ***The ICB is a signatory to the Sexual Safety in Healthcare Organisational Charter*** Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. NHS Gloucestershire ICB Board agreed on the 10 principles and actions to achieve this, at its September 2023 board meeting. • A compassionate leadership workshop was held with senior managers in March 2023 and a compassionate leadership intranet page has been produced with a range of resources for staff. **Staff Survey 2023 WRES data** ***Survey results reported are for Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups (BM & other ethnic groups) and White staff.*** • Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months was 8.7% for black, minority (BM) & other ethnic groups compared to 10.2% for white staff, with the organisation average at 10%; in 2022 it was 0.0% for BM & other ethnic groups compared to 9.3% for white staff. This is a deterioration of scores overall but particularly for our BM & other ethnic staff; it could well be that in 2022 the numbers of BM & other ethnic groups reporting harassment, bullying or abuse were low and below the threshold for reporting (set at 10 responses by Picker) or there was a		

		reluctance to report or both reasons contributed toward the lack of reporting. • Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was 17.4% for BM & other ethnic groups which was greater when compared to 12.2% of white staff and the organisational average was 12.7%; in 2022, the scores were 17.6% for all BM and other ethnic groups compared to 10.9% of white staff. • Percentage of staff experiencing discrimination from staff in last 12 months was 13.6% of BM & other ethnic groups compared to 3.8% of white staff, the organisational average was 4.4%. **WDES data** • Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues was 28.1% compared to 18.1% staff; the organisational average was 20.5%. Compared to 2022 where staff with a long term condition (LTC) 11.7% greater than staff without a LTC 7.8% but better than the average for staff with a LTC 10.7% • Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was 45.5% compared to 56.8% with the organisational average as 51.7%. Compared to 2022 for staff with a LTC it was 31.3% compared to staff without a LTC which was 44.4% and worse than the average for staff who have a LTC 40.9%. • Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties		

		22.4% compared to 8.6% and the organisational average was 14.6%. • Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work was 83% in 2023 and has significantly deteriorated from a score of 93% in 2022. **Staff Survey findings sexual behaviour at work** 2023 was the first-time questions were included about unwanted behaviour of a sexual nature at work. Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public. The overall response rate to this question was 99% confirmed that they had not experience unwanted behaviour of a sexual nature. Not experienced unwanted behaviour of a sexual nature from other colleagues. The overall response rate to this question was 98%. In 2021 a new question was introduced into the staff survey Feel the organisation respects individual differences; in 2021 and 2022 the score was 85% in 2023 it reduced to 81% which was still significantly above the national average for ICBs of 71%.		
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	The ICB has a range of resources and procedures in place to support staff as follows: • Flexible working policy to help staff achieve a work-life balance. • Leave and Other Leave policies including Disability Leave. • Additional Leave procedures and process whereby staff can purchase additional leave for 2023-24 57 staff have exercised	1.5	Christina Gradowski Associate Director of Corporate Affairs

		this choice with 70 staff taking additional leave in 2023-24 financial year. • Newsletters and communications around managing stress and encouraging a work-life balance. • Wellbeing days for staff to help them manage stress and promote wellbeing. • Training delivered on Building a Culture of Conscious Inclusion. • The ICB provides a range of employee support to help staff manage their health conditions including the Occupational Health Service – working well; the Employee Assistance Programme provided by Care First and the Gloucestershire Wellbeing Line. All three resources listed above are independent and provide advice and support to staff experiencing bullying and harassment, any physical violence and stress be that at work at home or both. Resources are promoted via the Corporate Induction, Health and Wellbeing intranet pages, ConsultHR portal, weekly Staff Bulletin. **Staff Survey** • In 2023 68% of staff *feel safe to speak up about anything that concerns me in this organisation* which is better than the national average for ICBs of 60%, However in 2022 it was 76.6% equivalent to the 'Best'		

	2D: Staff recommend the organisation as a place to work and receive treatment	In 2023 57% of Glos ICB staff reported If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation, this is above the national average 48% but has significantly decreased from 2021 with 71% of ICB staff reporting favourably on this question. However, 77% of Gloucestershire ICB staff reported that the care of patients / service users is my organisation's top priority in 2023 compared to the national average of 67%. 2019 2020 2021 2022 Glos ICB - **62.5%** **68.8%** **71.0%** **58.0%** Best - 88.6% 85.7% 88.5% 65.3% Average - 61.5% 66.0% 61.8% 53.6% Worst - 28.6% 30.9% 37.7% 35.7% It is evident that Gloucestershire ICB has positive scores in relation to recommending the ICB as a place to work compared to the national average however there has been a dip in scores between 2021 and 2022 and a further dip in 2023 to 75% but still compares well to the national average which is 52%. 2019 2020 2021 2022 Glos ICB - 75.9% **81.4%** **82.7%** **80.6%** Best - 95.7% 95.5% 94.5% 80.6% Average - 65.1% 71.0% 67.4% 62.1% Worst - 29.8% 42.9% 45.4% 39.6%	1.5	Christina Gradowski Associate Director of Corporate Affairs
Domain 2: Workforce health and well-being overall rating			6	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**EDI Objectives for all Board members** In line with the national EDI improvement plan all ICB Board members will have an EDI objective by March 2024. **Training & Support for Staff** 1. We have run a 2nd cohort of the Reciprocal mentoring programme - matching staff from a range of services and with different protected characteristics with Senior Managers to become co-mentees for a 6 month period • Cohort 1: 22 pairs, including 13 Executives & Non-Executive Directors • Cohort 2: 17 pairs, including 6 Executive & Non-Executive Directors 2. ***We have run a 2nd Cohort of the Inclusive Allies programme:*** • 107 staff from Public sector organisations across Gloucestershire participated in the 2nd Inclusive allies programme during 2023 3. ***Training for ICB employed staff*** • We commissioned cultural awareness training for ICB staff (72% of staff completed the training). Providers across the system has also run specific EDI training for their staff.	1.5	

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**<u>Board, Strategy & Committee meetings:-</u>** 1. We continue to ensure that health inequalities are regularly discussed at ICB Board meetings – a recent desk top review of agendas and meeting papers showed that there are frequent discussions on health inequalities. • 2 specific topic items and 15 separate references to EDI/Inequalities as part of the non-standard Board items across Public and Confidential sessions • 5 Patient Stories (every meeting apart from extraordinary Board). • Health Inequalities clearly referenced in Board Assurance Framework 2. A dedicated EDI development session for Board members took place in October 2023 3. The People Committee recently reviewed the Workforce Race Equality Standards which show the different experience of staff from Black and Minority ethnic backgrounds in relation to discrimination, bullying and harassment as well as the representation and disparity ratio between staff at different grades. This is an area for further focus in 2024/25.	1.5	

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**Tools to Support Staff across the system** GCC colleagues have launched the Prevention & health Inequalities hub. The hub is an online compendium of information, resources, and practical tools to help people to better understand and take action to improve health equity in their areas of work. It includes tools such as: • Health Equality Assessment Tool (HEAT) • Health Equity Audit (HEA) • Health Impact Assessment (HIA) The Hub can be found here: www.gloucestershire.gov.uk/PHI-Hub The ICB Board considered a draft Inequalities Framework at its February development session	2	
Domain 3: Inclusive leadership overall rating			5	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Staff Partnership Forum	**Independent Evaluator(s)/Peer Reviewer(s):** Working with People & Communities Advisory Group Maternity and Neonatal Voices Partnership

EDS Action Plan	
EDS Lead	**Year(s) active**
EDS Sponsor	**Authorisation date**

EDS Organisation Rating (overall rating): 19

Organisation name(s): NHS Gloucestershire ICB

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Reduce health inequalities and provide equity of access.	• Further data analysis is underway for cancer services to improve identification of variation and link further datasets to improve data quality. • Initial plans have begun to implement the Multi Cancer Blood Test Programme. Patients aged 50 to 77 will be identified through NHS records and invited to give a blood sample that has the potential to detect multiple types of cancer. Six sites have been identified across the county to provide more local access for tests. • Work to provide consistency and clarity of the maternity offer for labour and delivery.	
	1B: Individual patients (service users) health needs are met	Ensure equity of access	Review compliance with the Accessible Information Standard and ensure: • additional training and support for staff • sharing of information across the system via the Joining up your Information (JUYI) system;	

	1C: When patients (service users) use the service, they are free from harm	Understand our data and identify inequity.	• Ensure the systems in place to assure safety are embedded across the maternity pathway. • Further improvements are made to equality data recording, in order to achieve consistency.	
	1D: Patients (service users) report positive experiences of the service	Collect feedback on our Translation and Interpretation Services.	• Establish mechanisms for gathering patient experience of translation and interpretation services and explore innovation in improving access and visibility of the service. • There is excellent engagement work undertaken, but further improvements to equality data recording will assure there is a consistently good patient experience is reported across all protected characteristics.	

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• To increase positive scoring in staff survey of managers supporting staff with their health and wellbeing. • To increase positive scoring in staff survey that the organisations supports staff H&WB • To decrease the % of staff reporting MSK problems via staff survey • To increase % of staff reporting positively that the organisation made reasonable adjustment(s) to enable them to carry out work (via staff survey)	• A H&WB survey will be sent out to staff to gather ideas to improve staff health while at work in spring 2024 with a focus on protected characteristics. • Dedicated H&WB sessions involving managers and ensuring managers are aware of the Reasonable Adjustments policy, Health Passport and Guidance • Further physiotherapy sessions dedicated to tackling MSK issues • Publicising the resources available to staff for hybrid working and ensuring staff have access to DSE assessments and ergonomically designed chairs, hand and wrist gel rests etc	May 2024 July 2024 Sept 2024 May 2024
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• To decrease the % of BME staff that report bullying, harassment and discrimination from patients, service users, colleagues and managers as measured by the staff survey • To decrease the % of disabled staff that report bullying, harassment and discrimination from patients, service users, colleagues and managers as measured by the staff survey • To decrease the % of staff that report that they have experienced unwanted behaviour of a sexual nature from patients / colleagues / Managers as measured by the staff survey	• Continue to publicise the ICB's policies on bullying and harassment; Zero Tolerance of Abuse of NHS staff • To relaunch Civility Matters campaign and publicise this at directorate meetings • To work with system partners across the ICS on bullying and harassment reviewing what works and learning from best practice • Further work will be undertaken on wellbeing initiatives that are targeted to protected characteristics; a special session on domestic abuse and supporting staff by GDASS will be organised for the spring 2024.	April 2024 April 2024 March 2024 June 2024

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• To increase the % of staff positively reporting that they feel safe and supported to report incidents and or concerns as measured by the staff survey	• Further work will be undertaken to raise awareness of the range of staff support resources such as the Wellbeing Line, OH Service and EAP service through the Staff Bulletin, Team meetings, Staff Meeting, SPF meetings and ensure that resources are fully accessible on the new ICB intranet. • Further training will be provided on FTSU with the e-learning to be included on ESR and made mandatory for all staff to completed the training • Further publicity to be arranged on our FTSU Guardians their roles and the protections staff have by raising a concern under the ICB's FTSU policy.	April 2024 onwards July 2024 April 2024 onwards
	2D: Staff recommend the organisation as a place to work and receive treatment	To increase the % of staff who would recommend the organisation as a place to work and receive treatment as measured by the Staff Survey	The staff survey has been analysed with key themes that have been identified as improvement themes including: • Appraisals and the value they have to staff – further training and support provided to staff to link with career development and trialling the Scope for Growth model • Wellbeing – burnout and stress, and managers supporting staff with their wellbeing a detailed plan for 2024-2027 on wellbeing is being developed and shared with our Staff Side • Updated policies will be worked on during this year to take account of the national policy work being undertaken including Flexible Working, Flexible Retirement, Maternity / Paternity Leave etc • System wide work on ED&I focusing on bullying and harassment, recruitment and career development	April 2024 onwards May 2024 May 2024 onwards March 2024 onwards

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To further enhance Board members awareness and understanding of equality and health inequalities, creating confident and competent Board members.	To provide learning and development opportunities for Senior leaders e.g. Inclusion Allies and Reciprocal mentoring	Quarter 2 onwards 2024/25
			All Board members to have an EDI objective and assessed as part of the annual appraisal process	March 2024 (for objective setting)
			To hold a further dedicated Board development session on WRES and action planning.	Q3/4 2024/25
			To include health inequalities as part of topics within proposed senior leadership conference	June/ Oct conference dates (TBC)
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To provide clear evidence that the ICB is embedding its approach consideration of health inequalities in all service improvement activities	To work with the PMO to collate best practice, case studies and health equality impact assessments.	End of Q1 2024/25
		To ensure the risks are managed as part of our core governance processes	Continue to monitor risks through ICB Board Assurance Framework	On-going throughout 2024/25

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To improve visibility of the ICB's progress and performance on health inequalities	To finalise Board approval of the Health Inequalities Framework. To ensure Board oversight of progress through regular review of the health Outcomes Framework comparing Gloucestershire both nationally and to our peer group comparator. To publish key evidence and progress through our website, annual report and other fora.	June 2024 On-going throughout 2024/25

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**One Gloucestershire Joint Forward Plan 2024-2029**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting	Describe the prior engagement pathways this paper has been through:						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Operational Executive (update and approve approach)	09/01/2024	GHFT DOAG, TLT and Board	01/02/24, 20/02/24 14/03/24			
	ICS Strategic Executive (update and approve approach)	18/01/24 & 15/02/24	GHC Executive (please note GHC Board will review on 28th March).	21/02/24 & 28/03/24			
			Health & Wellbeing Board (for endorsement)	19/03/24			

			Healthwatch Readers Panel (reviewing the main JFP for accessibility)	18/03/24			

Executive Summary	ICBs and their Partner Trusts have a duty under the Health and Care Act 2022 to develop 5-year Joint Forward Plans (JFPs) before the start of each financial year. One Gloucestershire's first JFP was developed and published in July 2023. This Joint Forward Plan (2024-2029) sets out our renewed commitment to the delivery of the ambitions within the Integrated Care Strategy. This Plan is formed of a main document (reflecting our 10 Strategic Objectives) and an Appendix that sets out, for each of our ICS Transformation Programmes, an overview of what has been achieved in 2023/24 and future plans. There have been some significant achievements in 2023/24. For example, over 130 schools are now being supported through teams to assist with mental health and wellbeing, our newly opened Community Diagnostic Centre will be supporting an extra 80,000 diagnostic appointments a year and we will shortly be opening the new Forest of Dean Community Hospital that will be the first NHS net zero community hospital in England. Our plan also describes our commitment to improving healthcare services – with a particular focus on prioritising prevention and early intervention whether for people with physical or mental health needs as well as improving health equity in access, experience and outcomes for our local population. These ambitions are set in the context of a challenging financial climate and we will therefore need to ensure that the money we spend in health and care invested into priority areas. The Plan describes what we are doing next and a set of key specific measures that we will monitor delivery against. The Joint Forward Plan (Appendix) also describes the work we have undertaken in 2023/24 against the seventeen legislative requirements to deliver and improve healthcare services across Gloucestershire.
Key Issues to note	Our refreshed Joint Forward Plan has been developed in the absence of formally published National Planning Guidance from NHS England – as well as confirmed financial and performance submissions. There are a number of metrics / trajectories in the plan that are yet to be formally confirmed or are subject to change. These are indicated in the plan. Additionally, at the time of writing, the Joint Forward Plan has not been formally endorsed by the Health and Wellbeing Board (scheduled meeting on 19th March 2024) and Gloucestershire Health and Care NHS Foundation Trust Board (scheduled meeting on 28th March). **Therefore, in order to allow for final amendments following the publication of NHS Planning Guidance and any amendments following Partner Board review, it is requested that delegated approval be given to the Chair of NHS Gloucestershire Integrated Care Board to agree to final amendments required.**

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The Board Assurance Framework (BAF) sets out the specific risks associated with delivery our Strategic Objectives. These risks will continue to be reviewed by NHS Gloucestershire Integrated Care Board and relevant Committees.			
Management of Conflicts of Interest	None			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	X
	Human Resource	X	**Buildings**	X
Financial Impact	The Joint Forward Plan is set in the context of a challenging financial position. One of our Strategic Objectives set out in the Joint Forward Plan is to create a financially sustainable health and care system which includes moving the system towards recurrent financial balance. This Joint Forward Plan is underpinned by a Medium-Term Financial Plan setting out how this will be achieved.			
Regulatory and Legal Issues (including NHS Constitution)	It is a statutory requirement that the Joint Forward Plan is renewed annually to ensure it reflects progress as well as the evolving needs of the residents of Gloucestershire. This Plan (as well as the Annual Report) will inform the NHS England performance assessment of Integrated Care Boards.			
Impact on Health Inequalities	Our Joint Forward Plan sets out our commitment to improving equity in access, experience and outcomes for people within Gloucestershire. This is within the remit of all ICS Transformation Programmes but the Joint Forward Plan sets out our approach to coordinating and monitoring this commitment.			
Impact on Equality and Diversity	We remain committed as a system to undertaking Equality Impact Assessment as well as Quality Impact Assessments for significant projects and initiatives that are delivering changes to the way health and care is delivered.			
Impact on Sustainable Development	One of our 10 Strategic Objectives is to transform care through technology and effective use of our estate. Both of these areas will contribute to our climate change and sustainability ambitions as set out within the One Gloucestershire ICS Green Plan. The Plan also sets out how we will discharge our statutory duty as to climate change and its impacts.			
Patient and Public Involvement	Our Joint Forward Plan sets out our continued commitment to patient and public engagement including a number of our key engagement activities in the last year. The plan also describes how we will discharge our statutory duty to involve the public.			
Recommendation	**The Board is requested to:** • **Approve the 2024-2029 Joint Forward Plan** • **Agree to give delegated authority to the Chair of NHS Gloucestershire ICB to approve any subsequent changes following finalisation of 2024/25 Operational Planning commitments as well as final review by Health and Wellbeing Board and Gloucestershire Health and Care NHS Foundation Trust Board.**			

Author	Mark Golledge / Louise Holder	**Role Title**	Programme Director, PMO and Senior Programme Manager, PMO
Sponsoring Director (if not author)	Ellen Rule		

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
JFP	Joint Forward Plan

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Joint Forward Plan
2024-29

Our strategic delivery plan to meet the health needs of local people

Contents

Foreword

Everyone who lives in Gloucestershire deserves the best possible start in life, healthier and longer lives, and access to the right expert support when it is needed. I am delighted to introduce our second five-year Joint Forward Plan which sets out how health and care organisations in Gloucestershire aim to deliver and improve services to meet the needs of people in our county.

The health and care organisations in Gloucestershire work more collaboratively than ever. Achieving our shared objectives depends on us continuing to accelerate this collaboration at neighbourhood, county and regional level.

This is not just an NHS plan, it is about how the NHS will work with councils, charities, education, science and the voluntary sectors to combine our skills and resources, jointly improving the lives and communities of the people we serve. It presents the collective contributions of our GP Practices and other Primary Care Services, Gloucestershire Health and Care Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, and NHS Gloucestershire Integrated Care Board, as we work more closely with our social care partners and the Voluntary, Community and Social Enterprise (VCSE) sector. We all bring different skills, resources and perspectives to every person in our care, and together we are greater than the sum of our parts.

This Joint Forward Plan describes how we will stay on course, through our ten Strategic objectives, to deliver the three core aims and ambitions of the One Gloucestershire Integrated Care Strategy:

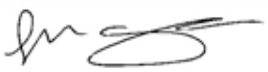
- Making Gloucestershire a better place for the future
- Transforming what we do
- Improving health and care services today

It incorporates more detailed, short-term operational plans and outlines some of the key objectives and work of individual NHS partners.

We have high ambitions to improve peoples' wellbeing with them as active participants in their own healthcare. We are proud of what we have achieved since we published our first Joint Forward Plan, and as well as reflecting on their impact this plan focuses on how we will build on them to meet our future challenges.

There are around 18,000 people working in the NHS in Gloucestershire, and over 50,000 when we include the people who work in social care, voluntary, community and social enterprise organisations. These frontline teams and our local communities know what matters most and can determine the best way to make improvements. Guided by them, we are increasingly shifting towards preventing ill health and not just treating it. This will allow the most unwell to get the best help as soon as possible and improve everyone's quality of life and chances to thrive. The people closest to the issues that affect health and care will get the time, skills, resources and trust to solve them. We will continue to embed continuous improvement at every level within our organisations and in our shared work as partners.

Our Joint Forward Plan will be reviewed and refreshed at least annually. We will monitor and continue to reflect on progress and challenges and adapt plans in line with the resources available to us and changing needs to ensure people in Gloucestershire can live happy and healthy lives.



Dame Gill Morgan
Chair, NHS Gloucestershire
Integrated Care Board

Statement from the Health and Wellbeing Board

The Gloucestershire Health and Wellbeing Board are fully assured that NHS Gloucestershire and the partners in the One Gloucestershire Integrated Care System (ICS) are committed to partnership working in order to fulfil the core purposes of Integrated Care Systems:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development.

The Health and Wellbeing Board and the Health and Wellbeing Partnership share a largely common membership. Over the last 12 months, members have welcomed opportunities for collaborative working in the alignment and delivery of priorities identified in the One Gloucestershire Integrated Care Strategy and the Gloucestershire joint Health and Wellbeing Strategy. Recent development work has highlighted how much system partners value the Board and Partnership meetings as a space for collaboration and shared vision setting for the county.

As part of the development of the updated Joint Forward Plan, the Integrated Care Board have engaged with our Health and Wellbeing Board members to ensure that our strategic leaders understand, support and can champion the direction of travel outlined in the plan. This builds on an ongoing process of engagement through formal meetings and development sessions.

The updated plan clearly builds on the strategic priorities of the Integrated Care Strategy; and the Board welcomes the focus on demonstrating impact through the Transformation programmes and the setting out of clear ambitions for the coming years. The plan reaffirms a commitment to putting people and communities at the heart of the ICS's work; and taking a community and locality-based approach to delivering health and care services, underpinned by work to achieve health equity. The Board notes the plan's ongoing focus on 'upstream interventions' to address the wider determinants of health and wellbeing and prevent ill-health.

It is the opinion of the Health and Wellbeing Board members that this Joint Forward Plan will support our Joint Local Health and Wellbeing Strategy ambitions to deliver a healthier Gloucestershire for the people who live, work and learn here. We are also assured that the ICS will continue to meet its legislative responsibilities, and that all remain aligned with these ambitions.

We look forward to continued engagement and collaboration on the shared commitment reflected in the Joint Forward Plan, to continually improving the health and wellbeing of the residents of Gloucestershire.

Councillor Carole Allaway-Martin
Chair, Gloucestershire Health and Wellbeing Board

Purpose of this Plan

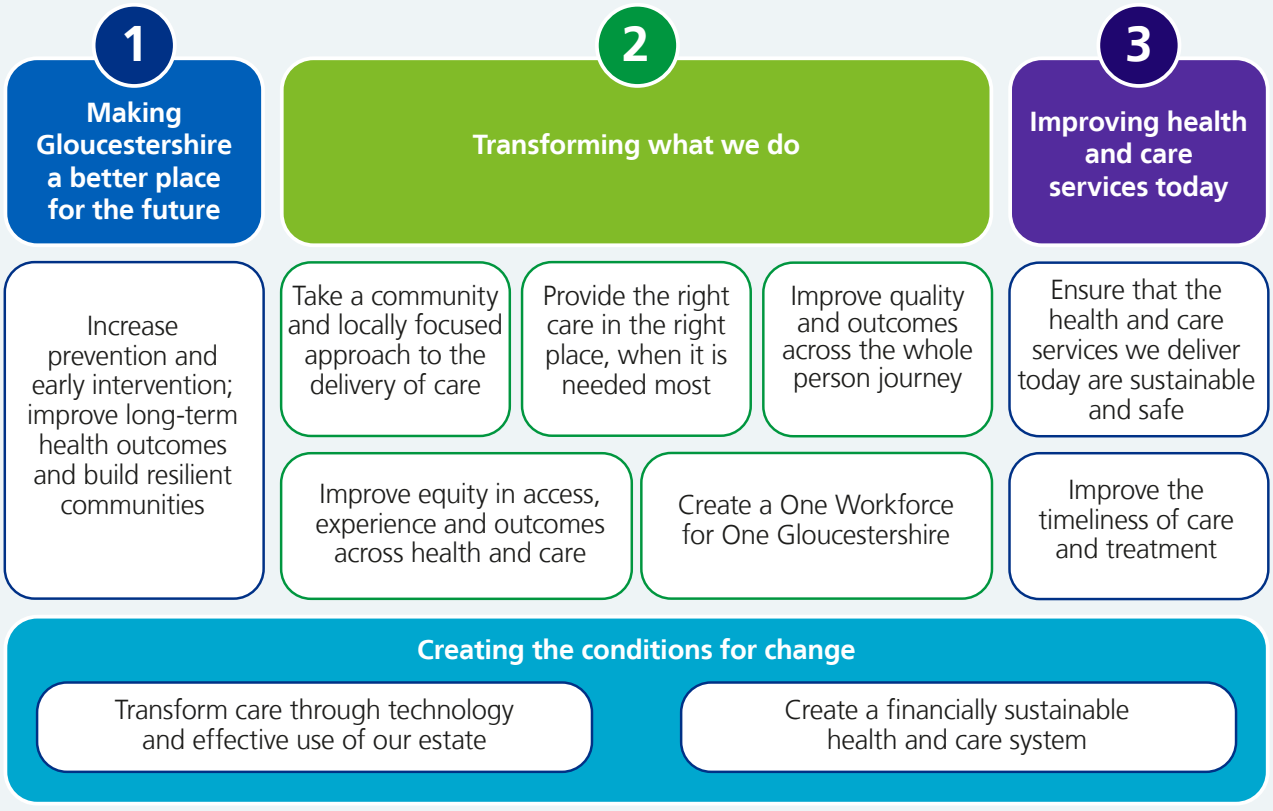
This is the second Joint Forward Plan published by NHS Gloucestershire Integrated Care Board (ICB) and written in collaboration with partners in recognition of our shared legal responsibility and ambitions. This plan is therefore from NHS Gloucestershire ICB and Partner Trusts (Gloucestershire Health and Care NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust).

Within the plan we have described our key achievements since we published our first Joint Forward Plan in July 2023. Further information will be included in our 2023/24 Annual Report.

We have updated our Joint Forward Plan for 2024/25 with ten strategic objectives. In refreshing these objectives we have ensured that there is a clearer alignment with the three pillars of the Integrated Care Strategy:

- **Making Gloucestershire a better place for the future** – working today to improve the health and wellbeing of our population in the long-term.
- **Transforming what we do** – improving the care that is delivered so it is more integrated, where we prioritise earlier diagnosis and support for people in their community.
- **Improving health and care services today** – addressing the challenges that we are facing today - improving access to care and reducing waiting times.

Our Joint Forward Plan is intentionally high level, pointing towards the areas that we are prioritising as partners together. This plan is accompanied by a companion document that describes our ICS Transformation Programmes with specific measures of success and key milestones. This companion document also describes how we have met our legal requirements in 2023/24. We will continue to refresh this Joint Forward Plan annually.



** Please note that metrics indicated with a * are included in NHS Operational Planning Guidance 24/25.*

About Gloucestershire

Gloucestershire is a great place to live and work. Our communities enjoy a variety of town, village and city life with access to countryside which gives us a great environment to stay healthy and happy. We do, though, have some challenges.

We serve a population of over 680,000 people across our urban and rural areas in Gloucestershire, most of whom enjoy relatively good health. Life expectancy at birth is 80 years for males and 84 years for females which is above the England average and on average people in Gloucestershire enjoy 67 years in good health.

While Gloucestershire has good outcomes compared with the rest of the country, we know that there are unfair differences in outcomes and wellbeing for different people. Our Integrated Care Strategy for Gloucestershire describes the disparity between those living in the wealthiest areas of the county and the least wealthy areas of the county, amounting to an average difference of 11 years of 'healthy life'. We want people to get the same good care and the same outcomes no matter who they are or where they live.

58,707 (8.2%) of the population in Gloucestershire live in the 20% of most deprived areas in England. These are mainly within Gloucester and Cheltenham but also includes an area of the Forest of Dean and Tewkesbury. We have set out a commitment within this plan to improving health equity as we know health outcomes can be lower amongst people living withing these communities.

The contribution that the NHS plays is only a small part of a person's total health, with significant influences from factors outside of clinical care. This is why our Joint Forward Plan not only describes the clinical work being undertaken across our organisations but also the commitment we have as partners to prevention, early intervention and improving long-term health outcomes for our population.

GP Practices
- Diagnosis, treatment and care of illness
- Refer patients to specialist services
- Long-term care and supporting self-care
- Supporting Out of Hours primary care

Community Health Services
- District nursing
- Health services, clinics and therapies
- Rehabilitation and inpatient care
- Minor Injury and Illness Units

Mental Health Services
- Assessment and crisis prevention
- Treatment and care
- Inpatient specialist services

Acute/ Secondary Care
- Diagnostics (samples, imaging and expert analysis)
- Specialist medical treatment, surgery and care
- Accident and Emergency departments

Social Care
- Fostering and Adoption
- Social care assessments and support
- Domiciliary care support where people live
- Carer assessments and short breaks

NHS 111
- Call centres for non-emergencies
- Advice, clinical review and booking into urgent care services
- Out of Hours GP services

Ambulance Service
- 999 call handling
- Ambulance and paramedic attendance and care
- Transfer patient care to services

Patient Transport
- Non-emergency transport of patients
- Commonly used to help patients return home after a hospital stay

About health and care services in Gloucestershire

- Serving 682,262 people, projected to rise to 715,095 people by 2030.
- +18,000 staff working in health & social care.
- The combined workforce includes over 10,000 staff providing direct care and over 8,000 professionally qualified staff (nurses, medics and Allied Health Professionals)
- 1 Integrated Care Board
- 1 Acute Hospital Trust (2 sites)
- 1 Mental Health and Community Trust
- 6 Integrated Locality Partnerships
- 15 Primary Care Networks
- 65 GP Practices
- 62 Dental & 7 Orthodontist practices
- 1 County Council with responsibility for education, public health, adult social care and children's social care
- Over 5,500 independent social care providers

Our shared principles that underpin delivery of this plan

In 2023/24 we adopted a set of shared principles to underpin the delivery of our Joint Forward Plan. These principles have remained central to our work over the last year and we will continue to embed them within the planned improvements that we have.

Principle 1:

We will work with people, patients, and communities to meet the health and care needs in Gloucestershire.

What we committed to:

In 2022 we published our Working with People and Communities Strategy setting out our commitment to putting people and communities at the heart of everything we do. We committed to ensuring that our work actively involves people, patients and communities in the work they do – involving them in how we deliver change. **The People Committee of the NHS Gloucestershire Integrated Care Board** is helping to ensure we deliver this principle.

What we have done:

Last year we engaged with local people in the re-design of health and care services in the county. This includes involving children and young people in shaping the design of a new navigation hub to support children's mental health, engaging with people through our InfoBus on the future of social prescribing in the county, and an engagement week asking people what matters to them as they age and what the barriers are to them staying well.

Principle 2:

We will live within our financial means and ensure that we robustly test what we do to ensure that it delivers value.

What we committed to:

Like other health and care systems we are facing a challenging financial position. We must continue to transform the way we deliver health and care as continuing as at present will lead to a significant financial gap. We are committed to *delivering value* which we define as 'achieving our priority outcomes within the resources available to us'. **The System Resources Committee of the NHS Gloucestershire Integrated Care Board** oversees our delivery of this principle.

What we have done:

Earlier in the year we developed a set of planning principles that we have used to guide what we prioritise both within the Joint Forward Plan and our operational plan. These principles recognise the importance of maintaining performance to achieve national ambitions and also ensure that we do not develop plans that compromise quality or safety.

Principle 3:

We will ensure that changes we deliver in health and care show how we will improve quality.

What we committed to:

Everyone has the right to feel safe and have confidence in our services. We are committed to delivering safe and effective services that provide a positive experience and are committed to Quality Improvement in how we solve problems. **The Quality Committee of the NHS Gloucestershire Integrated Care Board** oversees the delivery of this principle.

What we have done:

Last year we continued to monitor the quality and safety of services in Gloucestershire through our Quality Safety Group and ICB Quality

Committee. The Local Maternity and Neonatal System has played an active role in supporting the development of maternity services. As our financial position becomes more challenging, we are strengthening further our approach to quality and safety and taking a proactive approach to risk through the Patient Safety Incident Response Framework. We will ensure that we further ensure equality and quality impact assessments are a fundamental part of decision making.

Principle 4:

We will ensure that changes we make are made with the input from our workforce so they help achieve the best for our staff and people.

What we committed to:

In 2023 we published our People Strategy setting out our commitment to support our workforce. The strategy includes four focused themes – recruitment and retention; enabling innovation in care delivery and people services; valuing and looking after our people, and education, training and talent development.

We will need to change the way we work to deliver the commitments in this plan, but this should be led and informed by our workforce delivering care and support. **The People Committee of the NHS Gloucestershire Integrated Care Board** oversees our delivery of this principle**.**

What we have done:

We are proud of the clinical and care model that we have developed within Gloucestershire. Each of our ICS Transformation Programmes are led by one or more clinical or care professional leaders. For example, our 'Working as One' programme to transform Urgent and Emergency Care is clinically led by our Chief Medical Officer and supported by an Emergency Medicine Consultant.

The development of integrated models of care within Gloucestershire, that bring together multi-agency teams to support people living in the community, need to be informed by practitioners who deliver care and support. This has been the case for teams providing support to people with serious mental illness. We will continue to adopt this principle as we develop our plans for Integrated Neighbourhood Teams supporting people with frailty needs.

Public engagement

We are working to ensure that we involve people and communities in a variety of different ways and will be open and transparent in our work. Our Working with People and Communities Strategy is our commitment to the people of Gloucestershire.

Our Strategy sets out the principles and ways we will ensure the people and communities of Gloucestershire are at the heart of everything we do. It also outlines how we will ensure we meet NHS Gloucestershire's duties to involve people and communities in our work.

We will involve you; we will listen to you; we will act on what you tell us we need to know, and we will tell you what we have done.

The objectives in this plan are informed by what people in Gloucestershire say is important to them. Our engagement with local people takes place within both individual services as well as programmes of work, and we also engage with local people through dedicated activities such as:

Get Involved in Gloucestershire: Our online participation space where people can share their views, experiences and ideas about local health and care services. Their input helps to inform and influence the decisions local NHS organisations make.

One Gloucestershire People's Panel: We have recently launched a new One Gloucestershire People's Panel which seeks out the opinions of a representative sample of people living and/or accessing services across Gloucestershire. Over 1,000 people are part of the panel. Our first engagement in 2023/24 focused on sharing information and using technology.

Information Bus: In 2023/24 the Information Bus had the busiest year yet, travelling across the county and engaging with local people on matters that are important to them. This included:

- Support for the COVID vaccination rollout
- People's experience of and thoughts about social prescribing
- Creating strong links with the farming industry
- Nurse on Tour, facilitating the training of student nurses
- Blood pressure testing and 'Know Your Numbers'
- Volunteering opportunities
- Raising awareness of long-term conditions such as Diabetes and Coronary Heart Disease.

Pillar 1

Making Gloucestershire a better place for the future

Pillar 1 of our One Gloucestershire Integrated Care Strategy is about looking to the future.

It is about making changes now – but recognising that they may take some time to materialise.

This is about improving population health outcomes including the contribution we can make to improving life expectancy, years spent in healthy life as well as narrowing the life expectancy gap across the county.

In order to achieve this, we are playing our role in supporting people to take an active role in their health and wellbeing.

The contribution the NHS makes is only part of the picture. Making Gloucestershire a better place for the future is much more about communities and localities themselves, and a wider set of partners working together. That is why the NHS in Gloucestershire is a partner amongst many in improving health outcomes for the long-term.

Our plan sets out how we will continue to prioritise support at an early stage which have an impact on the wider determinants of health and wellbeing.

Strategic Objective #1: Increase prevention and early intervention; improve long-term health outcomes and build resilient communities

Why is this important?

We want to live in communities where everyone plays an active role in their own health and wellbeing. We are increasingly prioritising prevention and early intervention through localities in Gloucestershire.

It is also important that we actively promote a positive state of health and wellbeing - this includes reducing obesity, smoking, alcohol prevalence and the effects of poverty. For example, there are 67,600 smokers in Gloucestershire – around a third of whom live in the 20% of most deprived areas. The NHS cannot tackle this alone, but working in partnership with others like the voluntary sector and the people of Gloucestershire we can make a much greater difference.

Strengthening Local Communities – Grant Funding

Since 2021 we have invested £2.5m into local communities to draw on the skills, knowledge and assets of local communities. Over 50 initiatives have been delivered as well as 35 micro-projects across our 6 Integrated Locality Partnerships across the county.

In 2023/24, local communities have chosen to focus on areas such as improving children and young people's mental health, addressing pre-diabetes or supporting people who live with frailty or dementia. Time is spent on developing trust and relationships between partners and local communities - it is not just what we do but how we work together that is important.

What have we done?

We are investing in local communities, and ensuring local people are involved in the decisions about what matters to them. In 2023/24 we continued to prioritise investment into local communities through funding such as the 'Strengthening Local Communities Grant'.

A key part of this is building relationships and supporting the development and voice of the Voluntary, Community and Social Enterprise (VCSE) sector in order to build resilient communities.

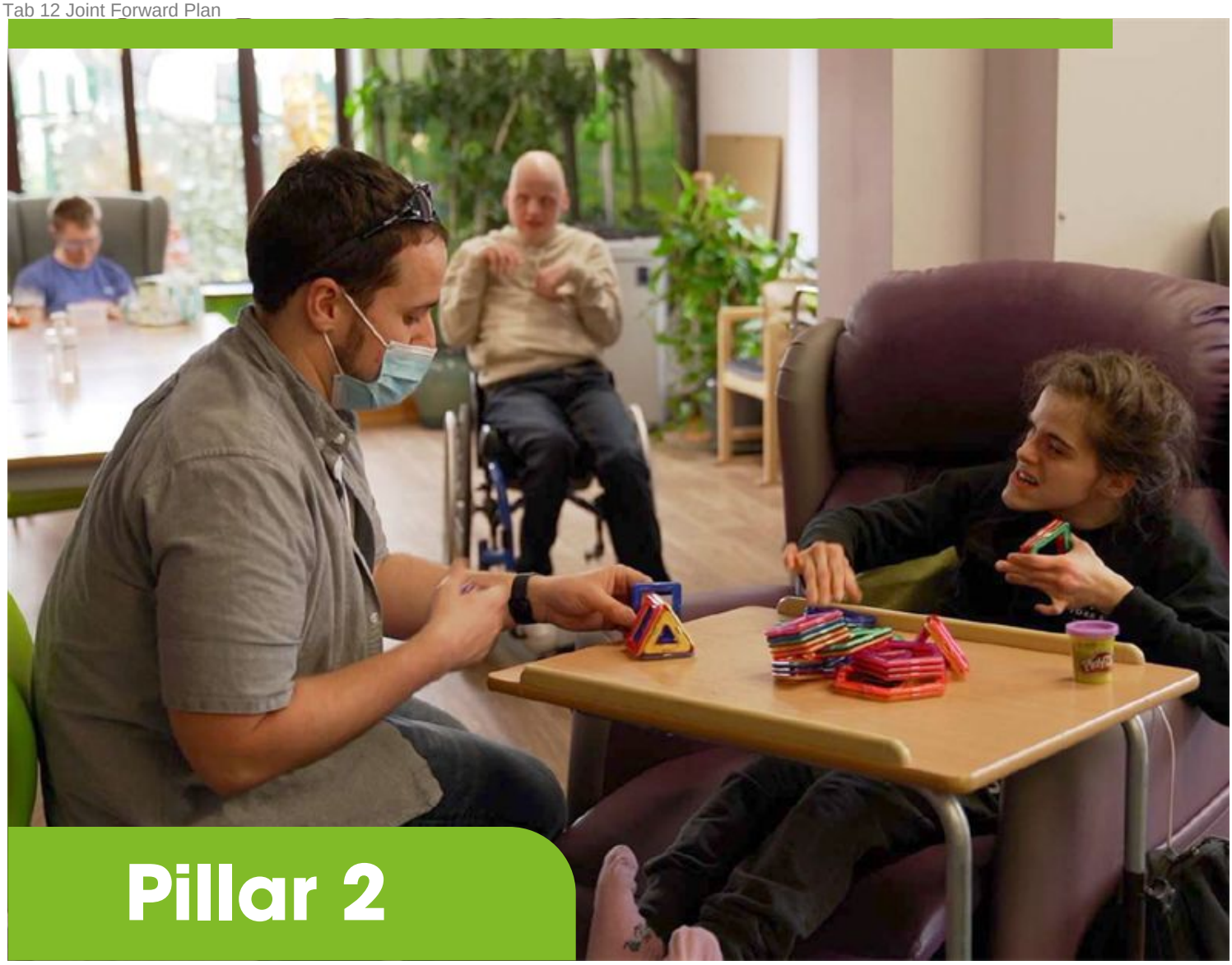
We also continue to prioritise support for people in areas such as: tobacco dependence support in hospital inpatient and maternity settings and improving weight management through initiatives such as We Can Move and other projects in specific areas of the county.

What are we doing next?

- Continuing to build and foster relationships with local communities and the voluntary and community sector.
- Continuing to fund local prevention initiatives in our local communities.
- Remodelling the Community Wellbeing Service in the County to help improve community health and wellbeing in 24/25.
- Expanding tobacco dependency support into settings such as mental health inpatients in 24/25.
- Developing a Social Value Policy to evaluate long-term impact on outcomes.

What difference will we make?

Measure	Where are we	Where do we want to be
Percentage of adults who smoke tobacco	11.5% (2022)	9.1% by 2030
Percentage of physically inactive adults	18.8% (21/22)	16.5% by 2030
Percentage of people adults identified as overweight/obese	62.4% (21/22)	60.0% by 2030



Pillar 2

Transforming what we do

Pillar 2 of our One Gloucestershire Integrated Care Strategy is about transforming the way we deliver health and care in Gloucestershire.

This recognises that some of the improvement we need to make to health and care services in the county will take some time to deliver, but the benefit of making these changes will be significant for our population.

At the heart of our planned improvements is a commitment to taking a community and locality approach. This is about ensuring that there is quick and early diagnosis and that when people need support, they can receive it both closer to home and that it is joined up across the services that deliver it.

We also know however that when people do need specialist care and treatment that they want the right support delivered in the right place, at the right time. We are therefore transforming urgent and emergency care services as well as outpatient services in the county to make them more accessible.

In Pillar 2 we also recognise that people are now living with more long-term health and care needs. We must radically change the way care is delivered for people across their whole care journey rather than delivering care based on individual episodes. This means taking a personalised approach to care, and one that supports people to manage their health conditions without deterioration.

Strategic Objective #2: Take a community & locality focused approach to the delivery of care

Why is this important?

Delivering care closer to home is a priority because it gives people the best possible opportunity to quickly access the support they need, to make the most of their community networks and to bring services together so that they are better-connected. In a county as geographically large and rural as Gloucestershire, access can be challenging so it is a priority for us to improve access to support whilst integrating community-based health and care teams, so they work more closely together.

We want to ensure that the care people receive is personalised and coordinated between different professionals. We are taking a population health approach – bringing together multi-disciplinary teams in localities to support people living with specific health and care needs in Gloucestershire.

What have we done?

More than 73,000 people in Gloucestershire over the age of 65 are identified as living with frailty. For people living with moderate and severe frailty needs we are prioritising creating Integrated Neighbourhood Teams in 2024/25.

For people with learning disabilities we have introduced a keyworker scheme for those at risk of hospital admission, and for people living with severe mental health needs, teams from the voluntary sector, mental health services and primary care have come together in multi-disciplinary teams known as Locality Community Partnerships (LCPs). Through these, we are ensuring that care is personalised based on what is important to individuals. We are already seeing an increase in people accessing these services.

For children we have been delivering earlier intervention and support for mental health and wellbeing needs in schools ("Young Minds Matter"). This is supporting over 130 schools in the county, reducing referrals to specialist services including Children and Adolescent Mental Health Services.

What are we doing next?

- Co-designing and piloting Integrated Neighbourhood Teams in 2024/25 in specific localities, proactively identifying and supporting people with frailty needs.
- Embedding LCPs for people living with severe mental health needs and evaluating its impact.
- Launching the 8th "Young Minds Matter" in schools to support young people with anxiety concerns.
- Piloting Early Language Support to support language and communication needs in children.
- Delivering our action plan to support young people with Special Educational Needs & Disabilities.

Integrated working for people with frailty

We have tested and are now implementing a new 'Personalised Proactive Care Whiteboard'. This tool enables practitioners to identify people who are frail and vulnerable in the community who would benefit from additional support, helping to avoid crisis. The whiteboard has commenced in 13 of 15 Primary Care Networks with plans to continue and embed the tool.

This will be an essential part of our plans to develop Integrated Neighbourhood Teams as we take a phased approach to rollout in 2024/25 across local areas in the County.

What difference will we make?

Measure	Where are we	Where do we want to be
Number of Cchildren and young people receiving with +1 contact from our Young Minds Matter teams	1670 (Nov '23)	Over 2,000 by March 2026
Number of patients with severe mental illness supported by transformed mental health services*	893 (Mar '24)	2,636 by March 2025
Percentage of people 65+ with moderate and severe frailty with a personalised care and support plan	13% (Feb '24)	18% by March 2025

Strategic Objective #3: Provide the right care in the right place, when it is needed most

Why is this important?

We are transforming our services so that people can access the right support in the right place, at the right time. Our Working as One programme is improving the way that urgent and emergency care services are delivered in the county. This will ensure that we improve care pathways – from admission avoidance, to support in hospital and to support on discharge.

We are re-designing how we provide diagnostic services, so they are more accessible. Similarly we are transforming outpatient services for patients requiring follow-up support after a hospital procedure as well as the provision of ongoing specialist advice.

What have we done?

Our Working as One Programme has established five work areas that are shaping work in urgent care. We expect this programme to deliver significant benefits, supporting more people in the community rather than in hospital, reducing length of stay and facilitating quicker hospital discharge.

Last year we launched our Virtual Ward enabling more patients to be supported at home through active health monitoring and commenced work to ensure that our Rapid Response service is even more effective at responding to patients in the community.

The new Community Diagnostic Centre at Quayside House in Gloucester will offer an extra 80,000 diagnostic appointments a year and is open 7 days a week.

We are continuing to transform outpatient services for patients requiring specialist advice. Last year we undertook a major redesign of our advice and guidance system for primary care and are making use of digital technologies so that people requiring outpatient support can have it more personalised, appointments are effective and people do not need to always travel for a face-to-face appointment.

Acute Respiratory Hubs

We have established Acute Respiratory Hubs in our two main urban areas - Gloucester and Cheltenham. These hubs support patients with higher levels of respiratory needs in the community and therefore avoid the need to go to hospital.

Clinics include access to multiple health and care professionals – including social prescribing allowing a holistic assessment and treatment in one appointment.

Between January and October 2023 the Hubs have seen 11,260 patients – 25% of patients indicating they would have attended hospital had they not been seen in the hub.

What are we doing next?

- Implementing the 'Working as One' programme for urgent and emergency care including expanding Virtual Wards and launching a new Integrated Urgent Care Service that brings together NHS 111, clinical assessment and other urgent care services.
- Transforming mental health urgent care including reviewing Crisis Resolution and Home Treatment.
- Continuing improvements in outpatients including introducing a new patient portal allowing patients to cancel or change hospital appointments directly.

What difference will we make?

Measure	Where are we	Where do we want to be
Percentage of patients with a length of stay in hospital over 21 days*	18.7% (Mar '24)	14% by March 2025
Category 2 Ambulance response times*	40 mins (Feb '24)	30 mins by March 2025
Percentage of outpatients who are moved to a pathway enabling them to self-initiate follow-ups*	11.9% (YTD 23/24)	Remain at 10% (exceeding the national target of 5%)

Strategic Objective #4: Improve quality & outcomes across the whole person journey

Why is this important?

We are about to see a significant increase in the proportion of older people living in Gloucestershire over the next 10 years. Along with this we are projecting growth in the number of people living with long-term conditions, including those living with two or more long-term conditions.

We want to educate people about preventing serious conditions before they occur (primary prevention) whilst providing early diagnosis and treatment. This means supporting people with major conditions like cancer, cardiovascular disease (CVD), diabetes and respiratory difficulties to live well and where possible support them to manage their conditions at home (secondary prevention).

The long-term impact will be to slow the growth in new diagnoses and hospital admissions and attendances, making things better for Gloucestershire's system and more importantly Gloucestershire's people.

Blood Pressure Monitoring and Support

Persistent high blood pressure can increase the risk of serious and potentially life-threatening conditions such as heart failure, heart disease and stroke.

We are increasing blood pressure monitoring and support for patients with hypertension. In the first half of last year, we diagnosed and are now supporting a further 1,300 people as a result of increased blood pressure checks. Our campaign during 'Know Your Numbers Week' has played a key part in this.

In Spring 2024 we will be recruiting 'CVD Champions' in Primary Care to assist with proactive monitoring and support for patients with hypertension.

What have we done?

To ensure we can prevent and treat the most serious conditions we have been making improvements to care pathways through our Clinical Programme Approach.

Early diagnosis of conditions is a priority. Last year we have increased diagnostic testing in primary care for respiratory conditions, increased blood pressure testing and are continuing to prioritise early cancer diagnosis. This means that people's conditions can be identified and therefore supported more quickly, and that there is less need for acute care.

Where people have long-term conditions, we are supporting them in the community. We have expanded support for people with diabetes through Continuous Glucose Monitoring, introduced monitoring for people with respiratory needs via a new Virtual Ward, and increased referrals to pulmonary rehabilitation for people with Chronic Obstructive Pulmonary Disease (COPD) (where referrals were up 21% in the first 6 months of 23/24).

What are we doing next?

- Widening access to diabetes-related technology allowing people to monitor their condition.
- Creating a network of Asthma Friendly Schools in Gloucestershire, increasing training for staff.
- Prioritising blood pressure testing in the community and supporting treatment of patients.
- Providing a new service to offer greater capacity and choice of rehabilitation for people following a stroke.

What difference will we make?

Measure	Where are we	Where do we want to be
Percentage of patients with hypertension patients treated to target	65% (Jan '24)	80% by 2029
Testing in primary care for COPD and asthma – Number of positive Spirometry & FeNo tests resulting in a 'new' diagnosis	Spirometry – 244 (annual) FeNo – 735 (annual)	500 by 2026/27 1,000 by 2026/27
Percentage of patients with diabetes receiving checks: 8 care processes – Type 1 and Type 2	Type 1 – 25.7% (Sept '23) Type 2 – 56.7% (Mar '24)	70% by 2028/29 70% by 2028/29
Percentage of cancers diagnosed at stages 1 and 2	54.4% (2021)	75% by 2028

Strategic Objective #5: Improve equity in access, experience and outcomes across health and care

Why is this important?

The NHS is founded on principles of universal access to healthcare. However, we know that people from more deprived communities as well as different population groups can experience varying access to, and experience of, services, as well as differing health outcomes. They arise because of the conditions in which we are born, grow, live, work and age. COVID-19 made stark these inequalities.

Whilst it might take longer to close the gap for some health outcomes (such as life expectancy), there are things we can, and are doing now to reduce the gap in health access. We made a commitment in our planning principles to address known variation in outcomes with a focus on prioritising delivery of Core20PLUS5 – prioritising work in the 31 most deprived areas of our county; prioritising work on race relations and working together to improve outcomes across 5 clinical areas for adults and children.

Equity & Inclusion in Maternity Services

As part of our Equity and Equality Action Plan we have undertaken an analysis of maternal and neonatal outcomes in Gloucestershire – including identifying a group of women who book late for maternity services and miss the opportunity for ante-natal screening.

We have engaged with different groups with a focus on areas of higher deprivation in Gloucester and the Forest of Dean.

This work has informed projects that focus on improving access and outcomes in these areas including breastfeeding, improving access for women booking late for maternity services, supporting women from ethnic minorities with perinatal mental health and introducing anti-racist training as part of our commitment to Core20PLUS5.

What have we done?

We are prioritising addressing this important area in Gloucestershire and have allocated two Executives to bring leadership to this area.

All our programmes have a role to play in improving health equity. Last year we prioritised work in some of our more deprived neighbourhoods. This includes Acute Respiratory Infection (ARI) Hubs, the rollout of Young Mind Matters teams in schools and improving weight management in Inner City Gloucester which has led to more referrals and additional support.

We have also undertaken work to close the gap in clinical outcomes both for adults and children. This includes work to identify disparities in different groups of people waiting for hospital treatment.

What are we doing next?

- Delivering commitments in Core20PLUS5 for adults (e.g. supporting people with serious mental illness and continuing hypertension treatment) and children (e.g. reducing over-reliance on medications for asthma and improving children and young people's mental health).
- Bringing together our work on health inequalities across Gloucestershire so we have a more comprehensive understanding of the work underway in order to shape our future plans.
- For Mental Health Services we will be delivering the Patient and Carer Race Equality Framework – an anti-racism framework delivering actions to reduce racial inequalities within services.
- Accessed funding to deliver schemes such as Warmth on Prescription which supports increasing energy advocacy, retrofitting and insulation for those in greatest need.

What difference will we make?

We will be monitoring progress against metrics (including those within this Joint Forward Plan) against deprivation and age (and sex and age where available) in line with the NHS England Statement on Health Inequalities

Strategic Objective #6: Create One Workforce for One Gloucestershire

Why is this important?

Health and social care together employ around 18,000 people in Gloucestershire. Demand for our services is growing and we do have shortages of skilled staff in some areas. The performance of health and care in our system depends on the people we employ. We are tackling this in a number of ways and know we need to attract people to come and work in Gloucestershire, as well as retaining and developing our existing staff.

Our commitment is to create 'One Workforce for One Gloucestershire' as articulated in our One Gloucestershire People Strategy published in September 2023. We want our workforce to be supported by a compassionate culture and to experience an inclusive working environment which inspires, motivates and rewards everyone with the values, behaviours, skills and opportunity to deliver high-quality care and support every day.

What have we done?

We have already started to deliver our strategy, for example by holding joint recruitment events with our system partners, including social care, to support people to choose jobs in health and care. We have also developed the 'We Want You' campaign in schools, with over 6,000 pupil interactions last year.

We are prioritising support in areas where there are known workforce challenges. We have targeted recruitment and retention in primary care, maternity services and domiciliary care. We launched the 'Be in Gloucestershire' campaign to promote our country as a great place to live and work as a GP, and have undertaken work to recruit 100 international domiciliary care workers to address high vacancy rates in this important sector.

What are we doing next?

- Simplifying recruitment processes so the time taken to on-board new staff is significantly improved.
- Piloting improvements in rostering within Gloucestershire NHS Foundation Trust.
- Continue to prioritise support to areas where we need to retain and recruit additional staff.
- Launch a campaign to promote Gloucestershire as a great place to live and work.
- Prioritise staff wellbeing with a particular focus on newly employed staff to support retention.
- Deliver the commitments in the NHS equality, diversity and inclusion plan.

Supporting our primary care workforce

We continue to prioritise supporting the primary care workforce in 2023/24.

In 2023/24 we launched our GP partnership support offer – promoting the benefits of taking up a partnership role and supporting GPs already in partnership positions.

We have continued the provision of our 'New to Primary Care' (Spark) Fellowship for GPs and Nurses, providing coaching and peer support.

This has led Gloucestershire to being a net importer of GPs qualifying in the region.

We have also launched a flexible pool for healthcare assistants and will be expanding this to receptionists / administrative staff in order to support General Practice resilience and sustainability.

What difference will we make?

Measure	Where are we	Where do we want to be
Percentage of posts that are vacant in a month	8.5% (Jan '24)	TBC
Percentage of working hours lost due to sickness absence in a month	4.93% (Jan '24)	TBC
Percentage of staff leaving during the last 12 months Staff turnover in healthcare services	13.2% (Jan '24)	TBC

Pillar 3

Improving health and care services today

Pillar 3 of our One Gloucestershire Integrated Care Strategy is about addressing the challenges facing us today.

This is about undertaking work where we face pressures to ensure that these services are both sustainable and safe. Consistently delivering services that provide excellent safety and quality is a key objective for all partners.

It is also about ensuring that people can be seen quickly when they need services most. COVID-19 had a significant impact on healthcare services across the country that we are still seeing the consequences of now. We are prioritising work to improve the timeliness for care and treatment across key services such as urgent care, cancer and elective procedures as well as community services.

We are making good progress across these areas but recognise that we still have more to do. The services we focus on may change if we identify new risks and pressures, but our Joint Forward Plan describes the progress we are making to improve outcomes for people receiving care, and to make it easier for our staff to deliver it.

Strategic Objective #7: Ensure the services we delivery today are sustainable and safe

Why is this important?

We aspire to ensuring that the services in Gloucestershire deliver excellent and safe care. In many cases services are good, but we know there are areas where we need to provide further support. We want to work together to identify issues before they arise.

Two key priority areas for us are primary care dental services and maternity services. We continue to prioritise the sustainability of General Practice and Dental services supporting resilience and demand pressures for these essential services. National studies into maternity services, such as the Ockenden and Kirkup Reviews highlight the importance of maintaining a focus on safety. Maternity services in Gloucestershire support more than 6,000 families in Gloucestershire every year, and we are committed to providing the best possible care for everyone who receives it.

Supporting Dental Provision in Gloucestershire

Patients want to be able to access timely dental appointments. But for this to be possible we must ensure the existing 67 providers of dental services in the County are sustainable.

We have brought together partners to develop long-term plans for dental services whilst addressing pressures today.

We have commissioned an additional 152 stabilisation appointments a week (initial urgent appointment & course of treatment) and an additional 62 urgent appointments.

An urgent care pathway has been finalised with 111 patients being directed to the Community Dental Service triage.

What have we done?

We took on the responsibility for primary care dental services from NHS England in 2023. We are engaging with current providers to identify how we can increase access for people living in our most deprived communities.

Primary care services in Gloucestershire have delivered 28% more activity since 2019 but face significant challenges. We are providing support for General Practice, increasing the headcount of additional roles by 107 since March 2023.

Our Local Maternity and Neonatal System (LMNS) leads work to monitor safety and quality in maternity services and deliver improvements in line with the 3-year national Maternity and Neonatal Delivery Plan.

Our staff are the most important asset we have. We continue to prioritise recruitment and retention, reducing midwifery vacancy rates from 14.8% in June 2023 to 7.8% in December 2023. We also work closely with our neighbour Bath, Swindon and Wiltshire LMNS to provide support and challenge via clinical peer review.

What are we doing next?

- Complete a plan for dental services setting out plans to expand access and support sustainability.
- Deliver and monitor against a single action plan for maternity services in the county.
- Introduce the Patient Safety Incident Response Framework to take a more proactive approach to risk.

What difference will we make?

Measure	Where are we	Where do we want to be
Stillbirth (per 1,000 all births) Neonatal mortality (per 1,000 live births)	3.0 per 1,000 (23/24 YTD) 1.1 per 1,000 (23/24 YTD)	2.5 per 1,000 by 2025 1 per 1,000 2025
Dental service activity contracted and delivered per annum	781,972 units contracted - 70% delivered in Jan '24	80% of contractual activity completed in 2024/25
GP appointment waiting times (in 2-weeks)*	75% (January '24)	75% by March 2025

Strategic Objective #8: Improve the timeliness of care and treatment

Why is this important?

We want everyone to have an equitable chance to be healthy, including where that means needing timely access to care and treatment.

This includes reducing the amount of time people need to wait for elective and cancer treatment. The same is true also in community services. We have seen greater demand in services such as neurodiversity, eating disorders, Children and Adolescent Mental Health Services (CAMHS) and speech and language therapy. We are working to reduce the amount of time people need to wait. Similarly, we are working to ensure that when people need urgent care it can be provided in the most efficient way possible.

What have we done?

For patients needing urgent care we have developed an accredited System Coordination Centre, allowing us to better manage the flow of patients across system partners. Working with Gloucestershire County Council, we have significantly reduced the wait time to arrange a package of home care, from 16.8 days to 5.5 days in 2023.

In the community we have prioritised services needing support and recruited staff to help reduce waiting times. The waiting list for Child and Adolescent Mental Health Services (CAMHS) continues to reduce with nearly 80% of young people having assessment within four weeks.

We are investing in additional Autism and ADHD assessments, bringing additional capacity alongside improving pathways. We have collaborated with Teens in Crisis (TIC+) to provide counselling support for young people which has helped to reduce waiting lists for eating disorder services.

Whilst there is still more to do, we have made good progress in reducing the number of people waiting for hospital treatment. Although impacted by industrial action throughout 2023 and into 2024, we are delivering elective activity above target levels set in 2023/24.

What are we doing next?

- Improving access to urgent treatment by supporting operational improvements that assist people waiting to be discharged from hospital.
- Bringing capacity into key community services such as neurodiversity and improving pathways.
- Continuing to prioritise work with the voluntary and community sector to reduce referrals to CAMHS.
- Optimising capacity in eating disorder services – prioritising early support and improving pathways.
- Undertaking work to improve productivity in elective care, prioritising work with specialities (such as endoscopy) where we can have the greatest impact in reducing people waiting for treatment.

Gloucester Hospitals: Elective Care Hub

We have improved the way we manage waiting lists through our Elective Care Hub. Since the Hub was introduced in October 2021, we have contacted 52,144 patients waiting for treatment.

This has led to about 12% of patients being referred to their speciality due to increasing health needs. Support has also been offered to patients waiting for treatment to help them manage their condition. The service has also provided reassurance to patients that they haven't been forgotten.

What difference will we make?

Measure	Where are we	Where do we want to be
Percentage of people seen and treated in 4 hours in A&E including Minor Injury and Illness Units*	71.3% (Feb '23)	TBC by March '25
Number of people waiting for community services*	12,351 (Mar '24)	12,209 by March '25
Percentage of people whose time from referral to treatment is within 18 weeks*	65.3% (January '24)	TBC by March '25
Percentage of people who have had a cancer diagnosis within 28 days of referral*	69.7% (January '24)	77% by March 2025
Percentage of people whose waiting times for cancer treatment is within 62 days*	60.1% (January '24)	70% Mar 2025

The new Community Diagnostic Centre in the heart of Gloucester.

Creating the Conditions for Change

In order to deliver the ambitions within the three pillars of our Integrated Care Strategy there are 'conditions for change' that we need to have in place as a system.

These conditions for change will enable our system to respond to the challenges we have highlighted within the Integrated Care Strategy and this Joint Forward Plan.

Our commitment to digital technologies and our estate are both enablers of change. Both of these assets will also support us to achieve our commitment to green and sustainability goals.

And finally, we describe our commitment to creating a financially sustainable health and care system. This is not simply about top-slicing funding from existing services but rather ensuring that we deliver value, prioritising the delivery of the objectives set out within this plan, within the resources available to us.

Strategic Objective #9: Transform care through technology and effective use of our estate

Why is this important?

Making the best use of digital technologies and our physical estate is crucial to our plan to deliver services that are integrated, efficient and high quality. Both of these areas will also contribute to our plans to tackling climate change. We are actively making changes to how we work so that we continue to deliver high quality health and care without adversely impacting the environment.

COVID-19 showed us the opportunities that digital technologies offer to how we deliver care. We want people to be able to easily use services and for our staff to have the information they need. Embracing the latest technologies can help us to improve diagnosis and treatment, to provide services at the best value and to move treatment closer to home.

Forest of Dean Community Hospital

Our new Forest of Dean Community Hospital will open in the Spring of 2024 replacing the Dilke Memorial Hospital and Lydney Community Hospital.

The new 24 bed hospital will be the first NHS net zero community hospital in England. It will achieve BREAAM excellence (energy efficiency) benefitting from Solar PV, Air Source Heat Pumps, excellent insulation and other energy efficient solutions. The hospital will be a net contributor of electricity to the national grid.

This exciting development will include provision for community space within the hospital itself as well as bringing together services such as Rapid Response, Therapy, Midwifery, Children's and Young People, Dental, Outpatient and Minor Injury and Illness Unit services.

What have we done?

In February 2024 we opened a new Community Diagnostic Centre in the heart of Gloucester, increasing diagnostic capacity, and have continued improvements to GP practices across the county.

Work on expanding and improving buildings at our main hospitals has continued with significant infrastructure improvements and ward reconfigurations as well as a new day surgery unit and two new adjacent theatres in Cheltenham.

In Spring 2024 Gloucestershire Health and Care will be opening the new Forest of Dean Community Hospital.

We are continuing to deploy technology, for example providing the ability for monitoring patients remotely which is fully integrated with the hospital record (Virtual Ward) and introducing a new Maternity Electronic Patient Care system to give women access to their own records and care plan.

What are we doing next?

- Implementing our Green Plan to achieve sustainability ambitions.
- Completing Strategic Site Development at Gloucestershire Hospitals NHS Foundation Trust
- Increasing the ability of patients to book, amend and cancel health appointments.
- Rolling out the upgrade to our shared care record – Joining Up Your Information (JUYI).
- Developing an estates plan for our future clinical model including Integrated Neighbourhood Teams.

What difference will we make?

Measure	Where are we	Where do we want to be
Carbon emissions from direct NHS activity	Data pending	Net zero by 2040
Increase in the physical capacity of primary care facilities by opening 6 new surgeries	-	Increasing the space available by 3.8% (1,745m2 extra) by 2029
Average monthly recorded patient views in the local health and care shared record (Joining up Your Information)	46,862 (Jan '24)	Increase of 10% by Jan 2025

Strategic Objective #10: Create a financially sustainable health and care system

Why is this important?

We are rightly ambitious about improving health and care outcomes. However, we are going to continue to see demographic changes – including growing health needs in the County plus changes in drugs and technology leading to increases in cost.

With such pressures it is going to be increasingly difficult to achieve exceptional performance in every area whilst living within our financial means. Our commitment as partners is therefore delivering value. Within Gloucestershire we have defined this as 'delivering our priority outcomes within the resources available to us'.

Our Joint Forward Plan, underpinned by the developing medium term financial planning, is therefore recognition that we must ensure that existing services are delivering value whilst ensuring that where we prioritise resources either within or across pathways maximises the delivery of outcomes. Our focus is also on understanding our population and the drivers of demand and identifying new ways to tackle this plus reducing unwarranted variation in the way we provide services.

Prioritising resources within a pathway

In 2023/24 we participated in a programme led by the Midlands and Lancashire CSU that is influencing our approach to how and where we allocate resources within a clinical pathway.

This programme focused on the COPD pathway – helping us to consider the areas of support for patients that deliver the most value. It was informed by both patients and clinicians across Gloucestershire.

The outcomes are ensuring that we prioritise support such as proactive case finding, 'Breathe in Sing Out' with the voluntary sector as well as make use of the Virtual Ward for respiratory patients.

What have we done?

We have implemented a process as a system that now ensures that spend over a certain value is robustly reviewed and considered by NHS partners.

We are already acting on a commitment to improve productivity. In elective care our hospital is increasing utilisation of clinics and theatres (increasing to 80%) allowing more patients to be seen. Primary care is offering more appointments than 2019 and we are delivering more diagnostic capacity.

Our ICS evaluation group has increased our focus on seeing benefits of investment realised. This is helping to ensure that we rigorously test and review investments made into the delivery of care so it delivers excellent value for money.

What are we doing next?

- Developing and delivering our Medium-Term Financial Plan (including savings) each year.
- Ensure that performance and productivity gains within transformation programmes are realised such as our Working as One programme and Planned Care programme.
- Apply the learning from the work with the Midlands and Lancashire CSU (on COPD) into other clinical pathways.
- Continuing to reduce how much we spend on agency staffing as a system.

What difference will we make?

Measure	Where are we	Where do we want to be
Performance and productivity improvements are delivered	TBC	Reducing underlying financial deficit by c50%
Use of agency staff in Gloucestershire	345 FTE (Nov '23)	TBC

Delivering this Joint Forward Plan

We remain committed as partners to working together to deliver the commitments within this Joint Forward Plan. In Gloucestershire we have a strong legacy of working together across organisations and have well-formed governance arrangements that will help us to deliver this plan.

Overall accountability for the plan rests with NHS Gloucestershire Integrated Care Board (ICB). The ICB brings together partner trusts and primary care with wider system partners including Gloucestershire County Council (adult social care, children's social care and public health)

Governance and oversight for the delivery of this plan remains as follows:

1. Delivery via ICS Transformation Programmes

Our ICS Transformation Programmes have overall accountability for delivering the commitments within this Joint Forward Plan. Each programme has an individual with overall leadership (known as a Senior Responsible Officer) from one of the partner organisations across Gloucestershire, representation from partner organisations, and is led by a professional lead to ensure that there is a strong clinical and care voice in the way we redesign services.

The remit of these programmes is to also ensure a strong patient/resident voice, so that our work is being co-designed with people who use our services. We are committed to ensuring that our review of progress in delivering this plan is focused on the impact that our changes have on local people, and that we continuously learn from this.

2. Oversight via Executive-led Boards

Existing executive-led boards which bring together partner organisations will have regular oversight for the delivery of this plan.

3. Accountability via NHS Gloucestershire Integrated Care Board

We report regularly to the Integrated Care Board against the commitments within this plan – and have demonstrated over the last year that we will report more regularly should there be a need to discuss progress in specific areas.

Our Integrated Performance Report provides information to the Board on progress towards our commitments. We will develop this to ensure that progress of the plan is visible and that there is accountability for delivery.

The Gloucestershire County Council Health Overview and Scrutiny Committee also has a key role in reviewing progress against this plan.

We will report formally on progress against this plan in the annual report for NHS Gloucestershire ICB. This plan will be refreshed annually.

One Gloucestershire
Transforming Care, Transforming Communities

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April 2024

One Gloucestershire Joint Forward Plan 2024 – 2029

APPENDIX

Table of Contents

Our Transformation Programmes:

The table below shows **key** contributions transformation programmes are making to the 3 pillars of the Integrated Care Strategy & 10 strategic priorities.

Integrated Care Strategy Pillar	**Pilar 1 - Making Gloucestershire a better place for the future.**	**Pilar 2 - Transforming what we do.**					**Pillar 3 - Improving health & care services today.**		**Conditions for Change.**	
Strategic Objective #	1	2	3	4	5	6	7	8	9	10
Strategic Objective / Transformation Programme	Increase prevention & improve long-term health outcomes.	Take a community and locality approach to the delivery of care.	Provide the right care in the right place when it is needed most.	Improve quality and outcomes across the whole person journey.	Achieve equity in access, experience and outcomes across health and care.	Create a One Workforce for One Gloucestershire.	Ensure the services we deliver today are sustainable and safe.	Improve the timeliness of care and treatment.	Transforming care through technology and estates.	Create a financially sustainable health and care system.
Enabling Active Communities & Individuals	✓				✓					✓
Health Inequalities Programme					✓					✓
Sustainability Programme					✓				✓	✓
Integrated Locality Partnerships		✓			✓					✓
Life-Course Programmes (Children and Older People)		✓		✓	✓					✓
CPGs – Condition-Based Programmes (eg. Diabetes)		✓		✓	✓			✓		✓
CPGs – Needs-Based Programmes (eg. Frailty)		✓		✓	✓					✓
Primary Care, Pharmacy Optometry & Dental		✓			✓		✓			✓
Diagnostics Programme		✓			✓					✓
Medicines Optimisation					✓		✓			✓
Planned Care & Elective Recovery Programme			✓		✓			✓		✓
Working as One (Urgent & Emergency Care)		✓	✓		✓		✓	✓		✓
Mental Health Programmes (Adults & Children)		✓	✓		✓		✓	✓		✓
Estates Programme					✓				✓	✓
Digital & Population Health	✓	✓		✓	✓				✓	✓
People / Workforce Programme					✓	✓				✓
Quality Improvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Enabling Active Communities and Individuals Programme

Our long-term ambition

We are committed to taking a more preventative approach to health and care. A system-wide focus is required to enable a preventative approach. Our ambition is two-fold:

- Weave prevention, early intervention and support that is focused on helping people stay healthy and live well with any long-term conditions, through all that we do.
- Address the wider social determinants of health outcomes including social networks, employment, housing and the environment.

We are committed to continuing work promoting and supporting people adopt positive health behaviours, through enacting new models of delivery, in new settings and targeted work with those in greatest need.

These healthy behaviours occur in the context of people's lives. Therefore, we recognise tackling the social determinants of health requires us to create the conditions which enable change – facilitated by the building of true partnership work between VCSE and statutory sector organisations and communities.

We are prioritising moving into tackling the social determinants of health – enabled by building of true partnership work between VCSE and statutory sector organisations and communities.

At its core our approach is all about partner and citizen engagement – shifting our system thinking to one where people and communities are at the very centre of how we approach health and care within the county.

This is long-term work requiring culture change in our whole approach to the creation of health in our communities. Putting the way we work on an equal footing with what we do, and consciously focussing effort and resource into developing our practice in that space.

The approach to transformational change is to experiment and learn. Our attention and investment is directed towards creating conditions for effective partnerships as we learn about what is needed in the system. Progress made in 2023/24 in developing our partnerships have laid the foundations upon which we are developing effective system working.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Improve life expectancy at birth and overall life expectancy including reducing the differential between different communities and different population groups.
- Slow the growth in people classed as obese amongst adults in Gloucestershire including reducing the differential between different communities and different population groups.
- Reduce smoking prevalence in adults in Gloucestershire including reducing the differential between different communities and different population groups.
- Reduce the number of physically inactive children and adults – including reducing the differential between different communities and different population groups.
- Continue to work with housing providers to increase the number of accessible properties in new developments. Including embedding Adapted Housing Registers with social housing providers.

Over the last year we have:

What we have done

- Put in place and spent time embedding a Memorandum of Understanding with the VCSE sector. This has led to an accountability representation model that solidifies the VCSE voice across One Gloucestershire Integrated Care System.

- Gloucestershire VCSE Strategic Partnership has been established to provide the overall direction and governance of VCSE sector engagement with ICS with members elected by the sector and all working within it.
- Secured investment and commenced a training and development upskilling programme for VCSE sector to support prevention and tackling inequalities.
- Continued investment in a range of community-based initiatives through our Strengthening Local Communities Grant.
- Delivered support to treat tobacco dependency for patients in Acute Inpatient and Maternity settings (the latter went live in October 23 in the most deprived areas of Gloucester).
- Continued to play a place-shaping role in improving healthy weight through initiatives such as We Can Move and locality-based initiatives such as Inner-City Gloucester Primary Care Network that has increased referrals in weight management and associated support.
- The Housing with Care Programme team are a consultee for planning applications for care facilities such as extra care housing, care homes and specialist housing and contribute to District Council Local Housing Plans.

What impact it has had

- Helped build the conditions for partnership working.
- Through our work to build partnerships with the VCSE sector, we have seen innovation across our system to involve more people, communities and organisations in our shared vision for a healthier county. The examples can be seen throughout our system as described within this Joint Forward Plan.
- Improved conditions for partnership have enabled a fuller contribution from VCSE in the commissioning in a CPG (Pain) particularly around co-production and development of peer support.
- More people have been supported to stop smoking.
- Supported 60 people a month with prevention and hospital discharge where people have an issue related to their home (through the integrated housing, health and care team).

Over the next 2 years we will:

What we are aiming to achieve next

- Increase the number of people being referred to digital weight management (healthy weights) service.
- Increase the number of people supported through stop smoking programmes – particularly in acute, maternity *(to 6% by 2025)* and mental health inpatient settings.
- Increase the number of people supported through the creative health programme – with a focus on engagement in more deprived communities and racially deprived communities.
- Refresh the Housing with Care Strategy with an aim to publish during Winter 2024

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Healthy Weight					
Continue to act as a key partner to increase physical activity levels across the county with We Can Move.	✓	✓	✓	✓	✓
Smoking					
Expand the tackling tobacco dependency programme in acute, maternity and mental health inpatient settings.	✓	✓			
Community Wellbeing					
Scope, engage and remodel the Community Wellbeing Service in Gloucestershire	✓	✓			

Social Value and Cultural Commissioning					
Develop a Cultural Commissioning Strategy to support an increase in capacity and capability across the Integrated Care System.	✓	✓	✓		
Work with partners to develop and embed a Social Value Policy that help us to evaluate the long-term work on improving heath and wellbeing outcomes for our population.	✓	✓	✓		

Health Inequalities Programme

Our long-term ambition

As a system we are prioritising our work to address health inequalities which are differences in health status, access to care, treatment and outcomes between individuals and across populations that are systematic, avoidable, predictable and unjust.

Whilst Gloucestershire's good overall level of health and wellbeing conceals large disparities. We know that we have a persistent, long-term health inequalities gap in our county.

The One Gloucestershire Integrated Care Strategy sets out our 5-year ambition that all staff working in our system, supported by our maturing Population Health Management approach and data, will understand health inequalities – what they are, why they matter and what action they could take within their roles.

It is a role for all transformation programmes to prioritise improving health equity. This includes addressing health inequalities in experience, access and outcomes and inequalities between different groups of people such as those with protected characteristics, socio-economic groups and geography.

This is the responsibility of all transformation programmes and has been embedded throughout the Joint Forward Plan.

We also have a programme of work that is helping to coordinate and bring leadership to our work in this area as described below. This includes improving data quality and completeness in order to improve how we assess whether improvements are being made to different population groups in access and outcomes.

Our long-term outcomes over the next 5 years and beyond are:

Through our coordinating work on health inequalities:

- To embed a commitment across all transformation programmes to tackle health inequalities – with a particular focus on a). the contributory activities they are making; b). the targeted interventions they are making to improve health and remove barriers and c). improving the equity of mainstream service delivery.

Through the work of our transformation programmes:

- To improve health equity for the 20% of most deprived areas in Gloucestershire (CORE20): Of the 373 Lower Super Output Areas (LSOAs) in Gloucestershire, 31 count amongst the most deprived 20% in England (8.2% of our county's population).
- To improve race relations across Gloucestershire (PLUS): Following an independent Commission report into race relations in Gloucester City we are prioritising work in this area, while ensuring that we consider a wider range of inclusion health groups who are more likely to experience poorer-than-average health access, experience and/or outcomes in our work.
- To improve outcomes across 5 clinical areas for adults & children across Core20PLUS5.

Over the last year we have:

What we have done

Our overall approach to improving health inequalities:

- Appointed two SROs for health inequalities including Director of Public Health for Gloucestershire County Council and CEO for Gloucestershire Health and Care NHS Foundation Trust.
- Developed a framework for considering health inequalities, using this as a mechanism for programmes to report back against the work they are doing to tackle health inequalities. This framework enables our focus on health inequalities to be visible throughout all of our work.

- Worked with research and VCS partners to deliver a project aimed at more proactively engaging with people and communities in health research with a specific focus on those impacted by health inequalities.
- Recruited over 1,000 local residents to join the One Gloucestershire People's Panel – people recruited are representative of the Gloucestershire population and engagement work has already been undertaken with the Panel to understand their views of health and care areas.

The specific contribution that transformation programmes are making to improving health equity as outlined within this Joint Forward Plan.

Looking to the future we will:

What we are aiming to achieve next

- Embed the framework of health inequalities enabling programmes and organisations to be able to report on their contribution to addressing health inequalities and through this ensure that there is a clear understanding of opportunities for improvement.
- Support transformation programmes in better understanding the actions they could be taking to improve health inequalities through communications and engagement, including promoting the Prevention and Health Inequalities Hub.
- Improve reporting of health inequalities within programmes – promoting data completeness and providing reports that highlight improvements and gaps in improving access, outcomes and experience for different population groups.
- Continue our commitment to Core20PLUS5 across our transformation programmes.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Programme Leadership and Governance					
Further develop our approach to health inequalities including system wide governance arrangements	✓	✓			
Carry out a stock-take to understand the breadth of work and identify gaps and opportunities for improvement	✓	✓			
Embedding Health Inequalities within Programmes					
Develop the approach to Equality and Engagement Impact Assessments across the system to ensure that service changes further describe the impact on health inequalities	✓	✓	✓	✓	✓
Launch the Gloucestershire Prevention and Health Inequalities Hub to help our staff better understand actions to improve health equity	✓				
Improving the equity of mainstream service delivery					
Produce an annual review of inequalities in particular areas to encourage better quality data, completeness, and transparency	✓	✓	✓	✓	✓
Develop a system outcomes dashboard to identify progress on reducing inequalities in life expectancy	✓	✓			

Sustainability Programme

Our long-term ambition

The NHS vision is to deliver the world's first net zero health service and respond to climate change, improving health now and for future generations. This means improving healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere.

In Gloucestershire, we share this ambition and our Green Plan (2022-25) serves as our shared proposals for how we will collectively reduce our emissions and support the delivery of our wider sustainability objectives.

Our six sustainability priorities to deliver against these ambitions are:

- **Transport and Travel**
- **Estates and Facilities**
- **Climate Adaptation**
- **Sustainable Models of Care**
- **Medicines and Procurement**
- **Workforce and System Leadership**

We will contribute to these long-term outcomes over the next 5 years and beyond:

- For the NHS to reach net zero by 2040 (Carbon Footprint) – achieving an 80% reduction in emissions between 2028-32 (against 1990 baseline)
- For the NHS to reach net zero by 2045 (Carbon Footprint Plus) – achieving an 80% reduction in emissions between 2036-39 (against 1990 baseline)

Over the last year we have:

What we have done

- Secured funding for the expert third-party review of our system estate to install Electric Vehicle charging points for fleet cars and district nursing teams, and formed a system project group, including the Local Authority, to develop An EV charging plan.
- Promoted the use of public transport with staff – seeking to reduce business mileage.
- Introduced automated meters and leak detection devices into community trust facilities.
- Introduced digital monitoring technologies enabling us to monitor patients more effectively through the new "Virtual Ward".
- Increased the green space and garden areas around Cheltenham General and Gloucestershire Royal Hospitals.
- Developed and launched shared education materials across all partner induction programmes, to deliver a consistent and ambitious message to all new staff members.
- Implemented sustainability initiative within primary care building on the previous year's scheme.
- Significantly increased the number of low dose inhalers in use within the County and reduced the emissions from anaesthetic gases (nitrous oxide).

What impact it has had

- More staff are using the shuttle bus for transport to our acute hospital sites in the county.
- Reduced nitrous oxide use saving 430 tonnes of CO2 per annum (equivalent of driving a family car 1.6 million miles or 65 times around the globe).
- Continued to reduce the environmental impact of inhalers.
- Our community and mental health provider reduced their carbon footprint by 33% (against the 19/20 baseline) in 22/23.

Over the next two years we will:

We will continue to deliver against our six sustainability priorities set out in our Green Plan. Our key commitments are set out below:

What we are aiming to achieve next

- Develop and start to implement sustainable travel plans across the county building on initiatives already in place.
- Reduce the use of single use plastics across the county including gloves and aprons.
- Work with System partners on a climate risk adaptation assessment and develop plans following this to mitigate risks.
- Continue to reduce emissions from our buildings.
- Continue to reduce emissions from medicines and procurement including further reduce the prescribing of CFC inhalers across Gloucestershire and medical gases such as Entonox.
- Continue to reduce emissions from fleet vehicles (initially through new electric vehicles).

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Transport and Travel					
Develop sustainable travel plans by 2026 including the development of e-bike, a bus incentive scheme and salary sacrifice schemes to support the move to electric vehicles.	✓	✓			
Ensure that all new vehicles in the NHS by 2027 will be zero emissions (excluding ambulances).	✓	✓	✓		
Estates and Facilities					
Introduce a new recycling contract to help reach our commitment to recycling of non-clinical waste.	✓	✓			
Develop a heat carbonisation plant & remove the oil fire central heating boiler at Gloucester Royal Hospital.	✓	✓	✓	✓	
Sustainable Models of Care					
Rollout a new patient portal to reduce paper copies of letters and other printing.	✓				
Implement electronic ordering of food to reduce waste (both GHFT and GHC).	✓	✓			
Medicines and Procurement					
Switch to low carbon inhalers and scope an inhaler recycling scheme.	✓	✓	✓	✓	✓
Continue to reduce the amount of anaesthetic gases we use in hospitals.	✓	✓	✓	✓	✓
Reduce the inappropriate use of single plastics such as gloves and aprons in operating theatres and across GP Surgeries.	✓	✓	✓	✓	✓
Workforce and System Leadership					
Relaunch the Green Champions programme during 2024/25 to help embed sustainability	✓	✓	✓		
Develop a Climate Risk and Vulnerability Assessment with Climate Leadership Gloucestershire	✓				

Review adaptation measures including heat wave plans, over heating events, assessment of flood risks to our sites with the development of actions as appropriate.	✓	✓			

Integrated Locality Partnerships

Our long-term ambition

In Gloucestershire we want to ensure we support communities to be empowered to build on the strengths and assets they have.

At the heart of this are the 6 Integrated Locality Partnerships across Gloucestershire. We are committed to the development of strong, mature partnerships in every locality with wide membership from partners and communities.

They are about bringing together partners to help:

- Proactively reduce the impact of root causes of health inequalities.
- Improve health and wellbeing.
- Work collectively to redesign care for people in localities and supporting them to live well at home.

Many of our ILPs are having a significant contribution to improving children and young people's mental health and wellbeing and supporting cohorts of pre-frail and mildly frail people to live and age well across the county.

Over the next two years, we aim to make sure we increase the involvement of people, the Voluntary, Community and Social Enterprise (VCSE) sector and communities more generally in projects across the county with a focus on increasing independence and health equity.

Our long-term outcomes over the next 5 years and beyond are:

- Support people and communities to be empowered to build on the strengths and assets they have and enable people to live well at home.
- Ensure that there is a close alignment between priorities and resource allocation within localities.
- Ensure strong, mature partnerships in each locality with wide membership from partners and communities.

Over the last year we have:

During 2023/24, we have built on the strong foundations created across the county with each of our six ILPs reviewing its membership and consolidating their priority projects. The work continues to be informed by a Population Health Management approach.

What we have done

- Supported projects in all localities through Strengthening Local Communities Funding
- Supported the delivery of the three exemplar themes in the One Gloucestershire Integrated Care Strategy – employment, smoking and blood pressure monitoring.
- Committed funding to the delivery of Community Health and Wellbeing Hubs in deprived areas of Gloucestershire that are designed to be flexible to meet the local needs in communities.
- Additionally, work in localities has achieved the following:
  - **Cheltenham**: Focused on projects falling within the Core20+ group such as such as substance misuse screening, a befriending scheme for people struggling with loneliness, and mentoring young people who are awaiting mental health interventions.
  - **Cotswolds**: Supporting people living with frailty - including offering strength and balance classes, healthy cooking and eating sessions.
  - **Forest of Dean**: Focus on projects that improve children and young people's mental health and educe obesity, support for drug and alcohol misuse and also pre-diabetics.
  - **Gloucester**: Delivering against 3 priority areas of Active Places; Active Spaces; and Active People.
  - **Stroud & Berkeley Vale**: Supporting people with frailty as well as their carers and developing a programme of activities for children to Get Active, Get Creative and Get Outdoors.

- **Tewkesbury**: Delivering against priorities of children and young people's mental health and employment.

What impact it has had

Some examples of the impact of the work in localities are:

- **Cheltenham:** Offering health, housing benefit and job support to over 40 people in West Cheltenham and supporting over 15 parents and carers to access support for children and young people in the locality.
- **Cotswolds:** 102 socially isolated and frail people have been supported via signposting to VCSE organisations such as Cotswolds Friends. In addition, healthy cooking and eating classes have been attended by 106 people with 27 families cooking over 25 different meals.
- **Forest of Dean:** 30-40 people have attended meals at the Lunch Club/Warm Space in the Forest of Dean. Additionally, welcoming 25-30 people to the Forest of Dean community hub, together with a growing number of Volunteers
- **Gloucester:** Use of the Strengthening Local Communities Grant in Gloucester has resulted in funding for 27 organisations supporting 14,000 individuals with 121 volunteers providing 1,457 hours of time.
- **Tewkesbury:** 117 young people (aged 12-16) took part in the Tewkesbury Youth Voice Forums.
- **Stroud and Berkeley Vale:** Over 3,000 carers have been supported in the locality with over 600 new carers being identified. 525 attendances to Harmony singing classes, 40 attendances to craft and arts sessions and a similar number of attendances to natural wellbeing and mindful photography sessions.

Over the next 2 years we will:

During 2024/25, each ILP will prepare an annual workplan which describes the work they will do to deliver their priorities and continue to involve local people in developing projects which promote independence and health equity.

What we are aiming to achieve next:

- Contribute to supporting pre frail and mildly frail people to live well at home.
- Contribute to supporting Children and Young People to live well in their communities.
- Ensure a greater involvement of people, VCSE and communities in priority projects across localities with a focus on improving independence and health equity.
- Support strong local governance (as non-statutory partnerships) with accountability for transformational change over the medium to longer-term.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Support delivery in ILPs against local and system priorities					
Contribute to supporting pre frail and mildly frail people to live well at home.	✓	✓			
Contribute to supporting Children and Young People to live well in their communities.	✓	✓			
Support the identification of priorities within ILPs ensuring alignment with Strengthening Local Communities Grant funding	✓	✓	✓	✓	✓
Contribute to the ICP exemplar themes – blood pressure, employment and smoking	✓	✓	✓	✓	✓
Support greater involvement of people & communities					

Consider where ILPs can strengthen their links to people and communities	✓	✓			
Strengthening links with Know Your Patch networks and VCS Forums	✓	✓			
Involve people with lived experience that help sharing ideas and aligning priorities.	✓	✓	✓		
Support strong local governance					
Periodic (likely annually) member surveys to inform our future direction	✓	✓	✓	✓	✓
Develop annual workplans with each ILP – commencing from 24/25 and report to EAC-I.	✓	✓	✓	✓	✓

Children and Young People, Ageing Well and End of Life Care Programmes

Our long-term ambition

Our One Gloucestershire vision is to make Gloucestershire the healthiest place to live and work – championing equity in life chances and the best health and care outcomes for all. Our programmes have areas of focus across all phases of the life journey, from childhood through to frailty and end of life care so that we can ensure that the services we provide, regardless of age are effective.

For children and young people we remain committed to early help and support, working together to improve health and care outcomes. This means integrating services so they are better connected (with a particular focus on children living with long-term health needs) and also support young people with transition to adulthood.

In line with our focus on SEND, we are committed to the development and implementation of a SEND Commissioning Strategy, to promote our joint approaches to meeting the needs of children and young people with SEND in a timely manner across universal, targeted and specialist provision.

For older people we are committed to interventions that build resilience, helping maintain independence - minimising periods of ill-health and the impact of frailty. We will facilitate networks of support within communities to support people to live longer in good health. Our future Proactive Care Strategy will set out our response to the National Proactive Care Framework. Our focus will be on maximising the number of years each person spends in good health adding quality to life, reducing crisis and unplanned care.

We know that over the next 5 years the largest increase in our population will be those living over the age of 85. We also know we have a growing number of children and young people living with life limiting and lift threatening conditions who also require palliative care. We will take a proactive approach to end-of-life care, promoting the importance of early identification and shaping services so that people receive the care and support they need to live well and die well. Our Palliative and End of Life Care Strategy (2021-2025) describes our aim to deliver good end of life care, so that the last stages of peoples' lives are they best they can be, and the people important to them are also cared for and supported.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Ensure that the services we provide, regardless of age, are timely, effective and accessible – with reduced waiting times for assessment and support.
- Provide personalised care and prevention services in the community that promote health and wellbeing for all and make every contact count.
- Slow the growth in attendances, admissions and length of stay for children and young people (with specific life limiting conditions) and patients living with frailty.
- Reduce the number of unplanned acute admissions in the last years of life for older people.

Over the last year we have:

Invested in a number of ways to improve outcomes for children and young people as well as older adults. We are increasing early help and support for children including in schools as well as proactively identifying older people to support them to remain at home for longer.

What we have done

- Designed an end-to-end pathway for children's weight management ensuring that there is a medical offer alongside existing voluntary and community sector provision for young people.
- Expanded medical needs in schools training provision - supporting teaching staff in special schools to support children and young people.
- Implemented a 'Personalised Proactive Whiteboard' to 13 of the 15 Primary Care Networks to identify adults in their last year of life.

- Established a Rapid Home to Die pathway with a discharge facilitator in the hospital enabling people to leave hospital quicker if their choice is to die at home
- Expanded the High Intensity Users Service in order to provide intensive support to adults who use health and care services disproportionately to their needs with evaluation showing a 50% reduction in hospital admissions.

What impact it has had

- More people requiring a 2-hour urgent response (via our Rapid Response Service) are receiving it now within that time frame and more than 80% of those treated do not require onward conveyance.
- More care homes now have Falls Champions – over 30% of care homes for older people now have this in place and bespoke support is being provided to the top 20% of homes with the highest rate of ambulance conveyances.
- More people on the end of life register now have a preferred place of death recorded a slight increase from 9.4% in 21/22 to 9.7% in 23/24.
- Fewer people are dying in an acute hospital compared to last year. In 2021/22 28% died in an acute hospital, in 2023/24 23% died in the acute hospital.

Over the next two years we will:

We will develop and pilot new ways of working while continuing to focus on reducing waiting times, especially for children and young people with higher needs.

What we are aiming to achieve next:

- Increase the number of children supported at school or in early years with speech, language and communication needs.
- Reduce waiting times for assessments and support in key services for children and young people.
- Increase the numbers of people accessing a 2-hour urgent community response service.
- Improve the experience of young people transitioning from children to adult health services.
- Increase the number of people with personalised care and support plans in place.
- Reduce the number of conveyances to hospital from residential care and nursing homes.
- Improved the identification of people who are approaching the end of life, ensure they have a recorded end of life care preferences and support them to die in their preferred place - therefore reducing the number of people dying in hospital.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Children and Young People Clinical Programme Group					
Continue the integration of health services for children in care (mental health with physical health)	✓	✓			
Pilot and evaluate the new children's integrated healthy weight service.	✓				
Pilot the Early Language Support for Every Child (ELSEC) to support language and communication	✓	✓			
Older People (Ageing Well Programme and Frailty Clinical Programme Group)					
Deliver a system wide Proactive Care Strategy to enhance our integrated neighbourhood team approach	✓				
Implement the refreshed National Enhanced Health in Care Homes Framework focusing on improving the quality of life for people living in care homes.	✓	✓			
Improve our delivery of proactive care to reduce geographical variation so more people living with	✓				

frailty and other long-term conditions receive support to remain at home for as long as possible.					
Increase the number of care homes receiving support including the falls programme and provide bespoke assistance for homes where conveyances are greatest	✓	✓	✓	✓	✓
Fully rollout and evaluate the Personalised Care Whiteboard to support proactive care deliver personalised proactive care in the community	✓	✓			
End of Life & Palliative Care Clinical Programme Group					
Introduce an urgent care hub that provides advice and support for families and carers at end of life	✓				
Review our commissioning arrangements for adult hospice provision across the county.	✓				

Clinical Programme Groups (Diabetes, Respiratory, Cancer and CVD/ Circulatory Programmes)

Our long-term ambition

Similar to other areas in the country, we have more people in Gloucestershire living longer with multiple long-term conditions.

Our well-established Clinical Programme Approach is our local response to the national ambitions set out in the national Major Conditions Strategy. This section describes our response to four of these areas – cancer, CVD (including stroke), diabetes and respiratory conditions.

Across these areas, we want to do educate people about preventing serious conditions before it occurs (primary prevention), diagnose and treat people earlier (secondary prevention), support people to live well with long-term conditions and where possible support them to manage their conditions at home (tertiary prevention).

Whilst our response here describes the work we are doing on addressing individual diseases, we are also shifting more towards integrated care – recognising that many people in Gloucestershire are living with multiple-long-term conditions.

Our 5-year ambitions are stretching, given that many of these changes will take time to deliver. But there is a commitment from across all partners to both prevent as well as support people living with these long-term conditions.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Continue to increase early diagnosis in primary care for key long-term conditions including type 2 diabetes, CVD, cancer and respiratory conditions such as COPD and asthma.
- Slow the growth in A&E attendances, ED admissions and acute length of stay for major long-term conditions – diabetes; CVD (including heart attack, stroke, heart failure) and respiratory conditions - and the number of patients diagnosed with cancer following an emergency admission.
- Contribute to slowing the growth in people living with long-term conditions including diabetes, CVD, cancer and respiratory. Empowering people to live well and self-manage conditions.

Over the last year we have:

What we have done

Diabetes

- Widened access to diabetes technology in line with NICE guidelines through our promotion and funding of Continuous Glucose Monitoring.
- Commissioned the creation of Diabetes Champion roles in primary care to support the upskilling of the primary care workforce.
- Participated in initiatives to improve outcomes for people with early onset Type 2 diabetes (aged 18-39).

Respiratory

- Increased the number of quality assured diagnostic tests for COPD and asthma conducted in primary care which are helping to ensure that people get the correct treatment at an earlier stage and optimise their medications.
- Launched two Acute Respiratory Infection (ARI) Hubs in January 2023 in some of the most disadvantaged communities in Gloucestershire, reducing secondary care related attendances, providing more effective management of acute presentations and optimising referrals into the virtual ward.

- Embedded COPD and Asthma diagnostic testing within Primary Care and the ongoing development of the Respiratory Champion role to support the upskilling of Primary Care respiratory workforce.
- Continued to provide Integrated Community Clinics with a view to reviewing complex respiratory and other breathlessness patients to improve their management plans within the community which would include medicines optimisation.
- Undertaken in depth audits of patients on nebulisers with clear outcomes that will influence ongoing pathways which will support the financial sustainability of this contract.

CVD/Circulatory

- Begun to develop a partnership approach to identifying challenges and solutions for and with our population relating to hypertension as part of the Exemplar Themes work.
- Ran public awareness events to help raise awareness about the importance of managing Hypertension as part of the 'Know Your Numbers' campaign. This included undertaking over 500 blood pressure checks with members of the public.
- Established a new Community Neurology Service which will give us more capacity and choice to support people to rehabilitate after a stroke.

Cancer

- Made changes to our cancer pathways to provide a more personalised approach and to ensure everyone can receive the diagnosis and treatment they need in a timely way.
- Ran public awareness events to help people recognise the signs and symptoms of skin, lung, colorectal and breast cancers.
- Piloted a prehabilitation service to help patients prepare for cancer treatment leading to a reduction in length of stay, admissions and use of the helpline post treatment.
- Completed roll out of the non-site-specific symptom pathway to help diagnose rarer cancers early and reduce the number of these cancers diagnosed following an emergency admission.
- Delivered a series of GP Masterclasses covering Lower GI, Gynae, Prostate, Haematology and Sarcoma cancers to over 143 GPs, nurses and other HCPS across 46 practices from all 16 PCNs.

What impact it has had

- Offering education on referral pathways to GPs and nurses to ensure practice teams knowledge is up to date, any local challenges on referral pathways are understood, to support clinical decision making and appropriate referrals. Improved relationships between GP practices and the hospital teams and peer support.
- Increased the quantity of prescribed continuous glucose monitoring (increase of 18% between June and August 2023).
- Ensured that 75% of people have a cancer diagnosis in 28 days (performance above target for 6 of 9 months of the year) and reducing time to diagnosis.
- Over 80% of Lower GI 2-week wait referrals are accompanied by FIT result improving triage times to diagnostics.
- Treated 65% of cancer patient referrals in 62 days (December 2023) – although this remains lower than the target of 85%. Unfortunately, the number of patients waiting (248 in January 24) has also remained higher than the target of 170 caused primarily by industrial action.
- Over in 600 complex patients with respiratory needs have been reviewed in primary care (since the implementation of the clinics) by a holistic team including a consultant who would have otherwise sought expert advice from secondary care.
- Over 12,700 patients seen in ARI hubs. The evaluation shows that there has been an impact on ARI ED attendances, showing a 7.1% difference in attendances from ARI hub areas compared to other non-ARI localities (lower attendances in ARI hub areas).
- Over 7400 FeNO tests have been undertaken in 23/24 in Primary Care as per best practice for the review and diagnosis of asthma, pre-covid there were 0 FeNO tests undertaken in county and therefore asthma was being diagnosed without any assured form of testing.
- Our diagnosis rate for hypertension is at 60.3% (June 2023) and our treated to target rate is 65.2% (June 2023).

- Feedback from the Know Your Numbers campaign was positive and over 100 people were signposted to additional support after having their Blood Pressure checked on the bus.

Over the next 2 years we will:

What we are aiming to achieve next

Diabetes

- Increase the number of individuals who are receiving annual diabetes reviews and completing the 8 care processes and three treatment target attainment.
- Support more people to access and complete the National Diabetes Prevention Programme
- Support more people to access structured education for self-management of their condition.
- Embed and develop the Diabetes Champion role in Primary care to improve diabetes care delivery.

Respiratory

- Increase the number and holistic quality of asthma and COPD annual reviews carried out in primary care.
- Implement a diagnostic complex breathlessness pathway with up to 1000 tests undertaken per annum and a comprehensive onward referral system.
- Increased referrals and completions to Pulmonary Rehabilitation.
- Develop a community offer to support patients to prevent or delay their deterioration prior to referral to pulmonary rehab.
- Improve integrated working across the respiratory pathway by improving and verifying the skill mix of the wider team to manage more complex patients in the community.
- Aim to introduce integrated community clinics within all 15 PCN's prioritising those with a higher clinical need or health inequalities.

Cancer

- Support more people to be diagnosed earlier for cancer (cancers diagnosed at stages 1-2).
- Maintain high numbers of people being diagnosed/given an all clear within 28 days of referral.
- Increase the number of people receiving treatment within 62 days of referral.
- Follow up and Surveillance (for potential reoccurrence and management of treatment related side effects)
- Improve the number of eligible patients attending invitation for cancer screening.
- Raise awareness of cancer signs and symptoms though a number of public engagement events.

CVD and Circulatory

- Increase the percentage of hypertension patients whose blood pressure reading is below the target treatment threshold *(ambition of 80% by 2029)*
- Increase the proportion of people aged 25-84 with a CVD risk score greater than 20% on lipid lowering therapies *(ambition of 60%).*
- Increase the percentage of patients receiving a medical thrombectomy as a percentage of all stroke patients *(target of 10% by end of 25/26).*

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Diabetes Clinical Programme Group					
Continue to widen access to diabetes technology (Continuous Glucose Monitoring & Hybrid Closed Loop Technology)	✓	✓	✓		
Improve access to structured education for people living with type 1 and 2 diabetes	✓	✓			
Improve access to national diabetes prevention programme	✓	✓			
Embed and evaluate the impact of the Diabetes Champion Role within Primary Care	✓	✓			
Respiratory Clinical Programme Group					

Create Asthma Friendly Schools in Gloucestershire including school training	✓	✓			
Deliver improvements to the Pulmonary Rehabilitation.	✓	✓			
Introduce wider skill mix to integrated community clinics within all 15 PCN's.	✓	✓			
Solidify diagnostic LES in Primary Care with a view to making it BAU by end of 24/25	✓				
Deliver complex breathlessness diagnostic activity from the Community Diagnostic Hub.	✓	✓			
Continue to support delivery of ARI hubs alongside the development of a cohesive winter resilience plan (subject to 24/25 funding).	✓	✓			
Cancer Clinical Programme Group					
Continued Best Practice Timed Pathway actions for cancer areas to improve waiting times.	✓				
Take part in the national pilot to carry out blood tests for early cancer screening (multi cancer blood test programme)	✓	✓			
Commence Targeted Lung Health checks to identify people with lung cancer before becoming symptomatic	✓	✓			
CVD/Circulatory Clinical Programme Group					
Launch an MOU to support primary care to continue to prioritise CVD prevention (e.g. carry out blood pressure checks and treat patients to target)	✓	✓	✓	✓	✓
Embed and evaluate the delivery of the Community Neurological Service	✓	✓			
Review the stroke pathway with the aim of developing an Integrated Stroke specification and pathway	✓				
Deliver Improvements across the Heart Failure Pathway (including via a Heart Failure Virtual ward).	✓	✓			

Dementia, Frailty, SEND, Learning Disabilities & Autism and Maternity and Neonatal Programmes

Our long-term ambition

We have a commitment to support people with different health and care needs.

In maternity services we will support implementation of the national Maternity and Neonatal Three Year Delivery Plan by 2026. We are developing a single system action plan that will better enable us to monitor progress of CQC, Safeguarding, Ockenden and Saving Babies Lives' action plans. We will concentrate efforts on four themes:

- Listening to and working with women and families with compassion.
- Growing, retaining, and supporting our workforce.
- Developing and sustaining a culture of safety, learning, and support.
- Standards and structures that underpin safer, more personalised, and more equitable care.

Both our Frailty Strategy (2022-27) and Dementia Strategy describe our plans for people living with these specific health needs. In both of these areas our emphasis is on:

- Prevention through education and awareness
- Early diagnosis through work in primary care and the community
- Supporting people to live well through support and integrated services
- Dying well through advanced care planning

Similarly, for children / adults living with Autistic spectrum conditions we published our All-Age Autism Strategy in 2023.

In line with national programme for LDA We are developing integrated models of care in the community that reduce the need for hospital wherever possible and to continuously improve pathways of support. By doing this, we aim to not only to minimise our need for hospital stays and out of area placements, but more importantly to improve quality of life.

Our long-term outcomes over the next 5 years and beyond are:

- Continue to increase early diagnosis for frailty and dementia in primary care.
- Slow growth in A&E attendances, ED admissions, inpatients and acute length of stay for frailty, dementia and for people living with learning disabilities and/or autism.
- Ensure quicker assessment and support for children and adults living with neurodiversity. Contribute to slowing the growth of people living with severe frailty and dementia in the county
- Continue to invest in SEND services working closely alongside education and social care to improve experience and outcomes for children and young people with SEND

Over the last year we have:

What we have done

Frailty and Dementia

- Commissioned the Dementia Adviser Service with Alzheimer's Society for 3 further years.
- Piloted a new approach to Dementia Co-Diagnosis in Forest of Dean which has helped people achieve timelier diagnosis and support.
- Developed a Frailty & Dementia Toolkit to provide best practice advice for health and social care practitioners.
- Developed a frailty interventions framework to ensure consistency of approach in the management of frailty across Gloucestershire.

- Developed an education framework to further develop skills and competencies across the county for the identification and management of frailty.

Learning Disabilities and Autism

- Introduced a Key Worker team and Dynamic Support Register to support children and young people with Learning Disabilities and/or Autism at risk of hospital admission.
- Appointed an Adult Learning Disabilities Dietician to train our system workforce to ensure people with learning disabilities are supported to achieve a healthy weight.
- Provided additional capacity to support adult annual health checks for people living with Learning Disabilities and ensuring health action plans are in place.
- Invested in improving pathways for both adults and children living Neurodiversity services to reduce waiting times.
- Maximised capital grant funding opportunities to develop bespoke housing solutions for people with complex environmental and support needs minimising risk of community breakdown.
- Recruiting an Autism Liaison Nurse to support those individuals accessing Gloucestershire's acute hospital.
- Learning into action from LeDeR reviews to reduce the health inequalities experienced by people with a learning disabilities and autistic people.

Maternity and Neonatal

- Put in place a Recruitment and Retention Team in Maternity services and developed a strategy to improve the retention and recruitment of midwives
- Rolled out a new Maternity Electronic Patient Records system across maternity services, giving women access to electronic maternity records and personalised care plans
- Continuing to monitor safety and quality in maternity services through the Local Maternity Neonatal System (LMNS) and established peer review arrangements with Bath, Swindon and Wiltshire LMNS.

Special Educational Needs and Disabilities (SEND)

- We have invested in our SEND workforce including recruiting a full time Designated Clinical Officer (DCO) and SEND Programme Lead.
- We have invested in our SEND Health advice service to improve experience and outcomes.

What impact it has had

- Ensured that there will be no commissioning learning disability out of county inpatient beds by end of March 2024 and reducing specialist inpatient activity.
- The Forest of Dean co-diagnosis project has increased dementia diagnosis from 59.9% to 67.4% - exceeding the national target.
- Increased our dementia diagnosis rate across Gloucestershire from 63% in March 2023 to 64% (national target is 66.7%).
- Reduced midwifery staffing vacancy rate from 14.8% (June 2023) to 7.8% (December 2023).
- The LMNS has established a dashboard to improve oversight of quality and safety outcomes.

Over the next 2 years we will:

What we are aiming to achieve next

Frailty and Dementia

- Increase the number of Comprehensive Geriatric Assessments for people living with frailty.
- Support the systematic identification of frailty across the 65 + population.
- Increase the diagnosis rate for dementia to achieve the national target of 66.7%.
- Roll out the dementia co diagnosis model across the county.
- Continue to deliver dementia public awareness focusing on minimising risk and how to get a diagnosis.
- Continue to deliver dementia education and training sessions to carers.
- Continue to deliver dementia education and training to staff.

Maternity and Neonatal

- Deliver safety ambitions for stillbirth, brain injury and neonatal mortality.

- Support recruitment and retention of the maternity workforce.
- Continue to develop a number of quality improvement projects to reduce health inequalities in maternity and neonatal, with a particular focus on women from ethnic minorities and the most deprived areas of the county.

Learning Disabilities and Autism

- Increase the percentage of people with learning disabilities receiving annual health checks and health action plans *(target of 75% and 100% respectively)*
- Reduce waiting times for assessments for ADHD & Autism.
- Reduce reliance on inpatient care for adults living with learning disabilities.
- Develop housing solutions to meet the needs of people with complex environmental and support needs.

Special Educational Needs and Disabilities (SEND)

- Work to reduce SEND waiting times improving access to services.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Dementia Clinical Programme Group					
Scope work to include a dementia awareness and prevention component in NHS health checks for the over 40s.	✓	✓	✓		
Determine the future model for dementia co-diagnosis across the county – learning from the pilot in Forest of Dean.	✓	✓			
Undertake a review of the Memory Assessment Service with a view to understanding waiting times and the service model.	✓				
Frailty Clinical Programme Group					
Engage and promote across the system the important of Comprehensive Geriatric Assessments for people with frailty needs.	✓	✓			
Continue to develop the Frailty and Dementia toolkit, bring together a range of resources and materials for practitioners.	✓	✓			
Support the systematic identification of frailty that will enable the targeting of interventions to build resilience and reduce the risks associated with ageing.	✓	✓			
Learning Disabilities and Autism Clinical Programme Group					
Continue to bring together pathways for autism and ADHD and recruit into the services to reduce wait times.	✓	✓			
Reducing our use of inpatient care by ensuring there are clear pathways of support and suitable housing options available in the community.	✓	✓			
Review enhanced LDA Pathway offer building resilient and robust community infrastructure to support people in their own homes.	✓	✓	✓	✓	✓

Reduce health inequalities experienced by people with a learning disability and autistic people through increased uptake of annual health checks and better access to good quality and accessible health action plans	✓	✓	✓	✓	✓
Analysis of the thematic issues arising from LeDeR Learning into Action to ensure implementation of strategic service improvements across the system.	✓	✓	✓	✓	✓
Maternity & Neonatal					
Develop a single action plan for maternity services enabling us to monitor key national and local objectives and deliver transformational change	✓				
Work with system partners to deliver safe, high quality and equitable care	✓	✓			
Special Educational Needs and Disabilities					
Delivery of SEND programme objectives which aim to deliver to deliver timely, effective, accessible, services.	✓	✓	✓	✓	✓

Primary Care, Pharmacy, Optometry and Dental Programmes

Our long-term ambition

We are committed as a system to supporting the sustainability of primary care whilst supporting appropriate access models for patients.

In 2023 as a system we took on responsibility for Pharmacy, Optometry and Dental Services. In 2024 we will be publishing a new Primary Care Strategy covering these services as well as primary care with the following commitments:

- Primary Care Sustainability
- Access
- Prevention and Proactive Care
- Health Inequalities
- Improving Quality
- Integrated Neighbourhood Teams

This strategy will also set out our commitments to delivering against the NHS England 'Delivery Plan for Recovering Access to Primary Care'.

In Gloucestershire, we have a strong track record of embracing new ways of working to enable us to offer the kind of care and access that people need. We know though, that pressures on services like General Practice are intense including significant financial pressures so we are working to ensure practices are sustainable while also delivering access, retaining our workforce and supporting people in their own communities.

Our Primary Care Networks have been introducing new ways of working to it easier for patients to make appointments with the most appropriate member of the team. Clinical pharmacists, physiotherapists, mental health practitioners, paramedics and other professionals working within or alongside practice teams, are also helping to meet the individual needs of patients.

Our long-term outcomes over the next 5 years and beyond are:

- Maximise the benefits of primary care working as integrated neighbourhood teams at scale –i.e. both between GP Practices and with wider community partners
- To continue to improve access to primary care – including urgent primary care when it is needed.
- To continue to work together to address population health needs within PCNs and improve outcomes for people.
- To develop a sustainable general practice model and workforce to support resilience.

Over the last year we have:

What we have done

- Taken on delegated responsibility for Pharmacy, Optometry and Dentistry services.
- Continued the ongoing delivery of the Primary Care Access Recovery Plan to improve access and experience for patients in primary care.
- Supported all 15 Primary Care Networks to provide Enhanced Access appointments on weekday evenings and Saturdays.
- Developed the primary care out of hospital offer to include ARI same-day access hubs and a review of our 7-day urgent care service (Gloucester Health Access Centre).
- Facilitated the delivery of Quality Improvement projects across Gloucestershire's Primary Care Networks (PCNs)
- Supported the delivery of national contracts in Primary Care including the establishment of new roles through the Additional Roles Reimbursement Scheme.
- Provided training for the primary care workforce including Nurses, Allied Health Professionals and Administrative staff in order to support recruitment and retention.

What impact it has had

- When compared with October 2019, we have seen a 28% increase in General Practice appointments provided in Gloucestershire.
- The number of patients seen on the same day (urgent) has increased compared to pre-COVID levels (155,000 in October 2023 compared to 122,000 in October 2019) whilst 40% of appointments (October 2023) are provided in 14 days (compared to 32% in October 2019).
- Overall, we have increased our headcount in primary care by 107 people primarily through the Additional Roles Reimbursement Scheme.

Over the next 2 years we will:

What we are aiming to achieve next

- Maintain high levels of available GP appointments and continue to offer appointments based on clinical need, including same/next day.
- Increase the percentage of regular / routine practice appointments taking place within 2 weeks.
- Provide enhanced access in primary care and enable efficient appointment utilisation.
- Continue to support recruitment and retention of staff across primary care – increasing the primary care workforce and reducing vacancy rates. Continue to work with practices to develop a sustainable model for primary care in Gloucestershire.
- Increase UDAs and dental access across County.
- Ensure smooth implementation and good utilisation of Pharmacy First prevision.
- Work with our Patient Reference Group to gain patients feedback and understanding to support delivery of high-quality primary care in Gloucestershire.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 27/28)	Year 5 (28/29)
Primary Care Access Recovery					
Deliver against the commitments in the Primary Care Access Recovery Plan, including developing a sustainable model for general practice	✓	✓			
Integrated Proactive Neighbourhoods					
Co-produce the design of Integrated Neighbourhood Teams in Gloucestershire	✓				
Launch initial phase of Integrated Neighbourhood Teams: Cheltenham Central, Rosebank Gloucester and Inner-City Gloucester	✓				
Learn from and widen the introduction of Integrated Neighbourhood Teams	✓	✓	✓	✓	✓
Primary Care Workforce					
Embed new staff roles, including the roles within the Additional Roles Reimbursement Scheme (ARRS), supporting retention and promoting development.	✓				
Expand the availability of our flexible workforce (e.g. Locum GPs) to support practices while we grow our workforce in the longer-term.	✓				
Pharmacy, Optometry and Dental					
Increase UDAs and dental access across county	✓	✓	✓	✓	
Ensure smooth implementation and good utilisation of Pharmacy First prevision.	✓				

Diagnostics Programme

Our long-term ambition

Over the next 5 years we aim to achieve an increase in the right diagnostic capacity that keeps pace with the increasing demand, with fewer patients waiting overall - and not longer than 6 weeks.

As part of this we are aiming to deliver an approach that focuses on high quality and clinically effective services.

We will continue to support and enhance our ability to meet longer term population needs, prioritising workforce, estate and equipment requirements, aligned to our values-based healthcare approach.

This will help us to meet our ambitions around addressing inequalities, with a locality focus and clinical pathway transformation.

Our long-term outcomes over the next 5 years and beyond are:

- Increase diagnostic activity which keeps pace with increased demand for diagnostics for the Gloucestershire population.
- Ensure that people receive diagnostics as quickly as possible (and as a maximum within 6 weeks).

Over the last year we have:

What we have done

- Opened the new Community Diagnostics Centre (CDC). The new facility at Quayside in Gloucester will offer an extra 80,000 diagnostic appointments a year by offering appointments 12 hours a day, seven days a week. Once fully operational, the centre will offer a wide range of diagnostic tests including X-Rays, MRI, CT, ultrasound, ECHO, DEXA, Phlebotomy, Sleep Studies and Lung Function.
- Mobilised MRI and CT scanners at Quayside House which has scanned over 6,000 patients so far this year.
- An ICS Diagnostic Workforce Strategy was developed and completed in 2023/24. The report focus was on the skills, competency, and capacity of the workforce now and what the anticipated future gaps and requirements will be.
- Endoscopy task and finish group established in 2023. The focus is to improve patient access and waiting times.
- CDC experience-based design data collection from patients and staff completed in 2023/24. This will help to inform the experience of people using and delivering the diagnostic services.
- The Gloucestershire Integrated Care Board is fully engaged with the West of England Networks to create and develop opportunities for optimising diagnostic delivery across the region. There is an ICS lead in post for each network.

What impact it has had

- Community Diagnostic Centre activity against plan has been delivered in the majority of modality areas and overall achieving 90% of agreed plan in 23/24.

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure that 95% of people have a diagnostic assessment within 6 weeks by March 2025.
- Deliver diagnostic activity levels to support the addressing of backlogs in elective care (planned care and cancer).

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Diagnostics					
Pilot an Ambulatory Blood Pressure Monitoring pathway through the Community Diagnostic Centre	✓				
CDC programme: continue to develop service improvement plans and pathway changes.	✓				
Support of the implementation of the Forest of Dean community hospital in 2024, opening additional diagnostic services at that site.	✓				
Continue endoscopy T&F group to improve access and waiting times for service.	✓				
Develop plans to improve turnaround time reporting in imaging and pathology to ensure results are communicated to patients in a timely way.	✓				
Support local hearing services to achieve accreditation for paediatric audiology.	✓				
Accreditation to be progressed across diagnostic modalities.	✓	✓			
Maximise our use of digital infrastructure to support intelligent booking and scheduling of patients.	✓	✓			
Implement a new ICS diagnostic workforce strategy so we develop a workforce with the right knowledge, skills and competencies now and in the future.	✓	✓			
Diagnostic Networks					
Procure and implement the Network image sharing solution to ensure effective scanning and reporting.	✓				
Continue to work with the diagnostic networks across imaging, pathology, healthcare science and endoscopy.	✓	✓	✓	✓	✓
Genomics					
Support mainstream teams to request genomics tests.	✓				

Medicine Optimisation Programme

Our long-term ambition

We want to work collaboratively across the ICS to develop a person-centred approach to safe, effective and sustainable medicines use.

We want to ensure a long-term approach which uses medicines to achieve better outcomes for our residents as well as improve health equity associated with the prescribing of medication and to ensure we achieve these outcomes within the available NHS resources.

In 2023-24 we have undertaken a review of activities to address inappropriate over-prescribing in primary care and are planning to deliver an Over-prescribing strategy to address recommendations from this review.

Our long-term outcomes over the next 5 years and beyond are:

- Ensure medicines are used in a way that improves outcomes for residents of Gloucestershire.
- Ensure we use medicines in a cost-effective way.
- Ensure that medicines are prescribed, used and disposed of in a way that reduces harm to the environment.
- Reduce avoidable harm associated with high-risk medicines.
- Reduce unnecessary prescribing (overprescribing).

Over the last year we have:

What we have done

- Drafted an overprescribing strategy which will inform the development of local implementation planning to address overprescribing in agreed priority areas of focus.
- Made significant savings for the ICS (on track to deliver £3.8m savings) by ensuring that we use the most cost-effective medicines whilst maintaining or improving outcomes.
- Significantly reduced CFCs in the environment by switching inhalers to more environmentally friendly versions.
- Provided a Gloucestershire service to ensure patients at high-risk of serious complications of COVID have access to medicines to reduce their risk.
- Reviewed patients in the community who are prescribed oral nutritional supplements to ensure they are still receiving benefits from the supplements.
- Updated clinical guidelines to ensure patients in Gloucestershire achieve better outcomes based on evidence-based reviews.
- Established a system wide medication safety group with a focus on high-risk medication (anticoagulants and sodium valproate).
- Worked closely with Clinical Programme groups to support their transformation programmes, including supporting the medicines element of the Virtual Wards.
- In order to reduce waste and improve outcomes we have worked with partners across the ICS to design a new way of ensuring nurses and patients have access to the dressings they need in a timely manner.

What impact it has had

- Reduced harm associated with inappropriate drug use, for example anticoagulants and over-prescribing.
- Savings generated have been used by the ICS to support patient care.
- Decreased our environmental impact associated with medicines.
- Reduced the risk associated with Covid infection for some high-risk patients.
- Reduced the impact caused by the over prescribing of oral nutritional supplements.

- Ensured patients have access to medicines most likely to improve outcomes.
- Reduced harm associated with high-risk medicines.
- Supported Clinical Programme Groups to achieve their transformation goals.
- Reduced the antibiotic burden in Gloucestershire.

Over the next 2 years we will:

What we are aiming to achieve next

- Continue to deliver financial savings through efficient purchase and use of medications.
- Improve the uptake of the most clinically and cost-effective medicines.
- Use the best value biologic medicines.
- Continue to reduce our environmental impact by focusing on inhalers and dressings initially.
- Continue to provide access to medicines for patients at high risk of Covid.
- Improve our antimicrobial stewardship by improving the documentation of penicillin allergy, reducing the number of broad-spectrum antibiotics prescribed and ensuring antibiotics are used for the most appropriate duration and reduce the number of times we use IV antibiotics in hospitals.
- Continue to reduce avoidable harm associated with high risk medicines.
- Plan for new medicines and treatments.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Continue our rolling programme of projects to ensure we use medicines in a cost-effective way (including biologic medicines)	✓	✓	✓	✓	✓
Implement NICE TAs (across all 5 years)	✓	✓	✓	✓	✓
Inhaler project to switch to more environmentally friendly inhalers	✓	✓	✓	✓	✓
Implement new way of providing dressings to patients and nurses (wound care project)	✓	✓			
Undertake a series of antibiotic associated projects (based on data)	✓	✓	✓	✓	✓
Complete actions associated with our Sodium Valproate implementation plan	✓				

Planned Care and Elective Recovery Programme

Our long-term ambition

Our overall ambition is to recover elective activity and performance targets back to, and better than, pre-pandemic levels.

Reducing elective waiting times and improving access while reducing health inequalities for specific cohorts of our population such as children and young people, ethnic minorities and areas of deprivation will require continuous improvement, service redesign, workforce planning and culture change.

This will be a challenge but one that all partners are committed to delivering.

Understanding the needs of our population and giving them the tools to better manage their health and care is also important, in particular through digital developments such as the patient portal and the NHS app.

This will enable patients to better navigate the health system and avoid unnecessary waste of clinical resources while empowering them to take more control of the health and wellbeing.

Our long-term outcomes over the next 5 years and beyond are:

- Continue to reduce the number of people waiting for elective care in Gloucestershire.
- Maximise our elective performance both within Gloucestershire Hospitals NHS Foundation Trust and the independent sector where needed - maximising productivity and efficiency of elective care services.

Over the last year we have:

What we have done

- The Gloucestershire referral pathway web-platform, G-care, has been revamped and relaunched to provide quicker and easier access to support GPs to manage patients in primary care and refer to the right service at the right time when specialist support is required.
- Made significant infrastructure improvements and ward reconfigurations as well as delivered a new day surgery unit and two new adjacent theatres in Cheltenham General Hospital.
- Via the Elective Care Hub, continued to proactively contact patients waiting for treatment to offer support and to identify patients who could either be safely removed from the list or who needed to be escalated for review. This year also included validation of overdue follow ups.
- Improved the utilisation of theatre time by initiatives to provide a retrospective and prospective look at theatre bookings using a new BI dashboard. Focus also on late starts and full booking of available theatre time.
- Optimised follow-up appointments to ensure that all appointments add value for the patient and free up capacity in the system. Patient-Initiated Follow-Up (PIFU) has been rolled out across all major specialties and GHFT now has the third-highest PIFU rate in the country.
- Introduced new ambulatory hip and knee pathway improvements with some patients now going home on the day of surgery.

What impact it has had

- Delivered value weighted elective activity above the revised 103% target compared to 2019/20 levels, a figure which we forecast will reach over 105% by the end of 2023/24.
- Whilst elective recovery continues to meet target levels, the number of people waiting over 65 weeks has not yet met target (819 waiting in early January 2024).
- Increased capped theatre utilisation of over 81% in November 23 compared to a low of 76% in June ’23 (against the target of 85%).

- The Elective Care Hub has safely removed 2,800 patients from waiting lists and escalated 1,100 patients where there were concerns about potential deterioration.
- Hip and knee surgery patients now recover more quickly from surgery (the average length of stay for hip patients has reduced from 4.5 days to 2.5 days on average. Similarly, knee patients' time in hospital has reduced from 5.4 days to 2.7 days).

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure that no-one is waiting longer than 65 weeks for treatment (by September 24) and reduce the number of people waiting longer than 52 weeks for treatment.
- Deliver a minimum of 107% value weighted activity (compared to the 19/20 baseline).
- Increase productivity of elective surgery (increasing the number of day cases as well as utilisation of theatres to a minimum of 85%).
- Increase the utilisation of outpatient clinic rooms and appointments while also reducing the number of DNAs.
- Reduce the number of outpatient follow ups without procedure and increase the percentage of outpatient follow-ups given a patient initiated follow-up appointment while also increasing the volume of follow ups who can be dealt with virtually.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Referral Optimisation					
System agreement of primary/secondary care interface principles and exploration of a primary care interface role within GHFT	✓				
Develop new G-Care pathway content as well as educational resources for GPs, helping to avoid unnecessary hospital appointments	✓				
Waiting Times and Waiting List Management					
Expand support to GPs by providing high-quality educational resources, including podcasts, videos, and formal training sessions	✓				
Elective Care Hub validation of follow ups and consultant note reviews pilots and roll-out	✓	✓			
Outpatient Transformation					
Introduce and optimise a new patient portal to make it easier for patients to contact the hospital if they need to cancel or change appointments	✓	✓			
Undertake clinic template reviews and develop clinic room utilisation reports to maximise use of existing resources	✓				
Inpatient and Daycase Services					
Embed the new ambulatory hip and knee pathways to maximise the benefits of a new day unit and theatres	✓				
Continue our theatre improvement programme with workstreams aimed at improving theatre utilisation, productivity and efficiency	✓				

Working as One Programme (Urgent and Emergency Care)

Our long-term ambition

Through our Working as One programme within Urgent and Emergency Care our vision is to deliver quality, integrated care for the people of Gloucestershire to support delivery of the best possible physical and mental health outcomes following access to urgent and emergency care service. The programme brings together key strategic partners across the One Gloucestershire system to redesign the way care is provided in our system by all partners working together to deliver the right care, in the right place, at the right time.

For the people of Gloucestershire, it will mean:

- Support for people to stay as healthy and independent as possible, preventing the need for care in the first place.
- Making it easier to get the help people need closer to home; with access to treatment at home or in a community-based setting as our first priority where a hospital attendance is not necessary.
- High quality services to help people recover independence after a hospital stay – with home as the preferred route.

For our staff, it will mean:

- Working in an integrated way to provide care.
- Empowering staff to make decisions that put the patient at the centre of the services we deliver and provide an environment to be innovative and provide quality care.
- A more connected system that enables us to flex our services to meet the needs of people as close to home as possible and facilitate access to the right urgent care services in a timely way.

The programme is further complemented by extensive improvement focus across our health and care system to improve performance delivery of our Urgent and Emergency services.

Our ambitious programme of work is based around five key workstreams: Prevention; Urgent Community Response and Front Door; Acute Hospital Flow and Decision Making; Intermediate Care and Access to Care packages.

Our long-term outcomes over the next 5 years and beyond are:

- Ensure a greater focus on prevention and anticipatory care.
- Ensure that there are effective alternatives to hospital within the community so that care can be provided when it is needed most as close to home as possible.
- Ensure that our urgent and emergency care services are accessible and timely when people need it.
- Ensure that effective discharge arrangements are in place with people supported and enabled to return home as often as possible, or to the most suitable discharge setting to deliver the best long-term outcomes focusing on independence.
- Maximise people's opportunities for independence, ensuring services are available to quickly support those who need it when they need it.

Over the last year we have:

What we have done

- We have provided a System Control Co-ordination Centre 7 days per week including bank holidays, to support partners through periods of escalation and increased demand across urgent care services to ensure that people require high quality timely care across Gloucestershire.

Prevention

- Provided clear information for primary care so they are informed about available alternatives to attending hospital Emergency Department (ED) in an urgent situation.
- Promoted the use of community-based services and pharmacies to support people to remain well and access urgent treatment for minor illness and injury.

Urgent Community Response and Front Door

- Developed proposals and commenced procurement for a Clinical Assessment Service which will enable people to access the most appropriate urgent care service at the most appropriate time to receive care and treatment.
- Consistently delivered improving standards of 2-hour urgent community response through our use of the Rapid Response service supporting delivery of urgent clinical assessment and treatment in peoples home where appropriate to do so and providing streamlined onward referral where necessary.
- Launched our Virtual Wards (respiratory and frailty) to enable patients to be monitored remotely and reviewed by specialist clinicians rather than require admission to hospital.

Acute Hospital Flow and Decision Making

- Carried out estate improvements at Gloucestershire Royal Hospital, increasing the available space and environment in the Emergency Department for adults and children and young people.
- Expanded Same Day Emergency Care within Surgery from December 2023 that will enable more people to be seen on the day through direct referral to surgical specialties, reducing congestion in the Emergency Department.
- Continued to expand the use of the discharge lounge at the hospital enabling 27% more beds to be released before midday on our Gloucester site (December 23 compared to December 22).
- Conducted Test and Learn trials to develop new ways of working at our hospital 'ED front door', to optimise access to members of the wider multi-disciplinary team early and maximise GP out of hours access to prevent admission to hospital where at all possible and improve the patient journey through our hospitals.
- Commenced Model Ward trials within Care of the Elderly wards in our acute hospital sites; aiming to improve and streamline the decision making of the multi-disciplinary team to make patient centred discharge decisions and reduce the time spent in hospital once people no longer require acute treatment.

Intermediate Care

- Put in place a range of options to support patients to be discharged from hospital in a timely way, including:
  - Additional home-based domiciliary care provision, to increase focus on discharging patients home with support as opposed to remaining in a bedded setting.
  - Implementation of the Forest of Dean Community hospital changes with a focus on providing rehabilitation care.
  - Maximising the use of the Community Assessment and Treatment Unit in Tewkesbury hospital, to step people up into a care setting for immediate bed based treatment not requiring acute hospital admission and facilitate timely discharge with appropriate support.

Access to Care Packages

- We have seen significant improvement in the time to arrange domiciliary care packages for people once they are ready to leave hospital.

What impact it has had

- Increased utilisation of our Minor Injury and Illness Units (attendances are up 5.5% over the period July 23-December 23 compared to the same time last year). This is supported by telephone triage and advice that continues to provide an alternative to attendance to an acute hospital.
- Reduced our use of Discharge to Assess beds by supporting more people to return home after a hospital stay with therapy support.

- Significantly reduced the time taken to arrange a package of home care from 16.8 days in January '23 to 5.5 days in December '23.

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure 70% of people requiring urgent community response services are responded to within 2 hours of asking for help; improving care closer to home and avoiding hospital attendance.
- Expand the number of people supported at home through Virtual Ward monitoring in partnership with primary care.
- Ensure that 80% of people attending our Accident & Emergency and Minor Injuries & Illness Units are assessed and treated within 4 hrs and either admitted transferred or discharged with appropriate support within these 4 hours.
- Support our ambulance service to respond to urgent calls more effectively (Category 2 calls) to ensure the most unwell patients in our community receive urgent treatment in line with national standards.
- Reduce the number of people ready, but unable to leave hospital and reduce inpatient stays longer than 21 days for all people to improve longer term outcomes and independence.
- Reduce general and acute bed occupancy in Gloucestershire Hospitals to improve efficiency of the patient journey.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Prevention and Anticipatory Care: Reduce or delay people getting to a point of urgent need					
Launch initial phase of Integrated Neighbourhood Teams	✓	✓			
Develop a trial focusing on falls prevention	✓				
Community Urgent Door Response & Front Door: Use other options to ED wherever possible					
Launch and embed the Clinical Assessment Service (CAS)	✓	✓			
Review and increase utilisation of the Rapid Response Service & meet the full requirements of Urgent Community Response	✓	✓	✓		
Hospital Flow & Decision Making: Optimise hospital length of stay and support onward discharge					
Continue to expand the Virtual Ward in Gloucestershire to support remote monitoring of patients who would otherwise be in hospital	✓	✓			
Embed the Same Day Emergency Care (SDEC) service and evaluate impact	✓				
Continue to expand the Model ward trial in order to achieve the optimal length of stay for a hospital admission	✓				
Intermediate Care & Reablement: Improve availability, flow & outcomes of care in the community					
Review the Discharge to assess bed approach to improve efficiency and reduce demand for bed based options	✓	✓			
Develop the Intermediate Care model for the Gloucestershire system	✓	✓			
Access to Care Packages: Ensure availability of long-term care for those who require it					
Review the approach to the provision of double handed care	✓	✓			

Adult and Childrens Mental Health Programmes

Our long-term ambition

Our ambitions are to ensure timely, effective and accessible mental health services for people across different population groups.

We aim to provide personalised and integrated models of care in the community that reduce the need for hospital wherever possible and to continuously improve the pathways of support for people with mental health needs and living with learning disabilities and/or autism, to minimise our inpatients and out of area placements.

Children and young people up to the age of 25 will be able to access mental health support within their community and schools from any trusted adult who will be confident in supporting them to access the right help.

We will provide earlier support for children, young people and families through digital interventions, train the trainer models, 1:1 and group support, reducing the need for referrals to our specialist services.

For those young people who present in crisis, support will be available within their local community preventing the need for unnecessary out of county placements.

By improving the experience of getting earlier help for all of our diverse communities across Gloucestershire, it will de-stigmatise accessing mental health support and help reduce health inequalities.

Our long-term outcomes over the next 5 years and beyond are:

- Contribute towards reducing premature mortality due to serious mental illness in adults and self-harm in children.
- Support the improved mental health and wellbeing of children and young people in Gloucestershire.
- Ensure timely, effective and accessible services for people across different population groups.
- Provide personalised and integrated models of care in the community that reduce the need for hospital and inpatient care for adults and children.

Over the last year we have:

Invested to improve access and outcomes for people with mental ill health. Our focus has been on reducing waiting times for children and young adults and on ensuring that care is available in local communities.

What we have done

- Implemented a place-based community mental health approach particularly for adults experiencing severe mental health. We have adopted DIALOG, a holistic questionnaire to measure quality of life of individuals and this is now central to the place-based approach we are taking for mental health.
- Local Community Partnerships are on the way to being established in all localities in Gloucestershire - bringing together partners to discuss how best to support people with a serious or enduring mental illness.
- Recruited in new roles to support people with mental health needs including people to work directly with Primary Care.
- Enhanced early support for children and young people including targeted provision of myHappymind placing importance on building resilience and promotion of good mental health and wellbeing as well as free, countywide access to Lumi Nova, a digital therapy app to help reduce anxiety.

- Piloted a multi-agency single point of access for children and young people experiencing mental health difficulties and educational barriers within Gloucester City encapsulating the approach that there is “no wrong door.”
- Continued the rollout of the Mental Health in Schools Trailblazer programme (Young Minds Matter) to over 130 schools in the county.
- Investment in increased capacity in existing services to so that children and young people experience earlier access to appropriate help and support.
- Commenced a review of provision for Eating Disorders including pathway re-design so that individuals are identified and able to access intervention earlier such as TEDS, a new counselling service for young people by TiC+, avoiding unnecessary deterioration.

What impact it has had

- Increased the number of patient contacts with community mental health services and ensured that wait times are within 4 weeks.
- Continued with improvements in Improving Access to Psychological Therapies (IAPT) – exceeding recovery and wait time ambitions.
- Reduced the reliance on out of area mental health placements.
- Begun to reduce NHS waiting times for eating disorder services.
- Reduced the number of referrals to Child Adolescent Mental Health Services - nearly 80% of children have an assessment in 4 weeks of referral.
- Increased recruitment into patient facing roles including as part of the place-based Community Mental Health approach.
- The Children & Young People's Multi-Agency Navigation Hub pilot has improved joint working across health, education, social care and voluntary sectors resulting in children, young people and their families accessing the right care, at the right time for Gloucester City.

Over the next 2 years we will:

We will develop and pilot new ways of working while continuing to focus on reducing waiting times, especially for children and young people with higher needs.

What impact are we aiming to have

- Increase recovery rates for people accessing IAPT services and increase reliable recovery and improvement rates for people completing courses of treatment.
- Increase access to transformed community mental health services (for children and young people as well as adults with serious mental illness).
- Increase the number of people with a serious mental illness who access an annual health check to improve their health outcomes.
- Maintain a low number of people placed inappropriately out of area for adult mental health support.
- Reduced waiting times for services including eating disorder services.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Children’s Mental Health					
Continue the rollout of Young Minds Matter into schools across the County (8th team in Sept. ’25).	✓	✓			
Provide additional capacity in TiC+ and Young Gloucestershire to support children and young people with mental health needs.	✓	✓			

Countywide expansion of the Children & Young People's Multi-Agency Navigation Hub.	✓	✓	✓		
Adult Mental Health					
Expand and embed the place-based community mental health offer.	✓	✓			
Continue the transformation of eating disorder services.	✓	✓	✓		
Rebrand Talking Therapies services, promote the service and recruit and train new staff.	✓	✓			
Implement improvements in urgent and emergency mental health services including review of Crisis Resolution and Home Treatment.	✓	✓			
Implement the Right Care, Right Person framework to assist the Police in decision making.	✓	✓			
Re-model therapeutic services for victims of sexual abuse and assault.	✓	✓	✓		

Estates Programme

Our long-term ambition

Across the Integrated Care System, we will prioritise capital (including estates) commitments and deliver against this – including backlog repairs maintenance.

In 2023/24 we have worked with primary care to develop a Service and Estates Plan for Primary Care Networks. Over the next year system partners will be coming together to develop a System Estates Strategy for Gloucestershire.

We have made significant achievements in 2023/24 to improve our use of estates and facilities across the system including:

- The development of a new Forest of Dean Hospital which will open in Spring 2024
- A new Community Diagnostic Centre that opened in January 2024 in Gloucester
- Continued work on the Gloucestershire Hospitals NHS Foundation Trust Strategic Site Development.
- Introduction of multiple new primary care premises and continued ongoing development across the County.

Our long-term outcomes over the next 5 years and beyond are:

- Support the move to ICS buildings across Gloucestershire being EPC B rated by 2030.
- Meet the need for a flexible, integrated estate that can be used by primary care, secondary care and community organisations.
- Deliver a revenue benefit from reducing building running costs and capital benefit from relevant building disposals.

Over the last year we have:

What we have done

- Gloucestershire Health & Care have focused on delivery of the New Forest of Dean Community Hospital which will phase going live in early 2024. It will include provision for community space within the hospital itself and which achieve BREAAM excellence (energy efficiency) benefitting from Solar PV, Air Source Heat Pumps, excellent insulation and other energy efficient solutions.
- Progressed a large extension at Quedgeley Medical Centre.
- Started building work for a new £6m Minchinhampton surgery in October 2023 which is due to open in October 2024.
- Completed significant work across our estate in respect to Fire Safety, Water Mains replacement (Cirencester), Alarm Systems (Charlton Lane), Lighting and Heating systems to address maintenance backlogs and to support patient safety.
- To make the best possible use of ICS property, to enable better system working and to reduce our carbon emission, the ICB moved into new offices within Gloucestershire County Council's Shire Hall in Gloucester.

What impact it has had

- In respect of the ICB office project reduced spatial requirements by around 50% from 2,200m2 to around 1,100m2.
- An absolute reduction in co2 emissions by 62.4% compared to Sanger House. Down from total carbon emissions of 105,732kgsco2 to 39,952kgsco2.
- Reduction in kgco2/m2 by 24.4% compared to Sanger House. From 48.06 kgco2/m2 to 36.32 kgco2/m2.

- Recurrent annual saving running costs of around £550k per annum in unneeded accommodation.
- Increased utilisation of an existing public sector asset by around 5.5%.
- Over the life of the 10-year lease, approximately £3.12m income remain within the ICS rather than being lost to the commercial sector.
- Increased capacity in primary care premises to deliver a wider range of services to an increased population by around 597m2 gross internal area- extra capacity for around 6,700 patients.

Over the next 2 years we will:

What we are aiming to achieve next

- Complete Phase 1 and 2 of Fit for the Future and Strategic Site Development and realise the benefits stated in the Programme.
- Complete key estates initiatives that support the separation of emergency and planned care and acute and community diagnostics.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Strategy and Framework Development					
Complete the development of a system estates strategy across Gloucestershire.	✓				
Produce a revised GP Premises Development Plan.	✓				
Develop an estates plan that will support the development of Integrated Neighbourhood Teams in the County.	✓				
Developing new facilities					
Open new surgeries including Minchinhampton, Coleford, Brockworth, Hucclecote, Lydney and Tetbury.	✓	✓	✓		
Opening of new Forest of Dean Community Hospital	✓				
Addressing backlog maintenance					
Continue a rolling programme of refurbishments in both the community/mental health provider and hospital.	✓	✓	✓	✓	✓
Releasing our assets					
Sell a number of NHS buildings contingent on new developments being delivered.	✓	✓	✓	✓	✓

Digital and Population Health Management Programmes

Our long-term ambition

As a system we approved our Gloucestershire ICS Digital Strategy in June 2023.

The strategy outlines our approach to supporting our citizens and staff to make the best use of technology as well as increasing the digital maturity and joining up care across our system.

The development of the Strategy was informed by comprehensive digital maturity assessments undertaken with partner organisations. As a system we remain committed to increasing digital maturity of both individual organisations and as a system.

The Digital Strategy is based around five key themes:

- **Delivery Framework**: establishing a delivery framework, plan and governance;
- **Data and Information Sharing:** Including procuring and implementing a new shared care record;
- **Levelling Up**: continuing to improve the digital maturity of our systems and continue to unify our infrastructure and systems;
- **Innovation and Growth**: Developing patient-facing technology that provides people with a less intrusive and alternative approach to managing their health and care needs.
- **Population Health Management (PHM)**: Enabling people to have population health insights that inform decision making. We remain committed to embedding a PHM approach across the system through our refreshed programme that takes a 'matrix' approach to contributing to the delivery of improvement and efficiencies across other programmes of work.

Our long-term outcomes over the next 5 years and beyond are:

Digital

- Ensure there is simplicity in how people access services and support through the use of digital technologies.
- Ensure that staff have access to the information they need to enable them to deliver the best possible care.
- Level up digital maturity across all organisations in the NHS in Gloucestershire.

Population Health Management (PHM)

- Ensure that all organisations in the ICS take a PHM approach: working in a way that uses data to proactively identify people and patients with the most capacity to benefit, supporting the most appropriate intervention design, and using evaluation to inform how the system addresses need.

Over the last year we have:

What we have done

Digital

- Developed a system-wide cyber security remediation plan which will enable health and care staff to safely have seamless network connectivity across the system.
- Over 1 million views of Gloucestershire ICS's Local Shared Care Record (Joining Up Your Information) have been undertaken by clinicians since it went live.
- Procured a new local shared care record. This record will mean that we are able to share real-time information across our system, improving the care and support we are able to offer.
- Increased local uptake and usage of the NHS app in Gloucestershire to 54% of the registered population aged 13 and over.

- Introduced a new maternity information sharing record system in our acute provider to support patient care for birthing people.
- Embedded digital monitoring as part of the rollout of the Virtual Ward hospital in the county to enable people to have their health monitored safely outside of a hospital setting.
- Approved a Digital Inclusion Plan which includes digital inclusion hubs provided by the VCSE in communities around the county.

Population Health Management

- Undertaken a strategic review of our approach to Population Health Management, using the resulting recommendations to drive forward our programme of work and investment.
- Undertaken a survey of skills across our analytical teams; this will inform training and development programme to support our developing PHM toolkit to share case studies and lessons regarding PHM with programmes.
- Linked health and social care datasets (for population health purposes) and continued analysis of this data to support targeted work within transformation programmes.
- Supported work on evaluation across key projects and programmes.

What impact it has had

Digital

- 43% of patients are enabled for online booking, amending and cancelling of appointments.
- 51% of patients are enabled to order repeat prescriptions and 35% of patients are enabled to view their detailed coded record.
- More people are enabled to make use of the variety of digital tools we will be rolling out.

Over the next 2 years we will:

What we are aiming to achieve next

Digital

- Support increased use of key digital applications by both staff and patients – including Joining Up Your Information (JUYI – our local shared record) as well as the NHS app.
- Increase the take up of digital services - increase the number of people able to book, amend or cancel appointments.
- Increase the use of Cinapsis to support smart referrals and enable easy access to advice and guidance.

Population Health Management

- Continue to support PHM projects within priority clinical programmes such as Urgent and Emergency Care, Frailty and condition-based programmes such as hypertension, diabetes, respiratory and cancer.
- Support local partners across the ICS in GP practices, PCNs, ILPs, and CPGs to initiate, establish, test, adopt and scale PHM approaches across the system.
- Invest in the development of analytical and wider workforce to enable PHM to be taken up across the system.
- Drive the use of our health and social care linked dataset, and work towards expanding and improving it to include partners who are responsible for tackling wider determinants of health.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Delivery Framework					
Develop a clear, costed roadmap for our whole system to allow us to shift resources and drive improvement across health and care by making sure	✓	✓			

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Delivery Framework					
that all system organisations have the digital foundations to support innovation and growth.					
Levelling Up					
Invest in improving the digital literacy and skills of our staff and communities so that people are easily able to access the timely and accurate information they need and we are able to make the best use of scarce resources.	✓	✓			
Innovation and Growth					
Launch and rollout the Person Held Record in our Acute provider enabling patients to have access to the information about their appointments	✓				
Data and Information Sharing					
Fully rollout the upgrade to the shared care record in Gloucestershire (*Joining Up Your Information*)	✓				
Population Health Management					
Invest to develop ICS-wide analyst capability to support the PHM approach	✓	✓	✓		
Drive implementation and impact of PHM including: wider workforce training and development; promoting evaluation; developing a PHM pipeline to support matrix work across clinical programmes and local organisations	✓	✓	✓		
Continue to analyse our existing linked dataset, and develop a clear roadmap to expand and improve the dataset with partners	✓	✓	✓	✓	✓

People Programme (Workforce)

Our long-term ambition

Our commitment is to create 'One workforce for One Gloucestershire' developed through our shared strategic priorities which are articulated in our One Gloucestershire People Strategy which was developed and published in September 2023.

Our People Strategy is based around the following 4 foundation themes followed by 4 pillar themes:

- Leadership and Culture
- Equality, Diversity and Inclusion
- Data, Digital and Technology
- Workforce Planning
- Recruitment and Retention
- Innovation
- Valuing our Staff
- Education, Training and Development

We want our workforce to be supported by a compassionate culture and experience an inclusive working environment which inspires, motivates and rewards everyone with the values, behaviours, skills and opportunity to deliver high-quality care and support every day.

Our long-term outcomes over the next 5 years and beyond are:

- Identify our talent and develop and support leadership at all levels across the ICS.
- Simplify and transform recruitment processes to improve accessibility and reduce the time to recruit.
- Grow our workforce for the future through continued efforts to attract and recruit new staff and their families to come and live and work in here.
- Develop new roles and ways of working including opportunities for rotation of staff and movement across our system.
- Retain staff through great induction, mentoring, learning and development, wellbeing support and flexible working options.
- Build a safe, compassionate and inclusive culture for all our staff.

Over the last year we have:

We have made good progress in working towards our goals, developing strong relationships with our ICS partners and ensuring we are in a position to grow a skilled, diverse and supported workforce which meets the needs of the people of Gloucestershire.

What we have done

- Developed the 'Be in Gloucestershire' project to promote Gloucestershire as a place to live and work as a GP.
- Developed the 'We Want You' project to promote health and social care careers in schools.
- Created an initiative to create a staff housing support hub and developed actions plans with our provider trusts to focus on retaining nursing staff.
- Developed a project to recruit 100 international domiciliary care workers to address a high vacancy rate in this important sector.
- Continued the development of system leaders including further cohorts of our 'systems thinking' programme and coordinating the One Gloucestershire Leadership Development alumni programme for the ICS
- Completed a system-wide nursing retention diagnostic and developed individual Trust action plans to address identified priorities.
- Both NHS providers have achieved Gold Employer Recognition status for Armed Forces veterans and reservists and the ICB has achieved Bonze status

What impact we had

- Increased staff recruitment – particularly into key roles such as in primary care, maternity services and mental health services
- Improved staff retention, reducing staff turnover and the number of staff leaving within 12 months
- Reduced agency usage and increased in Bank usage following visibility of agency booked shifts to bank staff (Nursing and HCA agency use has decreased by up to 50% in our community and mental health provider).
- Improvements across key staff survey measures.

Over the next 2 years we will:

We will continue to work towards our ambition of creating 'One Workforce for One Gloucestershire' across all of its 8 area themes.

What we are aiming to achieve next:

- Increase our focus on retention of staff, reducing staff turnover and the number of staff leaving within 12 months.
- Develop our ICS-wide Health and Wellbeing Strategy to provide staff support.
- Support strategic ICS priorities (such as neighbourhood working e.g. by facilitating staff to work across organisational boundaries and taking 'whole-system' perspective)
- Build our approaches to creating an inclusive and compassionate culture together with the HR and management processes that will improve the diversity of staff at all levels.
- Reduce the use of agency, temporary and off-framework staffing across Gloucestershire.
- Show an improvement across key staff survey measures.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Leadership and Culture					
Develop a system-wide leadership delivery plan and subsequently implement it	✓	✓	✓	✓	✓
Develop system capability and culture through leadership events and systems thinking masterclasses	✓	✓	✓	✓	✓
Workforce Planning					
Assess the implications and develop local plans to respond to the NHS LTWP	✓	✓	✓	✓	✓
Recruitment and Retention					
Launch and expand the "Be in Gloucestershire" campaign	✓	✓			
Facilitate staff moving & working across the system to enable strategic priorities	✓	✓	✓		
Improve recruitment processes (from EDI and efficiency perspectives)	✓	✓			
Reduce agency spend and use of off-framework in line with operational planning requirements	✓				
Valuing our Staff					
Develop and implement a system-wide HWB strategy and review of existing service offers (also links to retention)	✓	✓	✓		
Develop a Housing Hub service to support staff in securing accommodation	✓	✓			

Education, Training and Development					
Raise awareness of Health and Social Care career opportunities through school engagement, T-Levels, apprenticeships	✓	✓	✓	✓	✓
Strengthen relationships with research partners and increase the research capability and delivery	✓	✓	✓	✓	✓
EDI					
Develop and implement our EDI High Impact Actions	✓	✓	✓		

Quality Improvement Approach

Embedding an improvement approach across health and care.

Our long-term ambition

We are committed to embedding improvement approaches into our core strategy and operations at all levels within our organisations and in how we collaborate as health and care partners.

Improvement approaches provide systematic tools for delivering measurable benefits for the people we serve, staff, organisations, and our wider system. They enable us to effectively deliver improvements within care settings, across care pathways and when tackling large-scale service delivery challenges.

Our ambition is to create a system-wide culture of improvement, where everyone is an improver, collaborating with people and communities.

The benefits of an improvement approach are:

- **For people and communities:** improved care outcomes, experience, and safety. Better access, earlier diagnosis, and more streamlined care.
- **For our staff:** positive and collaborative culture, support to improve services, job satisfaction and development of professional skills.
- **For our organisations:** consistent delivery of high-quality care, effective allocation of scarce resources, removal of delays, duplication, and waste. Designing sustainable services.
- **For our system**: stronger collaboration, improved flow, scaling of innovation within new models of care.

Over the last year we have:

We have a strong track record of nurturing Quality Improvement in our organisations, with thriving educational programmes developing the capability and capacity within our teams. In October 2022 we formed a system-wide Improvement Board which brought senior leaders together and guides how we create the conditions for improvement across our system. In March 2023, we produced our first Improvement Community Strategic Approach, and an associated delivery plan which is now rapidly building momentum in line with the recommendations of NHS Improving Patient Care Together.

Over the last 12 months, our work as an Improvement Community has developed within our organisations and we have successfully designed and tested new approaches to supporting cross-system improvement.

What we have done

- Delivery of a tailored capability building offer across our system to meet the needs of all colleagues, spanning from foundation levels through to advanced practitioners. Our training programmes reached over 1600 participants this year.
- Developed our collective expertise through internal and external accreditation to ensure we meet the needs of staff in our system.
- Facilitated the delivery of system design work in the areas of highest strategic priority including urgent and emergency care, frailty, mental health crisis for both adults and children and young people, virtual wards, integrated neighbourhood teams and lower limb care.
- Worked in partnership to support the delivery and evaluation of improvement project work in primary care, in collaboration with business intelligence and engagement colleagues.
- Designed a new Adult Social Care quality strategy that embeds commitment to a quality improvement approach.
- Elevated the importance of improvement, with the launch of the ICB Improvement Story feature.

- Prepared for the delivery of ICB board and ICS leadership development sessions, incorporating the Health Foundation's new Improving across Health and Care: a framework.
- Communicated our progress as a case study in the NHS Confed & Health Foundation Paper 'Improving Health and Care At Scale: Learning From Experience Of Systems'
- Achieved recognition Gloucestershire through Health Service Journal awards, and other national and regional awards.
- Celebrated the achievements of improvers locally with regular in person celebration events.

What impact has it had

- Strengthened our ability to deliver continuous improvement, transform models of care across organisational boundaries and to adopt innovation.
- System staff survey data indicates people feel able to make improvements to their work.
- Supported our teams to deliver improved outcomes for quality of care, reduced health inequalities and better health and wellbeing.

Over the next 2 years we will:

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Convene					
Mobilising our collective leadership to connect with our shared vision, evolving our effective system improvement approach.	✓	✓			
Integrate					
Embedding an improvement approach into One Gloucestershire's strategic planning, prioritisation and transformation delivery programmes.	✓	✓	✓		
Learn					
Delivering a range of education programmes for our workforce, consistently founded on the Model for Improvement. Application to practice is enabled through Improvement Coaching.	✓	✓	✓	✓	✓
Facilitate					
Provide bespoke system facilitation for partners delivering complex change to design programmes which deliver positive outcomes. Targeted on ICS Priorities.	✓	✓	✓	✓	✓
Connect					
Bring together a unified community, with a cohered identity, enabling networking, connections and continued learning.	✓	✓			
Collaborate					
Partner in Organisational Development to build our collaborative culture and leadership for improvement.	✓	✓	✓		
Celebrate					
Recognising and share successful improvements and lessons learnt through celebration events and system-wide showcase opportunities.	✓	✓	✓	✓	✓

Delivering our legislative requirements

Duty	How we have / are delivering this requirement
1. Describe the health services for which the ICB proposes to arrange to meet needs	The refresh of this Joint Forward Plan describes what we are doing to improve the health needs of the population in Gloucestershire. In 2023/24 we have continued to monitor delivery of this plan through the Integrated Performance Report to our Integrated Care Board. Our Operating Plan (delivered in 2023/24 and being finalised for 2024/25) provides more information on the planned performance of our services. In addition, more detailed information can be found on our websites: • Gloucestershire Health and Care NHS Foundation Trust • Gloucestershire Hospitals NHS Foundation Trust • South-Western Ambulance Service NHS Foundation Trust • Voluntary, Community and Social Enterprise (VCSE) partners (VCS Alliance) • Gloucestershire County Council • NHS Gloucestershire Integrated Care Board
2. Duty to promote integration	We remain committed to providing health services in an integrated way with our system partners. Our long-term plans are set out within this Joint Forward Plan and our Integrated Care Strategy **Over this last year we have:** • Continued our commitment to bring services together around the needs of local people. For example, the Community Mental Health Transformation Programme is bringing together multi-disciplinary teams within communities to support people with severe mental illness. • Continued to progress with our wider Integrated Neighbourhood Team ambitions with a particular focus on proactively supporting patients with frailty needs. This will remain a key priority for Gloucestershire as we go into 2024/25. • Continued to show our commitment to addressing health inequalities. Our ICS Transformation Programmes are prioritising work with specific population groups or deprived communities. For example, we are prioritising mental health work in schools with areas of higher deprivation. • Continue to work together as system partners at a strategic level. Gloucestershire County Council and wider health partners are represented on the Integrated Care Board. We also have well established Joint Commissioning Partnership arrangements that are responsible for the management of Section 75, 76 and 256 funding. We remain committed to this principle as we look forward to 2024/25.

3. Duty to have regard to the wider effect of decisions	As a system in 2023/24 we have continued to ensure that all our transformation and development focuses on the triple aim of improving population health, improving quality and improving value. This year our System Resources Committee has led work on shaping our approach to value. As a system we have defined value as "achieving our priority outcomes within the resources that are available to us". Our approach continues to focus on: • **Improving population health:** This Joint Forward Plan sets out the work we have done and the outcomes that we have achieved to improve population health for our local communities. Our six Integrated Locality Partnerships are central to this work alongside the role of GP Practices and 15 Primary Care Networks. • **Improving quality**: Our Quality Committee and System Quality Group have continued, over this last year, to assess the quality of health and care services across Gloucestershire based on the three principles of experience, effectiveness and safety. This is underpinned both by quantitative and qualitative data. • **Improving value**: Our System Resources Committee provides both support and challenge on our approach to delivering value across the system. In this last year we have established an evaluation task and finish group that is focused on assessing the value delivered by our investments. Regular monitoring of benefits is taking place across key schemes including those outlined within our Joint Forward Plan.
4. Financial duties	Over this last year we have demonstrated our commitment to meeting the financial duty requirements of Integrated Care Boards. The national financial framework requires a collective responsibility to not consume more than the agreed share of NHS resources. We believe that working together towards common goals rather than competition is the best way to join up services to meet people's needs, tackle inequalities and improve outcomes. In 2023/24 we have continued to work towards a set of guiding values and behaviours – making decisions collectively together around the financial position and risk. Budgets of all our organisations are going to be challenging given the economic position and demand on our services. Our System Resources Committee has played an important role in providing support and challenge to delivery of our financial duties in 2023/24 and we have undertaken work across the system to define and develop our approach to values- based healthcare. **Going into 2024/25 we will collectively continue to prioritise:** • Reviewing current resources, testing the value of current services and transforming services where better value can be identified.

	• Monitoring the benefits from programmes of work within the Joint Forward Plan to ensure that financial and non-financial outcomes are delivered. • Improving the productivity of services through benchmarking, identifying opportunities which can then lead to improvements in the way that we use our collective resources and release cost reductions where appropriate. • Prioritising – and challenging any investments so that they are delivering the strategic priorities outlined within our Joint Forward Plan. • Ensuring that we have effective governance and controls in place across the system to ensure resources are managed appropriately.
5. Duty to improve the quality of services	Everybody has the right to feel safe and have confidence in the services provided across Gloucestershire. We are committed to securing continuous improvement and will strive to ensure that our services, and those we commission, are high quality and that we have robust mechanisms in place to intervene where quality and safety standards are not being met or are at risk. In 2022 we published our first ICS Quality Strategy and Quality Framework. These two documents describe how we have arranged ourselves to deliver on our ambition for the services we commission or provide to be safe, effective and that people who use them have a good experience. Our Quality Strategy describes our shared commitment to improving quality across services in Gloucestershire. **In 2023/24 we have prioritised our work to improve the quality of services through**: • Regular coordination of the ICB Quality Committee and System Quality Group which play a strategic role in assessing and improving quality across the system. • Reporting on quality achievements and issues through our ICB Integrated Performance Report with key metrics for system oversight • Providing specific support and assurance in key areas such as maternity services across Gloucestershire. **In 2024/25 we will undertake the following:** • Review the Quality Strategy and Quality Framework, reflecting our experience since becoming an ICB. We will take note of our successes and focus on our Quality priorities, ensuring improved outcomes for patients and focusing on inequalities being the 'golden thread'.

	• Continue to refine and develop our Experience, Effectiveness and Safety groups, which help provide insight and assurance to both Quality Committee and System Quality Group. • Introduce the new Patient Safety Incident Response Framework (PSIRF), taking the opportunity to strengthen our collaborative approach with all partners to ensure learning is shared system wide and can positively impact on patient safety.
6. Duty to reduce inequalities	We remain committed to work across the system to reduce health inequalities and take seriously our statutory duty to lead oversight and assurance for the system. Our Joint Forward Plan sets this as one of our strategic priorities and we have made progress in 2023/24 against this. The One Gloucestershire Integrated Care Strategy sets out our 5-year ambition that all staff working in our system will understand health inequalities – what they are, why they matter and what action they could take within their roles. **In 2023/24:** • We have contributed to working on Exemplar Themes within the Integrated Care Strategy of smoking, blood pressure and employment – with a particular focus on addressing inequalities within this. • We contributed to the first Gloucestershire Health Inequalities and Employment Summit that bought together organisations whose purpose is to support people who are or are at risk of becoming unemployed or economically inactive. • We appointed two Senior Responsible Officers (SROs) for Health Inequalities - the Director of Public Health for Gloucestershire County Council and the CEO for Gloucestershire Health and Care NHS Foundation Trust. The SROs have the remit to draw wider attention to the health inequalities agenda across the One Gloucestershire Integrated Care System. • We have contributed to the launch of the Gloucestershire Prevention and Health Inequalities Hub across the system, which is an online compendium of information, resources, and practical tools designed to help the Gloucestershire ICS workforce better understand and take action to improve health equity in their areas of work **Looking towards 2024/25, we will:** • Continue to expand our knowledge and reporting of health inequalities in our system. This includes adhering to the requirements set out in NHS England's Statement on Information on Health Inequalities to collect, analyse and publish information on health inequalities to inform development and planning of targeted action to reduce inequalities in healthcare.

	• Routinely and robustly consider health inequalities as part of service development/change through the application of the organisational Equality and Engagement Impact Assessment, ensuring that we comply with the requirements of the Public Sector Equality Duty (Equality Act 2010). • Embed the Prevention and Health Inequalities Hub resource into business as usual so that health inequalities are widely understood and routinely considered.
7. Duty to promote the involvement of each patient	We are committed to promoting personalised care across all the services we deliver across our organisations. We have nominated a senior executive to facilitate a peer network of system leaders and experts by experience to work collaboratively, pledging commitment to coproduce innovative approaches and collect evidence to demonstrate effectiveness on implementing a universal recognise approach to personalised care through the One Gloucestershire Personalised Care Programme Board. Across our organisations we are updating our pledge commitment to use plain language and foster a culture shift for health and care professionals and people, valued as equal partners, providing choice and control on the way their health and care is delivered based on 'what matters to you' conversations, recorded in easily accessible care plans, digitally interoperable between system partners, held in a universally recognised folder owned by a person living with a complex/long term condition. Our approach is based on the seven components of the comprehensive model of personalised care. This includes: Other interdependent work includes personalised proactive (anticipatory) care working to co-develop risk stratification tools to support NHS partners to profile vulnerable people; facilitate multi-disciplinary (agency) team meetings to discuss and agree to proactively reach out to people; arranging to hold 'what matters' conversations and coproduce personalised care and support plans." **In 2023/24 we have:** • **Shared decision making** – we are committed to 'what matters' conversations and have procured accredited training with the Personalised Care Institute to upskill our workforce in competencies associated with the model of personalised care. • **Personalised care and support planning** – we have made good progress in mobilising branded personalised care and support plans (Me at My Best and ReSPECT) for people living with complex/long term conditions, hosted in a 'What Matters to Me' folder across services which enables us, with people, to capture information about what matters to them. Areas such as frailty, end of life care and maternity are regularly using these. • **Enabling choice including legal rights to choice** – See duty to patient choice (above).

	• **NHS @ Home** – exploring the use of digital tools to support people maintain their unique wellness at home including Virtual Ward for Frailty and Respiratory care. • **Social prescribing and community-based support** and expansion of **personal health/wellbeing budgets** – these are a core part of our service offer to residents. For example, one-off personal wellbeing support budgets being used in partnership with Age UK to support timely hospital discharge and trialling of Frailty & Dementia Proactive Care Personal Wellbeing Budgets to support the integrated neighbourhood prevention agenda. • **Supported self-management** – with patients we are committed to continue to support self-management of health and care conditions. This includes the use of digital tools such as GetUBetter – a digital solution to support patients with a range of musculoskeletal conditions and My Concerns & Wellbeing (MyCaW) being deployed for people living with frailty. **Looking to 2024/25 we will be:** • **Shared decision making -** Exploring use of digital tools to reporting on real-time patient reported experience measures and patient reported outcome measures. • **Personalised care and support planning -** Continued expansion plans across the whole life cycle and we are exploring opportunities across clinical programmes as part of Living Well and Waiting Well in elective care. • **Enabling choice including legal rights to choice** – See duty to patient choice (above). • **NHS @ Home** – Exploring the use of digital tools to support people maintain their unique wellness at home. • **Social prescribing and community-based support** and expansion of **personal health/wellbeing budgets** - Expansion of personal health/wellbeing budgets and trialling of Frailty & Dementia Proactive Care Personal Wellbeing Budgets to support the integrated neighbourhood prevention agenda. • **Supported self-management -** Other offers include peer coaching through the Digital HOPE Programme and Live Better Feel Better
8. Duty to involve the public	In 2022 we published our ICB Working with People and Communities Strategy which sets out our principles, how we will work and the mechanisms we are putting in place to ensure that the people and communities of Gloucestershire are at the heart of all that we do. The Strategy is based around five commitments. **In delivery of this strategy, in 2023/24 we have:**

	• Introduced a new Citizens Panel with over 1,000 people – representative of the Gloucestershire population. This Panel is providing us with an opportunity to hear from different groups of people to shape health and care services in the County. We have engaged the Panel this year on priority areas for our strategy. • Undertaken focused engagement within our Core 20 communities as part of our commitment to tackle health inequalities. • Built and maintained relationships with previously underserved communities with the input of a dedicated resource. This working alongside partner organisations to collect individual and group experiences and liaise with ICS colleagues to ensure the insights gathered inform service development, delivery and evaluation of reducing health inequalities programmes. **Looking to 2024/25 we will be:** • Continuing to expand the engagement with the Citizens Panel on new areas that will support the delivery of our Integrated Care Strategy and Joint Forward Plan • Introducing an Insight Hub that will be an online library that will collate feedback from local people and communities. We will also use the learning from involvement activities such as Fit for the Future and a new community hospital in the Forest of Dean. The delivery of the Strategy is being overseen by our Working with People and Communities Advisory Group that is made up of community and public voice partners.
9. Duty as to patient choice	We remain committed to supporting our GPs to offer meaningful choice to people registered with their practice, as set out in the NHS Constitution for England and the NHS Choice Framework. Our commitments to patient choice can be found here. **In 2023/24 we have:** • Established a clear process for managing the national alternative choice (PIDMAS) programme, and successfully rolled this out to eligible patients in the nationally defined first cohort. This process will ensure that patients are offered the opportunity choose to transfer to an alternative provider if they have waited longer than agreed waiting times standards. We will roll this process out to further cohorts of patients in line with national requirements as an when further national guidance becomes available. • Put in place a robust provider accreditation process for services within the scope of choice to allow new providers to easily enter the NHS market or existing providers to deliver additional services in line with national choice guidance and the new NHS Provider Selection Regime. **Looking to 2024/25:**

	• We are working towards ensuring that patients are routinely offered an average of 5 choices of provider at the point of referral in line with Choice guidance issued in May 2023. Changes to the Electronic Referral System (eRS) are due to be implemented nationally in March 2024, which will enable our GPs to offer patients a mixed shortlist of both Directly Bookable and Referral Assessment Services. As soon as NHS Digital deliver this functionality we will work with our GPs to ensure that all patients are offered an appropriate provider shortlist in line with national guidance. • We will also continue to provide of GPs with accurate and accessible information via the ICB G-care platform on waiting times across local providers. This supplements the waiting time information available through public facing digital tools, including the NHS app.
10. Duty to obtain appropriate advice	As a system we continue to prioritise the importance of ensuring there is a strong clinical and care professional voice in advice and decision making across the system. We are continuing to implement the Clinical and Care Professional Leadership Framework that was published in 2022 – and our Clinical and Care Professional Council plays a key role in bringing together leaders from across Gloucestershire. **In 2023/24 we have further developed our approach in this area by:** • Appointing a new ICB Chief Medical Officer and ICB Chief Nursing Officer in Gloucestershire • Ensuring that our transformation programmes that are making improvements about health and care in Gloucestershire have strong care and clinical leadership. This year we have recruited into key roles to support our strategic ambitions. This includes clinical leadership for our Working as One (Urgent and Emergency Care Programme). • Our Clinical & Care Professional Council continue to work to deliver the intentions of the 2022 Framework and Action Plan. Membership of Council has been reviewed through 2023 to ensure a broader range of strategic system partners. • Continued to ensure that there is a strong clinical and care voice into the NHS Gloucestershire Integrated Care Board. This has included specific work on key areas such as children and young people and mental health. **In 2024/25 we will be:** • Undertaking a review of progress against the actions in our Clinical and Care Professional Leadership Framework including a refresh of actions.

	• Continuing to ensure that we embed a strong clinical and care professional voice through our transformation work across Gloucestershire. We remain committed ensure the breadth of expertise is drawn upon through formal governance structures to ensure the inclusive contribution of clinical and care leaders from across organisations in Gloucestershire.
11. Duty to promote innovation	Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. We remain committed to advance Gloucestershire's innovation profile and standing by actively seeking to adopt and spread new opportunities. **We are:** • Working with education and public sector organisations such as the University of Gloucestershire and Gloucester City Council in their regeneration of Gloucester City King's Quarter and the new Forum digital, innovation and social hub. • Playing an active role as NHS organisations in Gloucestershire in Health Innovation West of England (HIWoE - formerly the Academic Health Science Network) as they embark on their new five-year licence. This partnership provides a pipeline of opportunities to take part in 'adopt and spread' initiatives. We act as a pilot system for some of these innovations, again ensuring we are confident in the safety and potential benefit. • Prioritising research and innovation projects that address the health needs of our population drawing on the expertise of HIWoE and other groups such as National Health Innovation Network and the Accelerated Access Collaborative. • Working closely NIHR Applied Research Collaborative (ARC) West and with NIHR West of England Clinical Research Network to learn from and spread innovation. Gloucestershire also benefits from a range of existing locally commissioned innovation projects supported by HIWoE that tackle both healthcare challenges and improve our health equity. We also listen carefully to the good ideas that come from our own staff about how to improve their areas of work, or the wider life of their organisation and the system overall. Our approach and commitment to Quality Improvement helps take these ideas, clearly articulate the evidence for them, and helps implementation and monitoring of their benefits.
12. Duty in respect of research	There has been a significant increase in research interest in Gloucestershire that we will continue to build on in 2024/25. **In 2023/24 we have:**

	• Appointed a part-time Director lead for research with the aim of facilitating the joining up of research activity across the county and implementing the research strategy. The ICS research team has also made connections with Norfolk & Waverly ICB who have a well-developed community and primary care research resource. The aim is to learn from their experience. • Launched an ICS evaluation advisory group to provide advice on undertaking project and service evaluations. The group also provides expertise that has been assessing where investment has been made into projects with a view to informing decisions on whether these should be funded. • Supported Research 4 Gloucestershire who have expanded membership to include public health, adult and child social care as well as an independent health & care provider representative. The aim is that research should be multi-disciplinary and follow the patient's journey rather than being undertaken in service or professional silos. A draft research strategy has been prepared and from this strategy an operational plan will be developed to drive forward research and evaluation activities across the county. **Looking towards 2024/25,** • The ICB will continue to work with the University of Gloucestershire to establish an ICS research hub. Together we will support several staff to undertake PhD research studies as well as providing small grants for local research and evaluation activity. Our aim is to increase the number of publications from ICS staff and share the learning both inside and outside the county. • The ICB are keen to involve local people in research, increase participation and undertake research that is of value to them. The ICB was successful in bidding for resources from NHSE from the Research Engagement Network Development (REND) funds. We have now established the 'Sharing the Power: Get involved in research in Gloucestershire' group and have appointed an insights research officer to support this work. • Continue to expand research activity into primary care and community services. Despite CRN funding largely focused on acute hospitals, we have put in 7 funding bids to increase research capacity during 2024/25 in out of hospital health and care services.
13. Duty to promote education and training	Education and training underpins our whole system, both for our staff and our patients and the public. We will ensure our staff receive the development and opportunities they need to continue providing the best possible care. We will also deliver more education to patients to help with prevention and self-care, and to support their loved ones. **For our staff**

	• We are continuing to deliver a number of system wide training opportunities to support the development of our staff. This includes Oliver McGowan training at Tiers 1 and 2; Trauma Informed Care; Health Coaching and Equality and Diversity related training. We remain committed to ensuring that statutory and mandatory training are delivered across health and care services. System partners are working towards alignment to the Core Skills Training Framework to aid training passporting for staff with an ultimate aim of signing up for the national digital staff passport. The first step is to align our approach to statutory and mandatory training. • We are developing a sustainable talent pipeline to support employers and staff in future years. This includes embedding apprenticeships across the system and participation in national initiatives like St John's Ambulance NHS Cadet Scheme. **For Patients/public** We will enable services to work together better across mental health, community, care, and education to ensure people can quickly and easily find and get the support they need. We will continue to provide support and education programmes for patients that include: • Stay Well This Winter • Complex respiratory disease management supported by lifestyle, exercise and medication education programmes • Perinatal Pelvic Health Classes • Managing Memory Together Information Sessions, now IES in conjunction with Gloucestershire Libraries • All patients with cancer diagnoses are offered education and information about the services and support on offer • 'Know your Numbers' campaign to reduce heart attacks and stroke
14. Duty as to regard to climate change and adaptation to impacts	As partners (NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust) we approved our Green Plan in 2022. Our Green Plan serves as our central document for how we will collectively reduce our emissions and support the delivery of our wider sustainability objectives between now and 2025. As 'anchor organisations' we are committed to the two key targets that extend beyond the duration of this Joint Forward Plan: • **NHS Carbon Footprint**: Reaching net zero by 2040 • **NHS Carbon Footprint Plus**: Reaching net zero by 2045

	The plan (which also sets out individual organisational targets) does not replace green plans published by individual organisations but is intended to confirm common and collaborative actions and timelines. Our sustainability priorities to deliver against these ambitions remain as: • Transport and Travel • Estates and Facilities • Climate Adaptation • Sustainable Models of Care • Medicines and Procurement • Workforce and System Leadership The Joint Forward Plan "Green and Sustainability" section highlights some of our achievements in 2023/24. The ICS Sustainability Steering Group oversees delivery of these ambitions. **In 2024/25 we will be:** • Launching a shared approach and information for staff induction covering green and sustainability objectives. • Developing a longer-term sustainability programme plan to advance our work in this area.
15. Addressing the particular needs of children and young people	Addressing the needs of children and young people remains a high priority of NHS Gloucestershire ICB. Our ambition for children, young people and their families in Gloucestershire is for them to experience integrated services that are holistic in their approach, supporting their mental, physical, emotional and social needs. Our Joint Forward Plan sets out a summary of what we have achieved and our ambitions in this area. Within the ICB leadership we have an Executive Lead for Children and Young People as well as for Mental Health and Special Educational Needs and Disabilities. **In 2023/24 we have:** • Undertaken comprehensive work with NHS Gloucestershire Integrated Care Board to understand the needs of children and young people and identify future priorities. • With wider partners, formalised a Special Educational Needs and Disabilities (SEND) programme to deliver improvements across health and care for children and young people • Invested in services to bring improvements in outcomes for children and young people including our ICB SEND workforce as well as a number of health and care services that support children and young people including Neurodiversity, School Nurse Trainers and Early Language and Support for Every Child (ELSEC). • Supported work to bring together mental and physical health services for children in care into one integrated offer.

	Looking to 2024/25 we will be: • Supporting the implementation of the SEND action plan to ensure that commitments within the plan are being delivered. • Support the development of a wider plan for children and young people being undertaken by system partners. • Continue to support improvements in services for children and young people – including being an ELSEC pathfinder in Gloucestershire. • Continue to embed co-production with parent carers, children and young people and joint working with education and social care partners.
16. Addressing the particular needs of victims of abuse	Strategic leadership and partnership working are key elements to proactively support the effectiveness of Gloucestershire's Safeguarding System. We work with health providers and partners to ensure the ICB and our commissioned services comply with the NHSE Safeguarding Assurance and Accountability Framework and have regard for our duty to protect and safeguard against abuse. **In 2023/24 we have:** • Continued to provide a comprehensive ICB Safeguarding Primary Care Offer to General Practice and their GP Safeguarding Leads – including safeguarding information sharing requirements, quality assurance visits, completion of an annual safeguarding assurance audit, attendance at safeguarding adult and children training and other statutory safeguarding duties. • Continued to deliver our safeguarding statutory requirements including active involvement in the Gloucestershire Safeguarding Children Partnership (GSCP), as well as Board level membership at the Gloucestershire Adult Safeguarding Board (GSAB). • Continued to play an active role in the Safer Gloucestershire Partnership including the Domestic Abuse Partnership Board (DAPB) – supporting delivery of the Domestic Abuse Delivery Plan and Strategy alongside our partners. This includes the commissioning of health services to meet the needs of victims of all ages in both acute and community services and an ICB Domestic Abuse Staff policy. • Supporting the delivery of Sexual Violence Delivery Plan and Strategy through the Sexual Violence Strategic Board. This Strategy builds on the work of the Sexual Violence Partnership (SVP) and works in conjunction with the County Domestic Abuse Local Partnership Board (DA LPB) and Strategy **Looking to 2024/25, our ICB safeguarding priorities include:**

	• Continued commitment to the integration of core functions within the current three safeguarding services of the Integrated Care Board (ICB), Gloucestershire Hospitals Foundation Trust (GHFT) and Gloucestershire Health and Care Trust (GHC). • Working with our ICB contract leads to understand and therefore ensure safeguarding standards are embedded in all contracts (large and small providers) and further work on how this is monitored. • Further embedding integrated safeguarding supervision across the ICS and monitoring compliancy of mandatory safeguarding and children in care training at all levels across the ICB. • Embedding learning from adult and children's statutory safeguarding reviews to ensure we prevent further harm to our most vulnerable. In the next few years, we are prioritising putting in a rolling programme of safeguarding assurance visits to all commissioned large providers, including Primary Care to support the adherence to safeguarding NHSE standards in contracts.
17. Implementing any Joint Local Health & Wellbeing Strategy	The Gloucestershire Health and Wellbeing Board is responsible for overseeing the development and delivery of the Joint Health and Wellbeing Strategy which aims to improve the lives of people in Gloucestershire. The Health and Wellbeing Strategy is focused on seven key objectives – physical activity; adverse childhood experiences; mental wellbeing; social isolation and loneliness; healthy lifestyles; early years and best start in life and housing. The NHS in Gloucestershire continues to play a role in all seven of these priority areas to a greater or lesser extent. Our Joint Forward Plan describes how we are contributing to areas such as physical activity and healthy lifestyles (see our commitment to "ensuring a healthy Gloucestershire", mental wellbeing (see our commitment to "better care for different groups of people" as well as early years and best start in life (see our commitment to "better care at every age").

Agenda Item 13

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th March 2024

Report Title	**Interim Strategy for the Procurement of Healthcare Services Incorporating Market Management Strategy and Representations (Disputes) Resolution Policy. Final version.**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
Route to this meeting	Operational Executive.					
	ICB Internal	**Date**	**System Partner**	**Date**		
	Operational Executive	26/02/2024	N/A	N/A		
Executive Summary	Seek approval for the introduction of a revised interim strategy for the Procurement of Healthcare Services incorporating a Market Management Strategy and Representation (Disputes) Resolution Policy from 1 April 2024 to 31 March 2025.					
Key Issues to note	▪ Updated strategy for the procurement of healthcare services to reflect the introduction of the Provider Selection Regime from 1 January 2024. ▪ This is an interim document which will require further updates from 1 April 2025 to reflect the introduction of the Procurement Act 2023. ▪ The strategy also references the NHS net zero and carbon reduction plan for the procurement of NHS goods, services and works.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Potential risk of legal challenge if mandated PSR procurement processes are not followed by GICB. Add a risk rating, even if low: (4x2) 8 (4x1) 4 (residual meaning accepted risk)					
Management of Conflicts of Interest	Answer the following questions: • Who has been conflicted in the process / project ? Not applicable. • How was this managed? Not applicable. • Has it been logged on the declaration of interest register? Not applicable.					
Resource Impact (X)	**Financial**	N/A	**Information Management & Technology**	N/A		
	Human Resource	N/A	**Buildings**	N/A		
Financial Impact	None.					
Regulatory and Legal Issues (including NHS Constitution)	▪ New legislative changes enacted from 1 January 2024					

Impact on Health Inequalities	Not applicable.		
Impact on Equality and Diversity	Not applicable.		
Impact on Sustainable Development	Not applicable.		
Patient and Public Involvement	Not applicable.		
Recommendation	The Committee/Board (delete as appropriate) is requested to: 1. Approve the introduction of an Interim Strategy for the Procurement of Health Care Services (incorporating Market Management Strategy and Representations / Disputes Resolution Policy). 2. A comprehensive Procurement Policy document covering both the procurement of healthcare services and the procurement of goods and generic services with supersede the interim strategy document from 1 April 2025 and is in keeping with other ICBs and Trusts.		
Author	**David Porter**	**Role Title**	**Associate Director Contracts and Procurement**
Sponsoring Director (if not author)	**Mark Walkingshaw, Director Operational Planning and Performance**		

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

Interim Strategy for the Procurement of Health Care Services

Incorporating:

Market Management Strategy and Representations (Disputes) Resolution Policy

1 April 2024 to 31 March 2025

Document Control:

Date of Issue:	26 February 2024
Version:	Final
Author:	David Porter, Associate Director Contracts and Procurement
Next Review Date:	December 2024
Approved by:	ICB Board Body – 28 March 2024

Contents:

8. Conclusion.

Section 3: Representations (Disputes) Resolution Policy:

1. Introduction.
2. Receiving Representations.
3. Considering Representations.
4. Outcome of Representations.
5. Independent Patient Choice and Procurement Panel.
6. The Chair and Panellists.
7. The PSR Review Panel Process of the Independent Patient Choice and Procurement Panel.

Executive Summary:

This document incorporates reference to legislative changes resulting from the introduction of the Health and Care Act 2022. These came into force on 1 January 2024 for the provision healthcare services only.

Further changes to procurement legislation resulting from the introduction of the Procurement Act 2023 are anticipated to be enacted from October 2024 and this strategy document will be reviewed in December 2024 to incorporate these additional changes which will apply to the purchase of goods and generic services. A comprehensive Procurement Policy document covering both the procurement of healthcare services and the procurement of goods and generic services with then supersede this document.

This strategy takes account of the latest Conflicts of Interest (COI) guidance, issued by NHS England, as a result of the introduction of the Provider Selection Regime and provides advice on the requirement to ensure that organisations bidding for GICB contract opportunities (including the commissioning of services from GP practices in which GPs have a financial interest) declare COIs as part of the market testing processes.

Section 1: Procurement Strategy – Healthcare Services

1. Introduction:

1.1 NHS Gloucestershire Integrated Care Board (GICB) is responsible for the commissioning of high quality, value for money healthcare services to the patients of Gloucestershire. GICBs procurement strategy sets out its approach to achieving its delivery objectives through the application of good procurement practice.

1.2 The objective of this policy is to provide a framework to ensure that all procurement activity is transparent; evidence based and delivers key business objectives. Clinical services procured should be innovative, affordable, viable, clinically safe, and effective. Clinical service specification documents should set stretched targets to improve health outcomes and the quality of patient experience.

1.3 This procurement strategy does not offer detailed advice for specific healthcare groups or activity but sets out guidance for GICB on how to decide on the appropriate activity to be undertaken whilst ensuring compliance with current procurement regulation and Department of Health procurement best practice guidance.

1.4 GICB aims to provide patients with greater choice and focusses on the quality of clinical outcomes, rather than targets and seeks to empower clinicians and other healthcare professionals to use their judgement to innovate. To achieve these aims, GICB will:

- 1.4.1 Continuously review current healthcare services provision arrangements from a broad clinical and contractual perspective.
- 1.4.2 Obtain quality information data to inform transparent and fair decision-making processes.
- 1.4.3 Ascertain whether it is mandatory, desirable, or appropriate to invite competition in accordance / compliance with The Provider Selection Regime 2024.
- 1.4.4 Actively manage the provider market, creating greater patient choice whilst maintaining quality outcomes
- 1.4.5 Engage and work closely with the local community and a range of health care providers to deliver collaborative and integrated services.
- 1.4.6 Apply robust, fair, and proportionate procurement processes that follow all mandated and ‘good practice’ requirements.
- 1.4.7 Apply award criteria that takes account of quality & innovation, value, social value, Improving access, reducing health inequalities, and facilitating choice, Integration, collaboration, and service sustainability (Most Advantageous Tender)
- 1.4.8 Put in place robust contractual arrangements to ensure service delivery.

2. Procurement Legislative and Guidance Documents:

2.1 GICB procurement staff will work in accordance with UK legislation and local organisational guidelines which will include, but not be limited to, the following legislative / guidance documents:

Legislative / Guidance Documents:
Cabinet Office Guidelines and Procurement Policy Notes
Crown Commercial Service Guidance
GICB Equality Strategy
GICB Gloucestershire Joint Health & Wellbeing Strategy
GICB Integrated Annual Operating Plan
GICB Constitution
GICB Public and Patient Engagement Strategy
GICB Quality Strategy
GICB Prime Financial Policies
GICB Strategic Commissioning Intentions
Legislation: Equality Act 2010
Legislation: Health and Social Care Act 2012
Legislation: Health and Care Act 2022
Legislation: NHS Procurement Act 2023
Legislation: Public Services (Social Value) Act 2012
NHS England: Operating Framework (Annual)
NHS England: Patient Choice Guidance (2023)

3. Overarching Procurement Principles:

3.1 GICB will work to secure the needs of patients who use services and to improve the quality and efficiency of those services, including through providing them in an integrated way. It will act transparently and proportionately and treat providers in a non-discriminatory manner.

Healthcare services required will be procured from providers that are most capable of delivering the overall objective and that provide best value for money. GICB will continually consider ways of improving services (including through services being provided in a more integrated way, enabling providers to compete, and allowing patients to choose their provider).

3.2 GICB will adhere to the principles of public procurement whilst undertaking all procurement activity as follows:

Principle:	GICB Undertaking:
Transparency:	State Commissioning Strategies and Intentions:
	Publish short / medium procurement intentions on the GICB external web site and through its Atamis procurement pipeline as appropriate.

	State outcomes of service reviews and whether a competitive tender, Direct Contract Award or other procurement process permitted by the Provider Selection Regime is to be used.
	Pricing tariffs and other payment regimes will be fair and transparent.
	Advertise suitable procurement opportunities and contract awards via Find a Tender and / or Contracts Finder and the GICB external website as applicable.
	Maintain an auditable competitive tender documentation trail (including any decisions not to tender such as the application of the Direct Award Processes A, B, C, and the Most Suitable Provider), providing clear accountability.
	Publish details of all contracts awarded on its external website, including contractor names, addresses, contract type, value, duration, and procurement process used.
Proportionality:	Commissioner resources to be proportionate to the value, complexity and risk of the service being procured.
	Contract duration to be proportionate to service type being commissioned.
	Whilst maintaining quality standards / patient safety, additional award criteria (including financials) to be proportionate to the value, complexity and risk of the service being procured and will not discriminate against smaller organisations such as voluntary sector / social enterprises etc.
	GICB will seek to minimise bidder tender costs by avoiding timetable delays and significant changes to scope
Non-Discrimination:	GICB will ensure that the entire procurement process and associated documentation will not contain bias towards any particular bidder
	All evaluations criteria and associated weightings will be fully disclosed
	All relevant information will be disclosed equally and in good time to all prospective bidders
Equality of Treatment:	GICB will not favour a particular market sector i.e., public over private. Award decisions will always be taken based on a bidders ability to deliver the service rather than on the organisational type.
	Finance and quality assurance checks will be applied equally to all bidders

4. Procurement intentions:

4.1 Procurement schemes undertaken are determined by GICB and are dependent on its annual Commissioning Intentions.

5. Triggers for Competitively Tendering or to undertake a Direct Contract Award for Healthcare Services:

5.1 New service requirement: Where GICB commissions a new service contract (a service not previously provided).

5.2 Contract expiration: Where an existing contract is coming to the end of its agreed term or can reasonably be considered to be likely to end for other reasons (for example a provider notifying commissioners that it is considering withdrawing service provision).

5.3 Failure to achieve quality standards: Where an existing provider is failing to achieve (or make sufficient progress on achieving) local or national quality standards or targets or is not meeting the reasonable expectations of service users.

5.4 Value for money: Where an existing service offers poor value for money when compared to other relevant local or national benchmarking data.

5.5 Service redesign: Where a new type of service differs significantly from that currently in place (in terms of service model, volumes or types of activity, or financial value) such that a new range of service providers or partnerships might offer advantages in terms of patient care or cost compared to that currently in place.

6. Decision to Competitively Tender or undertake a Direct Contract Award for the Provision of Healthcare Services:

6.1 GICB, in reaching a decision will consider the anticipated benefit versus risk assessment which will cover, as a minimum, information in response to the following risk assessment checklist:

6.1.1 Has the Commissioner considered the whole life costs of the proposed contract?

6.1.2 Has the Commissioner clearly identified and documented the reason(s) for subjecting the healthcare service to a competitive tender or direct contract award process (see triggers for contesting a service, paragraph 5 above)?

6.1.3 Is the Commissioner clear on the service specification and quality standards that are required for the healthcare service?

6.1.4 Has the Commissioner identified any linked services which are highly likely to become clinically, operationally, or financially unviable for Gloucestershire residents and which may impact on the decision to competitively tender or direct award a new contract?

6.1.5 Is there evidence of a sufficient market of providers, or potential providers, to minimise the risk of significant gaps in the service(s) concerned and to ensure that patient choice is maintained or expanded?

6.1.6 Have current service costs been benchmarked, and an assessment of current and future demand and capacity been undertaken, such that the risk of increased costs is minimised and there is explicit information on affordability as part of the decision?

6.1.7 Has the proposer ensured that other key co-commissioners have been informed of GICB's proposals, and that explicit agreement is being secured where a service is jointly commissioned for Gloucestershire residents?

6.2 Where a decision is taken by GICB to undertake a competitive tendering process or a direct contract award, GICB will adhere to the Provider Selection Regime.

7. Provider Selection Regime:

7.1 The Provider Selection Regime Regulations (PSR) came into force on 1 January 2024.

The PSR is a set of rules for procuring health care services in England by organisations termed relevant authorities. Relevant authorities are:

- NHS England
- Integrated care boards (ICBs)
- NHS trusts and NHS foundation trusts
- Local authorities and combined authorities.

The PSR does **not** apply to the procurement of goods or non-health care services (unless as part of a mixed procurement), irrespective of whether these are procured by relevant authorities).

The PSR was introduced by regulations made under the Health and Care Act 2022. In keeping with the intent of the Act, the PSR has been designed to:

- Introduce a flexible and proportionate process for deciding who should provide health care services.
- Provide a framework that allows collaboration to flourish across systems.
- Ensure that all decisions are made in the best interest of patients and service users.

7.2 PSR introduces the following processes:

Direct Award Process A:	May be used where there is no realistic alternative to the current provider.
Direct Award Process B:	Where people have a choice of providers, and the number of providers is not restricted by GICB.
Direct Award Process C:	Where the existing provider is satisfying the original contract and will likely satisfy the proposed new contract and the services are not changing considerably.
Most Suitable Provider:	Allow GICB to make a judgement on which provider is most suitable based on consider of the key criteria. A transparency notice must be published. A standstill period of 8 days will apply.
The Competitive Process:	Where the ICB wishes to run a competitive tender process.

7.3 There are five Key Criteria that must be considered when assessing providers under Direct Award Process C, the Most Suitable Provider Process, or the Competitive Process. These are:

- Quality and innovation
- Value
- Social value
- Improving access, reducing health inequalities, and facilitating choice
- Integration, collaboration, and service sustainability

7.4 GICB will follow the PSR regulations for all clinical healthcare procurement related activity. We will utilise the NHS England PSR toolkit available at: NHS England » Provider Selection Regime toolkit products this includes end-to-end process maps and decision flowcharts.

7.5 The PSR requires that:

- Transparency notices are published when a contract is awarded and in some situations before contract awards are made.
- The ICB will keep detailed evidence of its decision- and decision-making processes which it may be required to share with providers.
- An annual summary will be published which details how many contracts were awarded using the various provider selection processes as shown in 7.2 above.

7.6 Transparency notices that require publication under PSR:

	Direct Award A	Direct Award B	Direct Award C	Most Suitable Supplier	Competitive Process
Clear Intentions: Publish the intended approach in advance.				**Yes**	
Clear Intentions: Publish a notice for a competitive tender.					**Yes**
Communicating Decisions: Publish the intention to award notice			**Yes**	**Yes**	**Yes**
Confirming Decisions: Publish a confirmation of the award notice	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Contract Modification: Publish a notice for contract modifications	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

7.7 The standstill period starts after the intention to award a contract notice is published. During this time representations can be made by providers and responded to. The

standstill period only applies to the Direct Award Process C, Most Suitable Provider and Competitive Process.

- Representations must be made within the first eight working days of the standstill period. If a representation is received, then the standstill period must be extended.
- If no representations are received during the first eight working days, then the standstill period can come to a close and the contract can be awarded.
- The standstill period must close before a contract can be awarded. Therefore, if a representation is received then it must be considered and dealt with before the contract can be awarded.

7.8 Modifications are not permitted under the PSR if the modification is attributable to a decision made by the ICB and:

- The changes render the contract materially different in character or.
- The changes are over £500,000 (cumulative value per annum) and represent over 25% of the original contract value.

8. Procurement Processes:

8.1 The procurement process starts from identification of need, the decision to market test through to the conclusion of a healthcare services contract and its on-going management. The development and management of provider markets to ensure capacity and capability is essential.

8.2 Once a decision has been made to procure, there are two procurement procedures available to GICB: The Open and Competitive Flexible procedures.

8.3 Advice should be sought from GICB procurement staff on the most appropriate route for each healthcare service tender.

9. Market Analysis:

9.1 GICB procurement and contracts staff will use service specification detail to benchmark comparable contracts to determine a range of fair and appropriate service costs. This activity will be conducted routinely for all high value healthcare services and prior to determining whether formal procurement is undertaken.

9.2 Market analysis is conducted to determine if commercial sources exist and to establish whether a preferred contract option will result in fair and reasonable service costs. GICB should seek to determine:

- Likely (whole service) costs.
- The types of organisations in the market place capable of delivering the required services.
- Whether existing or new organisations have sufficient capacity to deliver the services solutions sought.
- The most appropriate / proportionate procurement route.

9.3 Market analysis should allow GICB to recognise local SME's and voluntary sector organisations operating in the area and help GICB to develop a capacity building plan for these organisations where required. This is useful when making service

commissioning and procurement decisions by identifying market trends, market stability and performance profile of key prospective bidders.

9.4 Capacity building is an opportunity to identify areas of strength in supplying organisations to GICB and setting out opportunities for their development. To achieve this, GICB staff should work with potential service providers, as requested, to offer support, advice, training appertaining to the competitive tender process. This should enable SME's to compete more fairly with larger organisations.

10. Provider Engagement:

10.1 Engagement with potential providers of healthcare services is an essential element of effective commissioning. It is essential that both incumbent providers (where applicable) and prospective providers are included equally in the engagement process.

10.2 GICB Commissioners may, and in accordance with Department of Health and Social Care guidelines, use provider engagement to:

- Consider provider willingness / capability to deliver a service.
- Establish / understand current provider landscape.
- Lessons learnt from previous procurement schemes.
- Assessing barriers to entry
- Development and testing of service specifications.
- Determine most appropriate procurement routes.
- Establish provider approaches to cost, risk, innovation, capacity, service locations and staffing requirements.

10.3 Resulting specifications will focus on service outcomes and not specific bidder technologies to ensure that any procurement process is without prejudice.

10.4 GICB may instigate pre-procurement market engagement via the following means:

- Placement of a Contracts Finder advertisement (and relevant specific journal advertisements as applicable)
- Public reference groups
- External website notifications

11. Public and Patient Engagement:

11.1 Integrated Care Boards are required to involve and consult patients and the public:

- In their planning of commissioning arrangements.
- In the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of health services available to them.
- In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

11.2 GICBs patient and public engagement will be conducted in accordance with its engagement strategy. The strategy will use The Engagement Cycle to inform its engagement activities.

GICB will actively engage and support patients and other members of the public in procurement processes to ensure:

- Their views inform the development of service specifications.
- Identification of service providers who better meet the needs of patients.
- Innovative approaches to service development are considered.
- Potential service providers are identified and able to bid for contract opportunities.
- Active participation in decision making panels including clarity about patient representation on panels, their role, terms of reference, support, and training.

The benefits of this approach include increasing public confidence and better relationships with providers of services. It also paves the way to improved monitoring and performance management, particularly if patients are also part of those monitoring processes.

11.3 GICB will keep the wider public informed, hold briefing events so that the public find out what is going on and about proposals being developed and ensure that Healthwatch Gloucestershire and locally elected representatives such as local MPs and HCOSC members receive early briefings regarding planned procurement activities.

12. Procurement of Goods and Generic Services:

12.1 Procurement for the supply of all goods and generic services is the responsibility of the South, Central & West Commissioning Support Unit (SCWCSU). GICB Operational Planning and Performance Directorate shall be responsible for monitoring the quality of the service provided by the SCWCSU.

12.2 The service level agreement between GICB and SCWCSU will contain key performance indicators to assist with the monitoring of the procurement service provided.

13. Waivers of standing orders

13.1 GICB is committed to ensuring that healthcare services are procured in accordance with legislation. In some circumstances the need to request quotations or competitive tenders may be waived.

13.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant or contractor originally appointed through a competitive tender procedure.

14. e-Tendering:

14.1 GICB procurement staff will conduct procurement processes via an e-tendering information technology system wherever possible. An automated system provides a secure and clear management audit trail.

14.2 From December 2023, GICB has elected to use the Atamis e-procurement and e-pipeline system for all procurement related activity.

15. Collaborative Procurement:

15.1 GICB Procurement staff will design procurement work plans in accordance with year-on-year GICB commissioning intentions and any ad hoc in-year requirements as may arise from time-to-time. While it is envisaged that most procurement will be conducted in-house, GICB procurement staff will actively engage with South Central & West Commissioning Support Unit (SCWCSU) staff, other NHS procurement staff or nationally designated procurement teams to deliver complex / cross-boundary procurements where required.

The SCWCSU will provide transactional and generic services procurement to GICB in-line with its service level agreement.

15.2 GICB procurement staff will work collaboratively with its Integrated Care System partners on joint procurement initiatives where it is in the interests of all partners to deliver cost effective and integrated service solutions.

16. Contract Durations:

16.1 The NHS Standard Contract will be applied for the majority of healthcare services procurements undertaken. GICB will take account of the following factors before finally determining contract duration (and prior to procurement advertisement):

- Overall contract value
- Confirmation of re-current funding allocations
- Complexity of the procurement process (i.e., nature of healthcare service to be commissioned and its interaction with other services and service providers)
- Number of potential providers in the market place.

17. Social Value Legislation:

17.1 The Public Service (Social Value) Act 2012 came into force in January 2013. Under this legislation, public sector organisations are required to consider how the services that they commission and procure might improve the economic, social, and environmental well-being of the area that they serve.

17.2 Social value is a broad term and can be interpreted in a number of ways but could mean; a local person for a local job, an NHS Trust commissioning local patient groups (at cost) to run consultation events or a public body contracting with a private firm who employs local / long-term unemployed to service its contract requirements.

17.3 GICB will consider the social value implications of all prospective procurement processes and incorporate its responsibilities under the Act in key procurement documentation. GICB will ensure that positive health, social and environmental outcomes are captured and assessed during the commissioning process at ITT stage and ensure that these added benefits are measured and linked to the performance of the contact.

18. Conflicts of Interest:

18.1 The routine declaration and management of conflicts of interest is a key aspect of good governance, and critical both in maintaining public confidence in decision-making and in protecting staff, councillors, and trustees from allegations that they have acted inappropriately.

GICB must respond appropriately to effectively prevent, identify, and remedy conflicts of interest arising during the application of the PSR. GICB must ensure that its governance arrangements for making provider selection decisions can manage conflicts that arise. It may wish to give board committees or non-executive directors (or other senior persons independent of the decision-making process) a role in managing and resolving conflicts of interest relating to provider selection decisions.

The way conflicts of interest are managed needs to be sympathetic to the vision of collaboration and joint working set out in the NHS Long Term Plan and to the policy intent of the 2022 Health and Care Act in relation to bringing NHS organisations and local authorities together to collaborate in making decisions about care provision.

GICB is expected to follow and have regard to that vision and policy, when managing conflicts of interest around provider selection decisions.

18.2 GICB should manage conflicts of interests based on the following principles:

A. All decisions made under the PSR must be clearly and objectively directed towards meeting the statutory functions and duties of GICB. Individuals involved in decisions relating to these functions are expected to act clearly in service of those functions and duties, rather than furthering their own direct or indirect financial, economic, or other personal, professional, or organisational interests.

B. ICBs have been created with the intention of giving statutory NHS provider, local authority, and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and while the Regulations allow for the fact that an ICB member may also be an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interest arising will remain. In addition, any member who is an employee, director, partner or otherwise holding a position within a provider taking part in a procurement process must recuse themselves from the decision-making process. For all PSR decisions, GICB must carefully consider whether an individual's role in another organisation may result in actual or perceived conflicts of interest and if so whether that outweighs the value of the knowledge they bring to the process.

C. The personal and professional interests of all individuals involved in decisions about provider selection need to be declared, recorded, and managed appropriately, following GICBs established conflicts of interest arrangements. This includes being clear and specific about the nature of any interest and of any conflict that may arise with regard to a particular decision, and how any conflicts are managed for each decision. To fulfil the transparency requirements under the Provider Selection Regime, GICB must keep internal records of individuals' conflicts of interest and how these were managed.

D. Any conflicts of interests and how they were managed must be published alongside the confirmation of the decision to select a provider. When the decision is made by

a committee/group, it is advised that the interests of the committee/group as a whole are declared and not the names of individuals in the committee/group to whom they relate. When an individual makes the decision, it is advised that conflicts of interest are declared against the individual's job title rather than their name.

E. Actions to mitigate conflicts of interest when making procurement decisions are expected to be proportionate and to seek to preserve the spirit of collective decision-making wherever possible. Mitigating actions are expected to account for a range of factors, including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision. Mitigations may include:

- Excluding a conflicted person from both the discussion and the decision-making
- Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source
- Arranging decision-making structures so a range of views and perspectives are represented, rather than potentially conflicted individuals being in the majority.
- Convening a committee without the conflicted individual present, e.g., when dealing with particularly difficult or complex decisions where members may not be able to agree, or to prevent an unsound decision being taken and/or the appearance of bias.

F. GICB must clearly distinguish between those individuals who are involved in formal decision-making and those whose input informs decisions but who are not involved in decision-making itself (such as through shaping GICBs understanding of how best to meet patients' needs and deliver care for its population). The way conflicts of interest are managed is expected to reflect this distinction. For example, where independent providers (including those in the VCSE sector) hold contracts for services, it would be appropriate and reasonable for GICB to involve them in discussions, such as about pathway design and service delivery, particularly at place level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

G. Where decisions are being taken under the competitive process, any individual who is associated with an organisation that has a vested interest in the procurement must recuse themselves from decision-making during that provider selection process. This includes ICB members who are also employees, directors, partners, or otherwise holding a position within a provider when that provider is intending to take part in the procurement process.

H. The way conflicts of interest are declared and managed is expected to contribute to a culture of transparency about how decisions are made.

18.3 GICB has commissioned a bespoke COI training programme which is implemented at the start of each new procurement process. All staff involved in a procurement process, including external advisors, are mandated to participate in this programme.

19 Quality and Sustainability Impact Assessments:

19.1 It is essential that services delivered improve quality and enhance patient experience. GICB has developed a Quality and Sustainability Impact Assessment which is used when there is any change to the way services are commissioned and delivered. The Impact Assessment includes:

- Duty of quality

- Patient experience
- Patient safety
- Clinical effectiveness
- Prevention
- Productivity and innovation

20. Net Zero Commitment and Carbon Reduction Plan for the Procurement of NHS Goods, Services and Works.

20.1 Procurement Policy Note (PPN) 06/21, initially published in June 2021, set out how to take account of suppliers' Net Zero Carbon Reduction Plans in the procurement of major Government contracts. The NHS has committed to reaching net zero by 2040 for the emissions we control directly, and by 2045 for the emissions we can influence, through the procurement of goods, services and works. To achieve this goal, we will require the support of all our suppliers. To that end, the NHS has published the NHS Net Zero Supplier Roadmap, a series of milestones to help suppliers align with our net zero ambitions.

The 2024 CRP and Net Zero Commitment (NZC) policy sets out how, from 1 April 2024, the NHS will proportionately extend the CRP requirements to cover all procurements. It introduces a two-tiered approach, where a CRP requirement will be extended to a wider set of procurements, and a NZC (which includes selected key CRP requirements) will be required for lower value procurements. This one policy, two-tiered approach helps support suppliers of all sizes and at various stages of their sustainability journeys to align with the NHS's net zero ambition.

The requirements apply to the commissioning and purchasing of goods, works and services, (including pharmaceuticals and healthcare services) by in-scope organisations. In-scope organisations are defined as NHS organisations as well as organisations acting on their behalf.

20.2 From April 2024 Carbon Reduction Plan (CRP) requirements applicable to the commissioning and purchasing of goods, services and works for in-scope organisations are as follow:

- A full CRP will be required for procurements of high value (£5m per annum exc. VAT and above) and new frameworks operated by in-scope organisations, irrespective of the value of the contract, where relevant and proportionate to the framework. If suppliers already have a CRP in place, they meet all requirements of the Net Zero commitments.
- A Net Zero Commitment will be required for procurements of lower value (below £5m per annum exc. VAT and above the relevant Public Contracts Regulations (PCR) threshold). From April 2026, a Net Zero Commitment will also be required for procurements below the relevant Public Contracts Regulations threshold.

Section 2: Market Management Strategy

1. **Introduction:**

1.1 This strategy sets out the way in which NHS Gloucestershire ICB (GICB) will work to develop a healthcare market which supports delivery of its strategic commissioning plan. The strategy will identify the principles by which the organisation will enable the development of an appropriate provider market to meet local needs and improve patient experience. This strategy should be read in conjunction with GICBs Procurement Strategy (Section 1).

1.2 Our understanding of what constitutes an effective market management strategy in the NHS continually evolves. However, the dual functions of market analysis (understanding the current and potential market) and market development (supporting the development of innovation, quality, and a diverse health care market) are central to developing a competitive provider environment and informed decision making about procurement routes.

1.3 This strategy will support the commissioning organisation to understand the steps to good market management that enables the delivery of the strategic commissioning plan and helps describe the market development needs at each stage in the commissioning cycle.

1.4 GICB is keen to ensure that the benefits of a competitive environment and new providers are harnessed. The ultimate aim in applying any system or market management techniques is to ensure that it results in an improvement in patient experience, outcomes, and value for money.

2 **Market Management in the NHS:**

2.1 As leaders of the local health system GICB has a responsibility to lead and manage the local NHS system. Market Management is a pivotal element of effective system management.

Step:	Description:
Ensuring Local Strategic Coherence	▪ Engaging with the population around the strategy for the system (including formal consultation). ▪ Ensuring that all system tools and techniques including market management result in a cohesive local system.
Building and Working the Market	▪ Design of local incentives and local choice offer. ▪ Market development. ▪ Procurement. ▪ Contracting.
Maintaining Market Effectiveness	▪ Information for, and communication to the Patients, Public and the Market. ▪ Managing service change through the market ▪ Managing the market by:

	- Managing service / provider failure. - Managing disputes. - Driving quality in provision. ▪ Managing local political interface on market decisions.

2.2 The ultimate aim in applying any system or market management techniques is to ensure that it results in an improvement in patient experience, outcomes, and value for money.

One of the best ways we can achieve this is to construct excellent provider relationships based on a mutual understanding of the service requirements through clear specifications for services based on good care pathways and models of care; effective contract performance monitoring and management systems, and to build up strong relationships with providers over time.

In some cases, it is necessary and appropriate to have competition for services in order to secure improved outcomes, maintain complex service integration and patient experience. In other cases, it is possible and desirable to maintain existing suppliers, whilst continuing to drive quality improvements.

3 NHS Gloucestershire ICBs approach to Market Management:

3.1 GICBs approach to market management will focus on three clear activities; contract management; market analysis (including robust procurement processes) and market development. Market analysis and market development activities need to be undertaken in a planned and prioritised way in order to maximise the benefits to be derived through any procurements offered to the market.

3.2 The vision for the future provider landscape for GICB is to provide greater diversity where this is appropriate underpinned by two key principles:

- Increasing choice for users of services.
- Provider development or contestability to drive up the quality of services and reduce costs.

This will be achieved through a considered use of competition to improve quality.

3.3 It is not always possible or appropriate to increase the number of providers in the market; there are other levers which need to be used to improve and shape the market and drive-up quality. These include using contract performance levers, patient user participation in service reviews and analysis of data in respect of quality of services.

3.4 Contract management:

The first stage of Market Management will be to consider the appropriateness of competitive tendering as a system lever. In some cases, as described in paragraph 5, below, robust contract management and effective supplier management, i.e., collaborating with our current providers of patient care will improve outcomes; patient experience; quality and reduce failings. There are some circumstances where it is

immediately apparent that competitively tendering the service is not feasible or beneficial to improving outcomes and value for money:

- The service is a specialised service where provider designation has already taken place at a national or regional level.
- Where the service to be procured has such strong service alliances with an existing service that an extension to an existing agreement is appropriate (complex service integration).
- Where the cost of undertaking a competitive approach cannot be justified in light of the contract value (proportionality)
- Where GICB wishes to encourage provision from within a sector that might otherwise not prevail through a competitive approach
- Where failing to award a contract to a preferred provider would put other core services at risk i.e., recognising the need to safeguard against unintended consequences relating to service viability and tipping points.

3.5 GICB will also ensure it demonstrates how as many of the possible benefits associated with a competitive tender approach are realised through strong commissioning and specification of services.

3.6 Market analysis:

GICB will adopt an eight-step approach to market analysis as shown in the table below.

Delivering outputs for each of these steps will require joint working across organisation. GICBs contracts and procurement staff will support lead commissioners in understanding the tasks required to undertake market analysis.

Step:	Description:
Agree Scope:	Identify and clarify market segment area to be addressed: ▪ Geography. ▪ Specific pathway. ▪ Providers. ▪ Competition and choice for patients. Agree which part of the overall system for that market segment will be reviewed: ▪ Prevention. ▪ Assessment. ▪ Diagnostics. ▪ Intervention. ▪ Post-acute.
Assess Market Needs & Demand:	▪ What services are required. ▪ How can these be delivered. ▪ Where are services required.

	▪ How will needs/demands change or grow.
Assess Current Market Performance:	▪ Comparative analysis of existing providers. ▪ Articulate performance issues.
Provider Analysis:	▪ Map providers: ▪ What capacity sits where. ▪ What is the balance of spend/activity. ▪ What access is there for the patient group. ▪ Provider performance: ▪ Do they meet GICB requirements. ▪ Do they meet patient needs. ▪ Why over or under performing. ▪ What plans to improve.
Competitive Environment:	▪ Is there competition in the market. ▪ What is the basis for competition. ▪ Review barriers to entry or exit. ▪ Who are the potential providers who could enter the market. ▪ Are there examples of good practice elsewhere.
Map out a Preferred Future Landscape:	▪ What provision does the GICB want to see and where. ▪ What will the basis for performance measurement be. ▪ Should it be subject to competitive tendering. ▪ Should integration be encouraged at certain points of the system.
Assessment of Market Intervention Levers:	▪ What can GICB do to change the provider landscape: ▪ Competitive tendering. ▪ Direct award contracting. ▪ Talking to service providers. ▪ Incentives. ▪ Penalties.
Implementation Plan:	▪ What levers should be used and when. ▪ How does GICB want to monitor market performance. ▪ What information does GICB need to do this better in the future.

3.7 Market Development:

The aim of market development activity is to encourage a range of providers, willing and capable of responding to GICB contracting opportunities and hence facilitating the commissioning of services of a high quality and which demonstrate effective use of NHS resources.

As services are reviewed and potentially redesigned and as commissioners gain a greater understanding of the needs of their patients, the provider(s) best placed to deliver the needs of the patient may well be different from the current service provider(s), this will only be possible if there are effective and willing providers in the market capable of responding to GICB contracting opportunities.

GICB procurement and contracting staff will undertake a number of activities to support the development of existing and potential providers.

- Develop and manage its relationship with existing and potential providers, including NHS, Private and Voluntary / Third Sector organisations.
- Advertise for new and potential providers using appropriate procurement processes.
- Provide advice to potential providers on the qualification and assurance process required to become a local provider of NHS Services
- Proactively shape the market through dialogue and procurement
- Qualify providers who are interested in providing services to support GICBs commissioning intentions. This will include an assessment of the providers capacity and capability to meet the minimum standards required to deliver NHS care under its Supplier Accreditation Process.
- Ensure that appropriate support is available to providers to facilitate their involvement in the procurement process.

4. Developing Provider Competence and Capability:

Where provider options are limited, and the preferred procurement approach requires the development of providers to ensure that appropriate services can be secured; GICB will identify and support the development of providers to enable market entry.

Support may take the form of advice, signposting to education, training, and business development opportunities. Any offer of support in this way must be transparent, proportionate, and non-discriminatory.

5. Market Management Support to the Commissioning Cycle:

5.1 Assess needs / Review of provision:

- Produce an updated map of current service providers relevant to the commissioning programme.
- Identify providers that could be involved in helping define the needs assessment.
- Provide market intelligence on the current provider market and any future trends.
- Identify provider market gaps and any failing providers.
- Are the current services delivering key national and local targets?

- Do current providers offer services that are consistent with best practice and local and national strategy?
- Determine the impact on the current and future provider market (will the introduction of new providers have a detrimental impact on the provision of services to patients)
- Where required begin a search for alternative providers.

5.2 Decide Priorities and Investment:

- Identify and qualify potential providers.
- Gain decision whether to invest in developing providers.
- Engage potential providers in the commissioning process.
- Is the effort of developing the supply market justified by the benefits for patients?

5.3 Define the Service:

- Ensure clear service specifications are developed.
- Identify the implications on the provider market of the proposed service.
- Support providers in bidding for services

5.4 Shape Structure of Supply:

- Provide assurance on the selection process of providers.
- Ensure provider requirement documents are robust.
- Oversee the commissioner selection process.

5.5 Formalise and Communicate :

- Clear awards process with feedback to unsuccessful providers which may help them develop for the future.
- Clear implementation plan for delivery of new services

6. Contract and Performance Management Frameworks:

Market management is underpinned by effective contract, performance management (including quality) and procurement frameworks.

6.1 Contract Management:

- Regular discussions with all key providers. Formal Contract Management Boards and appropriate subgroups in place for all major contracts
- Clear issue resolution / escalation processes
- Consistent and rigorous negotiation processes
- Use of the Standard NHS Contract (unless bespoke contract documentation is appropriate)

6.2 Performance Management:

- Predictive modelling, analysis, and performance management
- Clear Key Performance Indicators (KPIs) and defined performance improvement targets.
- Regular and timely performance data analysed by efficiency, quality, outcomes, comparative benchmarks, and patient experience.
- Achievement of national targets and local KPIs.

6.3 Service Quality:

Understanding the quality of services provided is a key element of market management. The following indicators will all be considered as part of a provider review i.e.

- Mortality rates.
- Readmission rates.
- Length of stay.
- First to follow up ratio's - outpatients.
- Conversion rates.
- DNA rates.

7. Measurement of Success:

- Clear articulation of current and future provider market
- Robust contracts negotiated with clear outcome measures.
- Robust contract/performance management processes in place
- Capability is improved within the organisation.

8. Conclusion:

This strategy sets out GICBs approach to market management and, together with the GICB procurement strategy, forms an integral part of GICBs approach to system management. It explains the way in which the dual functions of market analysis and market development will support delivery of GICBs commissioning intentions.

Market management is an evolving concept for the NHS and this strategy will require regular review to ensure that it is consistent with patient experience, national policy, and local requirements.

Section 3: Representations (Disputes) Resolution Policy:

1. Introduction:

1.1 If a provider is unhappy about the way in which a procurement process has been undertaken, including which provider was awarded the contract, then they can make a representation to GICB. GICB must then consider the representation fairly and impartially.

1.2 Receiving Representations:

Providers may make a representation to GICB within the first eight working days following the start of the standstill period (i.e., eight working days starting with the first working day following the day after the intention to award notice has been published). Providers cannot submit a representation after that period, even if the standstill period has been extended in response to a representation from another provider.

The purpose of making a representation is to seek a review of the decision made, to determine whether GICB has applied the regime correctly and made an appropriate provider selection decision.

GICB is only obliged to respond to representations that meet all the following conditions:

- The representation comes from a provider that might otherwise have been a provider of the services to which the contract relates.
- The provider is aggrieved by the decision of GICB.
- The provider believes that the GICB has failed to apply the regime correctly and is able to set out reasonable grounds to support its belief.
- The representation is submitted in writing (which includes electronically) to GICB within eight working days of the start of the standstill period.

When awarding a contract based on a framework agreement, e.g., following a mini-competition, only providers that were party to the framework agreement and i) took part in the mini-competition but were unsuccessful, or ii) were excluded from the mini-competition, may make a representation to GICB.

GICB may also respond to representations that do not meet the conditions above.

GICB must follow the relevant transparency requirements for the approach they take and must keep internal records of their decision-making.

1.3 Considering Representations:

GICB should ensure that appropriate internal governance mechanisms are in place to deal with representations made against provider selection regime decisions. To this end, GICB should, where possible, ensure that decisions are reviewed by individuals not involved in the original decision. Where this is not possible, GICB should ensure that at least one individual not involved in the original decision is included in the review process.

If GICB is considering representations on the same issue from multiple providers, it may consider these together if appropriate.

Where a representation is received within the eight working days, GICB:

A. Must ensure that the provider is afforded an opportunity to explain or clarify its representation(s) if these are not clear.
B. Is expected to provide an indicative timeframe for when the representation might be considered by, and when the provider might reasonably expect a decision to be made.
C. Must provide any information requested by the provider that GICB is required to keep under the regime as soon as possible, except where this:

- Would prejudice the legitimate commercial interests of any person, including GICB.
- Might prejudice fair competition between providers.
- Would otherwise be contrary to the public interest.

D. Must review the evidence and information used to make the original decision, taking into account the representations made.
E. Must consider whether the representation has merit (e.g., it identifies that the process has not been correctly followed or brings to light information that has a bearing on the decision reached).

The provider that made the representations is expected to respond promptly and concisely to questions from GICB about the points it has made, and if it cannot respond within a reasonable timeframe then it is expected to provide a justification.

GICB is expected to allow sufficient time and opportunity for the provider that made the representations to respond to questions from GICB. In the event that the provider fails to respond / communicate, then it is for GICB to decide whether to complete its assessment of the representations and communicate their decision to the provider.

1.4 Outcome of Representations:

Where GICB finds that a representation has merit (e.g., it identifies that the process has not been followed correctly or brings to light information that has a bearing on the decision reached), it must further consider whether this impacts on the intention to award a contract to the selected provider. It must then decide whether to:

- Enter into a contract or conclude the framework agreement as intended.
- Go back to an earlier step in the selection process, either to the start of the process or to where a flaw was identified, rectify this, and repeat that step and subsequent steps.
- Abandon the provider selection process.

GICB must communicate the decision described above promptly and in writing, to:

- The provider that made the representation
- The provider to which GICB intended at the beginning of the standstill period to award the contract, or all providers with which GICB intended at the beginning of the standstill period to conclude the framework agreement.

The standstill period can only end once GICB has reviewed its decision, shared its conclusion (in writing) with the relevant providers, and concluded that it is ready to award the contract, or that it is going to return to an earlier step in the process, or abandon the process.

GICB must allow at least five working days following the day on which they sent their response to the provider, before the standstill period ends. This time allows the provider to consider GICBs response, seek further clarifications, and to consider

whether to request a further review by the Independent Patient Choice and Procurement Panel. This time also allows GICB to reconsider their decision and make any subsequent decisions if necessary. GICB must communicate any such further decision in writing to the provider (as outlined above).

If a panel review is requested and accepted, then the standstill period would usually continue until after the Independent Patient Choice and Procurement Panel has given its advice and GICB has made its further decision in light of that advice.

1.5 Independent Patient Choice and Procurement Panel:

NHS England has established the Independent Patient Choice and Procurement Panel to provide independent expert advice to relevant authorities, including GICB, with respect to the review of PSR decisions during the standstill period, and separately to support reviewing decisions with respect to the application of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended).

If a provider remains unsatisfied about the response given by GICB to their representations, then that provider may seek the involvement of the panel. The panel may consider whether GICB complied with the Regulations and may provide advice to GICB. GICB should then make a further decision about how to proceed.

1.6 The Chair and the Panellists:

The panel Chair presides over the Independent Patient Choice and Procurement Panel. While there is a single Chair for the panel, the panel members reviewing representations in relation to the PSR are different to those reviewing patient choice complaints.

Panel members for the PSR element of the panel are independent experts who are made available by, or endorsed by, NHS England or the Secretary of State for Health and Social Care to provide advice relating to GICBs compliance with these Regulations.

Panel members must be able to offer an impartial and unbiased opinion, and they must not have any conflicts of interest in the provider selection process in question. This means that panel members must not have, directly or indirectly, a financial, economic, or other personal interest that might be perceived to compromise their impartiality and independence in the context of the provider selection process in question. Panel members must recuse themselves from providing advice on any provider selection processes where they have a conflict of interest or a perceived conflict of interest.

1.7 The PSR Review Panel Process of the Independent Patient Choice and Procurement Panel:

If a provider wishes to request the panel to consider their representation further, then they must submit their request through the panel's website within five working days of receiving GICBs decision following GICBs review of their representation.

If the provider submits a request for advice from the panel, GICB will be notified, and GICB should:

- Keep the standstill period open for the duration of the panel's review.
- Make a further decision once it has considered the independent expert advice.

In exceptional circumstances, GICB may conclude that it is necessary to enter into a new contract before the panel can complete its review and share its advice. In those circumstances, GICB is expected to note the advice of the panel for the next time they use the PSR to arrange health care services.

Where multiple providers seek the involvement of the panel, in relation to the same provider selection process, the panel may choose to address the points raised by each provider individually or consider all of the points together. The standstill period should continue until the last advice is provided (unless in exceptional circumstances).

If the provider does not submit their request to the panel within the five working day period, or the panel does not accept the request for advice, then at any point after the end of that period, GICB can bring the standstill period to an end and proceed to award the contract to their chosen provider.

The panel will set out acceptance criteria to assess whether a request should be reviewed, and prioritisation criteria to determine the priority/urgency of a particular case. The acceptance and prioritisation criteria will be published.

Information requested by the panel from GICB for the purposes of offering advice, and provided by GICB, does not breach any obligation of confidence owed by GICB. However, it may be subject to restrictions on disclosure imposed by other pieces of legislation.

Where the panel accepts a representation for review, it will endeavour to consider it and share advice, or a summary of its advice, with the provider and GICB within 25 working days. However, this timeframe is indicative and contingent on the engagement and timely responses of the provider and GICB throughout the review process.

The panel will also publish its advice, or a summary of its advice.

NHS Gloucestershire Audit Committee, Part 1

Held at 09.30am on Thursday 7th December 2023

Hybrid Meeting via MS Teams and ICB Canton Room, Shire Hall Gloucester

Members Present:		
Julie Soutter (Chair)	JS	Non-Executive Director, NHS Gloucestershire
Dr Jo Bayley	JB	Chief Executive, GDOC
Marcia Gallagher	MG	Non-Executive Director, GHC
Mike Napier	MN	Non-Executive Director, GHFT
Participants:		
Andrew Davies	AD	Audit Manager, Grant Thornton LLP
Cath Leech	CL	Chief Finance Officer, ICB
Adam Spires	AS	Partner, BDO LLP
Paul Kerrod	PK	Deputy Head of Local Counter Fraud Service
Christina Gradowski	CGi	Associate Director of Corporate Affairs, ICB
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon	RB	Board Secretary, ICB
Benedict Leigh (*Agenda Item 15)*	BL	Director of Integration, ICB & GCC
Declan Mclaughlin (*Agenda Item 17)*	DM	Head of Primary Care Contracts, ICB
Una Rice (*Agenda Item 11)*	UR	Associate Director, Digital Transformation, ICB
Dr Marion Andrews-Evans (*Agenda Item 16)*	MAE	Chief Nursing Officer, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members and the participants present and she introduced Mike Napier who was a new member of the Committee.

2. Apologies for Absence

2.1 An apology was received from Ayesha Janjua.

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

3. Declarations of Interests

3.1 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. MN, MG and JB also declared their professional influence in GHFT, GHC and GDOC respectively.

3.2 The Chair advised that MN, MG and JB represented common and joined-up interests with the ICB; MN, MG and JB were as a matter of fact not pursuing goals undermining interests of the ICB. The Chair presented a Register of members' interests and explained that such interests were published on the web as part of the main Register of the ICB, for the benefit of the public.

4. Minutes of the Last Audit Committee Meeting Held

4.1 Minutes of the meeting held on Wednesday 4th October 2023 were approved as an accurate record of the meeting.

5. Matters Arising

5.1 **16.03.2023, Items 18.1** Primary Care Delegation: POD Services. Members requested that an update or outcome of POD services implementation be added to the agenda of 7th December 2023. **Closed.**

5.2 **09.05.2023, Item 6.3** Annual Accounts. JS directed that more information on IFRS16 and associated literature be circulated to members or alternatively be incorporated in a report to be brought before members. **Closed.**

5.3 **27.06.2023, Item 9.2.3** External Audit: Evaluation of Data Arrangements and Accounting Policy. JB suggested that data quality arrangements and policy in place should be subject to further review by internal auditors and, if practicable, be incorporated into work plans. Members requested that a report be prepared and be brought before the committee on 7th December 2023. **Closed.**

5.4 **27.06.2023, Item 14.2** Counter Fraud Report. PK described how Counter Fraud was working with the Governance Team to reduce and manage fraud, bribery and corruption risks. PK added that such risks had through collaborative effort, been reduced from Red to Amber. JS suggested that options to support further reduction of risks from Amber to Green should be explored and brought before members. **Closed.**

5.5 **04.10.2023, Item 6.2.3** Environmental Sustainability. Cath Leech provided an update to the Committee. **Closed.**

5.6 **04.10.2023, Item 6.7** Business Reports. BL and MAE presented their respective reports as part of the agenda. **Closed.**

5.7 **04.10.2023, Item 8.3** Risk Management. Developmental risk assessment tools were developed and presented before the Committee. It was acknowledged that work remained ongoing and regular reporting would come back to the Committee. **Closed.**

5.8 **04.10.2023, Item 8.4** Risk Management Deep-dive. Arrangements were put in place and Finance & BI were the first directorate to deep dive as part of the agenda. **Closed.**

5.9 **04.10.2023, Item 8.5** Risk Management. The workshop was rescheduled and plans for the workshop were going ahead with a new date for December. **Closed.**

5.10 **04.10.2023, Item 16** Any Other Business**.** Self-assessment platform and tools rolled out. **Closed.**

The Chair directed that for practical purpose, meeting items would not necessarily follow the order set in the agenda. The Chair and members collectively agreed that the meeting appraisal guidance at the bottom of the meeting agenda be removed as it had been superseded by the newCommittee performance review.

6. External Audit Report

6.1 AD presented the report and stated that Grant Thornton LLP had started audit planning and the auditors would discuss the initial plan with the ICB in January 2024 and present the substantive plan to the Committee in March 2024. AD added that auditors expected to finalise their audit work in June 2024; and this would culminate in auditors issuing their opinion and fulfilling other audit arrangements.

6.2 AD explained that the audit on Mental Health Investment Standard (MHIS) was progressing well, and it was expected that the final report would be completed within the deadline of 16th February 2024. AD stated that Value for Money (VFM) audit would run concurrently with conventional audit work, and that Grant Thornton LLP had a specialist VFM team for that purpose.

6.3 AD stated that an annual workshop for Chief Accountants was planned and scheduled for February 2024. AD added that emerging trends and other topical issues would be discussed, and he placed emphasis on the importance of the workshop to Chief Accountants. Members were satisfied with the report and agreed a Green Assurance rating.

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

7. Internal Audit Report

7.1 Progress Update Report

7.1.1 AS presented the report and added that work on Business Continuity & Emergency Planning was ready for review by the Committee. AS explained that audit on Key Financial Systems including that on controls relating to POD services was going well. AS described how BDO LLP was working jointly with Local Counter Fraud Service (thereafter “Counter Fraud”) to review and improve controls on the administration of Personal Health Budget (PHB).

7.1.2 AS described the delay in producing the cyber security report as the joint report required review across the system prior to being finalised. JS expressed a concern regarding the slippage and stated that such slippage had the effect of compromising the effectiveness of cyber risk mitigation. JS suggested that it was therefore best to submit the report not later than January 2024. CL proposed that the report be circulated to Audit Chairs of partner organisations for consideration. Members concurred. **Action: AS and JT to circulate the cyber security report to JS, MG, MN and John Cappock (JC).** **AS & JT**

7.2 Integrated Care Systems: Changing Landscape and Impact on Organisations

7.2.1 AS presented the report and stated that this was a reflection on work covered by ICBs one year after establishment. AS described the priorities of ICBs as including population health needs and social wellbeing. AS highlighted how BDO LLP provided advice in critical areas such as issues of governance, risk controls, and controls over tools and processes commissioned to reduce health inequalities.

7.3 Internal Audit Follow-Up Report

7.3.1 AS presented the report and noted that three of the audit recommendations had been fully implemented. AS stated that the recommendations on ICB governance were being addressed and that the five recommendations relating to POD were receiving attention and any slippage was caused by national pressures beyond control of the ICB.

7.3.2 MG concurred and clarified that the recommendations were awaiting required guidance from NHS England. **Action: HG, JW, JG and DM to update on the guidance and POD implementation.** AS stated that slippage relating to recommendations on controls over PHBs was a result of need to accommodate policy change. AS noted that the ICB's commitment to implementing audit recommendations was evident. Members agreed a Green Assurance rating on internal audit report. **PC Team**

The Chair directed that part of BDO LLP report addressing Business Continuity and Emergency Planning be presented together with the Emergency Preparedness and Resilience report (agenda item 16) which was to follow.

RESOLUTION: The Audit Committee:

- **Noted the Internal Audit Progress report.**
- **Noted the Integrated Care Systems: Changing Landscape and Impact on Organisations report.**
- **Noted the Internal Audit Follow-up report.**

9. Declarations of Interest

9.1 GN presented the report and reassured the Committee that members and staff were compliant with policy which stipulated a standard of 95%. GN presented the compliance statistics which confirmed that members were 100% compliant and the rest of staff were 97% compliant. GN stated that the Governance Team advised and guided pharmacists working in the ICB on how to avoid interactions and activities which could create conflict of interest.

9.2 GN explained that a Register was kept for the purpose of capturing activity associated with pharmaceutical industry (APBI Register) and one to record gifts and hospitality from third parties. GN highlighted that there were no activities requiring registration in either Registers. Members discussed the report and agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Declarations of Interest report.

18. ISFE 2 Update Report

18.1 CL presented the report and stated that ISFE2 was a nationally procured cloud-based Oracle system which is being implemented as the financial accounting system for ICBs. CL explained that introduction of ISFE2 required changes to coding and reporting and that procedures would be different from the system being replaced. CL explained that the contract for the system is held by NHSE England who were running the implementation.

18.2 CL stated that training and implementation of ISFE2 in the ICB had begun and a project manager had been hired to drive the project forward and ensure resilience of the project. CL reiterated that the timeframe for implementation of ISFE2 was nationally driven rather than locally, and the system was projected to go live in October 2024.

18.3 CL also cautioned that the ICB expected workforce pressure emanating from the operation of two ledgers during the transition period. Members discussed and acknowledged the challenges faced in implementing ISFE2 but agreed a Green Assurance rating overall.

RESOLUTION: The Audit Committee noted the ISFE 2 Update report.

19. Losses and Special Payments Register

19.1 No report was presented on this item.

20. Debts Proposed Write-offs

20.1 No report was presented on this item.

21. Aged Debt Report

21.1 CL presented the outstanding debt report as of 20th November 2023; this showed total debt of £907,306 of which £509,811 was NHS and £397,495 was non-NHS. Members discussed the individual items constituting the outstanding debt and the actions required to recover such debt. CL stated that all controls were in place and functioning well. CL explained that the only moderate pressure requiring attention related to a few salary overpayments and that the issue was being addressed. Members expressed satisfaction with management action and the low level of risk. Members agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Aged Debt report.

12. Counter Fraud Report

12.1 PK presented the report and presented the Economic Crime and Corporate Transparency Act. PK explained that it was expected that the Act would have effect starting from early 2024. PK stated that the new Act would compel organisations to produce and demonstrate evidence of reasonable controls against commission of fraud. PK stated that the government would publish guidance on fraud prevention procedures before the Act took effect.

12.2 PK presented the draft Statement of Bribery and explained that this was still work in progress. JB expressed a concern that the Statement appeared to focus on the ICB instead of having

a system-wide focus. CL explained that focus on the ICB was informed by statutory requirements that sought assurance and accountability from the ICB.

12.3 PK stated that Counter Fraud and the Governance Manager worked through the fraud, bribery and corruption risks to reduce the risks from Red to Amber. PK highlighted that Counter Fraud and the Governance Risk Lead were continuing to work on this and that the updated report would be presented to the Committee in March.

12.4 PK highlighted risks associated with conducting business with third party providers and stated that Counter Fraud was working with the ICB Procurement Team to strengthen controls and further mitigate procurement risks. He reported that Counter Fraud was working with BDO LLP to investigate and advise on controls relating to PHB, and that an update on both areas would be included in the March report. PK updated the Committee on live investigations. Members discussed the report and agreed a Green overall rating for Assurance.

RESOLUTION: The Audit Committee noted the Counter Fraud report.

15. Personal Health Budget Policy Update Report

15.1 BL presented and highlighted that whilst originating in Continuing Health Care (CHC), personalisation had a broader remit across the ICB with multiple teams offering Personal Health Budgets. BL clarified that the multiple teams constituted a wide range of people across the system, including in quality, nursing, mental health, children services and finance. BL emphasised that this made working on policy and its update a complex issue.

15.2 BL added that despite the challenges faced, the policy had been updated and would go before the System Quality Committee for scrutiny and approval. Whilst acknowledging slippage in clinical and quality elements of the policy, BL provided reassurance that the financial aspect of the policy was complete and was already being utilised. BL stated that he would keep members updated on developments. Members discussed the report and agreed an Amber Assurance rating.

RESOLUTION: The Audit Committee noted the Personal Health Budget Policy Update report.

16. Emergency Preparedness and Business Continuity

16.1 MAE and AS co-presented and MAE stated that the evidence gathered and analysed by the EPRR Team and BDO LLP respectively gave similar results. MAE explained that record keeping relating to emergency preparedness and the documentation of training records were found to be inadequate. MAE stated that resilience planning was moving to a more system-based approach and, apart from resource pressures the ICB had the knowledge and skills to comprehend and handle expected challenges.

16.2 MAE reiterated that ICB workforce was small, even in comparative terms, and impacted adversely on emergency planning and preparedness. MAE explained that the ICB was increasing focus on cyber security as a response to increased cyber incidents, and this included a recent cyber-attack against SWASFT. MAE added that industrial action and the

relocation of offices from Sanger House to Shire Hall had a disruptive effect on resilience programmes.

16.3 MAE stated that partner organisations in the system also faced resilience challenges to varying degrees. MAE added that it appeared options for reducing risk included a joined-up approach to emergency preparedness and planning. AS concurred and reiterated that key factors needed to develop resilience included investing in staff training and testing business continuity processes to support continuous improvement.

16.4 MAE highlighted that the ICB had become a Category 1 Respondent; and this meant that the ICB by default was required to lead the system in emergency preparedness and planning. Members discussed the report and acknowledged the challenges faced in the Emergency Preparedness Resilience and Response (EPRR) environment. Members agreed a Red Assurance rating to reflect the risk and work remaining.

RESOLUTION: The Audit Committee noted the ICB Emergency Preparedness and Business Continuity report, considered together with BDO LLP's Business Continuity and Emergency Planning report.

The Chair proposed a 5-minute break and members agreed. The meeting adjourned from 10:55am – 11:00am.

8. Risk Management Report

8.1 RB and CGi presented the report and outlined the improvements being introduced to risk management. RB highlighted that the Governance Team were introducing new tools, including spreadsheets and dashboards and he presented initial drafts. RB explained that new methods would run concurrently with the reports generated from 4Risk until testing of the new tools was complete. RB presented the Corporate Risk Register (CCR) before members and highlighted 33 risks with a residual score of 12 or higher. RB presented 5 risks requesting closure.

8.2 CGi presented an upgraded Board Assurance Framework (BAF). CGi also clarified that the newly introduced BAF was at developmental stage. JS commended the upgrade but cautioned that Risk Leads and Risk Owners could benefit more from further training to help improve the focus and accuracy across basics such as risk description, risk impact and risk controls. **Action: CGi and RB to organise workshops, or alternatively, one to one training for Risk Leads and Risk Owners.** JS highlighted the importance of getting executive directors' contribution through their current insight on issues impacting strategic risks. **CGi &RB**

8.3 CL presented the finance and business intelligence risks. CL described some internal processes employed within the directorate to manage risk, and highlighted emerging system risks arising from backlog maintenance, ageing estate and the rising cost of Primary HealthCare estates. Members explored options available to mitigate the risks presented. JS commented that bringing risk Owners before the Committee fostered a deeper culture of risk awareness and control. Members discussed the risk management report and BAF and agreed an Amber Assurance rating.

RESOLUTIONS: The Audit Committee:

- **Noted contents of the CRR.**
- **Noted contents of the refreshed BAF.**
- **Noted the Deep Dive into finance risks.**
- **Approved the closure of 5 risks.**

10. Annual Review of Committee - Audit Committee, 2023

10.1 CGi presented and stated that the Governance Team had modified the Annual Review tool for corporate governance. The tool followed a standard survey template containing questions about the effectiveness of the Committee. CGi explained that a survey containing a wide range of questions was sent out electronically to members and regular attendees. The survey which employed a Likert scale contained a range of questions which looked at governance effectiveness. CGi presented feedback from the survey. The survey outcome showed favourable feedback on effectiveness of the Committee.

10.2 Members discussed the findings and recommended that such an assessment tool be considered for use by other committees of the Board to drive best practice. **Action: Members requested that CGi propose the use of the modified assessment tool (or its variation) accordingly.** **CGi** JS suggested to engage with CGi to review the survey outcome and possibly create an action plan to address areas identified as requiring improvement. **Action: JS and CGi to meet to discuss the survey outcome.** **JS & CGi** Members agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Annual Review of the Audit Committee and recommended use of the modified assessment tool by other committees.

11. ICB Policies for Approval & Extensions

11.1 CGi and UR presented the following policies to the Committee for approval following updates:

a) Engagement of Internal and External Auditors for Non-Audit Work Policy.
b) Digital Clinical Safety Policy.

Members reviewed the policies.

RESOLUTION: The Audit Committee approved:

- **Engagement of Internal and External Auditors for Non-Audit Work Policy.**
- **Digital Clinical Safety Policy.**

13. Procurement Decisions Report

13.1 CL presented the report which related to the decision to award a 5-year contract with a value of £665,000 to the Drybrook Partnership for the provision of Primary HealthCare service. CL explained that there was an option to extend the contract for a further 3 years. Members discussed the report and agreed a Green Assurance rating.

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

14. Waiver of Standing Orders

14.1 CL presented the 10 waivers of Standing Orders requested and approved by the ICB Executive. Members examined the waivers and focused on waivers that showed significant sums of money. Members however agreed that such waivers were necessary and reasonable. Members considered the report and agreed a Green Assurance rating.

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

17. Primary Care Delegation of Pharmacy, Optometry and Dental (POD) Services

17.1 DM presented the report and stated that the POD Project Team regularly updated relevant committees on progress made on POD transition. DM described the ICB's collaboration with Collaborative Commissioning Hub (CCH) and NHSE Regional Team to drive the transition process forward. DM stated that BDO LLP offered advice on POD transition. DM also explained that POD risk had been added to the Corporate Risk Register (CCR).

17.2 DM stated that further update would be brought before the Committee in March 2024. Members agreed an Amber Assurance rating. **Action: DM, JG and JW to update members in March 2024.** **PC Team**

RESOLUTION: The Audit Committee noted the Primary Care Delegation of Pharmacy, Optometry and Dental (POD) Services report.

22. Any Other Business

22.1 There was no other business.

The meeting ended at 12:15pm.

Date and Time of Next Meeting: 7th March 2024 at 09:30am (Hybrid).

Minutes Approved by the Audit Committee:

Signed (Chair):Julie Soutter
Date: Thursday 7th March 2024

AUDIT COMMITTEE 7th March 2024

ASSURANCE REPORT

Part I

Area	Assurance	Notes
External Audit	Green	Year-end work progressing as planned. Approach to include work on non-contractual expenditure and variable payments – not expected to be material overall – and year end accruals as before. Contracts signed off improved over 23/24 with mainly OOC remaining to do. Discussion on CCH services and how ICB receives assurance over its operations. MHIS work and report finalised.
Internal Audit	Green	Progress report and follow-up reviewed and noted some responses from ICB slower than expected. No concerns over follow up of recommendations. Draft HOIA opinion discussed – overall moderate opinion based on financial position and results from audit reports conducted during the year. Move to substantial would require more consistency across report areas. IA draft plan 24-25 - approved with amendment to include review of conflict of interest areas. Key financial systems audit report – substantial across design and effectiveness. PHB report – BDOs first audit of this area in ICBs. Acknowledged good policy and breadth of work increased but noted some key areas to address. Includes staff awareness and need to look at more integrated approaches between partners. Actions agreed and to be led by Director of Integration.
Risk Management	Amber	Corporate Risk Register – Commended improvement work on risk reporting and information presentation. Red risks reviewed and actions discussed. Further improvements to come including completeness and timeliness of updates. Continued training and support provided. BAF – improved format and content with actions ongoing to develop further. Commended work so far. Directorate discussion – Strategy/transformation. New and high risks discussed and assurance sought on management of risks. Red – risks Green – management action
Conflicts of interest	Green	Noted compliance against targets and inclusion of audit review in 24/25 IA Plan. Scope to be agreed.
Annual Governance statement	Green	Draft reviewed.

Policy approvals	n/a	Clinical records – policy to be reviewed for suggested amendments pre submission to SQC. Intellectual rights – further cross check to partner policies to be done pre sub mission to SQC
Counter Fraud	Green	Progress report received. Counter Fraud Functional Standards Return (CFFSR) proposed ratings for 23/24 discussed Draft work plan 24-25 approved.
Procurement	Green	Recent decisions and waivers reviewed. Report on trends requested for future meeting.
Financial Management	Green	Annual accounts timetable, losses and special payments and debtors reports reviewed.

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Public Session

Thursday 7th December 2023, 14.00-15.30pm
Board Room & Virtually at Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Ayesha Janjua (Chair)	AJ	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:		
Andrew Hughes	AH	Associate Director, NHS Gloucestershire
Becky Parish	BP	Associate Director Engagement and Experience, NHS Gloucestershire
Carole Alloway-Martin	CAM	Councillor, Gloucestershire County Council
Christina Gradowski	CGi	Associate Director of Corporate Governance, NHS Gloucestershire
Helen Edwards	HE	Associate Director of Primary Care & Place, NHS Gloucestershire
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire
Jo White	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire
Julie Symonds	JS	Deputy Chief Nursing Officer, NHS Gloucestershire
Nigel Burton	NB	Local Board Member, Healthwatch, Gloucestershire
Olesya Atkinson	OA	GP and Clinical Director of Cheltenham PCN
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
In attendance:		
Cherri Webb	CW	Primary Care Development & Engagement Manager, Primary Care & Place, NHS Gloucestershire
Katrice Redfearn	KR	PCN Service Implementation Manager, NHS Gloucestershire
Charlotte Griffiths	CG	PCN Service Development Manager, NHS Gloucestershire
Meryl Foster	MF	Senior Programme Manager, NHS Gloucestershire
Maniza Rahman	MR	Associate NED, NHS Gloucestershire

1. Introduction & Welcome

1.1 AJ welcomed members and attendees to the Primary Care & Direct Commissioning (PC&DC) Committee.

1.2 AJ welcomed MR to the meeting who had joined the ICB as an Associate Non-Executive Director (NED).

1.3 There were three members of the public in attendance via MS Teams.

2. Apologies for Absence

2.1 Apologies were received from Jeanette Giles (JG).

2.2 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 held on Thursday 5th October 2023

4.1 The minutes of the previous meeting held on Thursday 5th October 2023 were approved as a true and accurate record of the meeting, subject to the minor amendment to the title of agenda Item 8 from Improvement, to Infrastructure.

5. Matters Arising and Action Log

5.1 **Action 4 –Tewkesbury, Newent & Staunton (TWNS) Primary Care Network (PCN) Evaluation.** Delayed until the February 2024 meeting. **Action to remain Open.**

Action 10 – Patient Participation Groups: This action was covered and described within the Primary Care Quality Report as found within agenda Items 12.5 and 12.6. **Action closed.**

Action 12 – PCN Support Sessions update. Action for JW to bring to a future meeting with more specific details on timelines and staff involved. **Action to remain Open.**

6. Questions from members of the Public

6.1 There were no questions received from members of the public.

7. Delivery plan for Recovering Access to Primary Care

7.1 JW updated members around the national programme of work for practices and Primary Care Networks (PCNs) which aims to support the increase in demand within Primary Care which has four areas of focus:

- Empowering patients
- Implementing the modern general practice access model,
- Building capacity
- Cutting bureaucracy

Many practices were already using the modern general practice access model by signposting patients and triaging people using a number of different clinicians and non-clinicians to ensure that patients could access services either by calling, walking in or making online requests. This became a contractual requirement from August 2023. This programme was also aiming to support some of the digital elements which sat alongside improving access to general practice.

7.2 JW described how ICBs had been asked to put together a System Delivery Plan, with a national requirement from NHSE for all ICBs to also submit reports to their public Boards in October/November 2023, with an update in February/March 2024. The Gloucestershire ICB report was taken to the Board in November and contained substantial detail about the local context during challenging times. 2024/25 contract negotiations were not yet known and there was still a lot of uncertainty in practices and PCNs, which was an added pressure.

7.3 However, Gloucestershire was averaging 24% more appointments than those pre-Covid including more urgent, and same day appointments. 73% of appointments were face-to-

face, with most patients being seen on the same or following day. or the next day. The overall patient experience in Gloucestershire showed that 80% reported a good experience compared to 71% nationally.

7.4 The System Delivery Plan linked with the Fuller Report, some of the neighbourhood transformation work and with the Primary Care Strategy. The System Delivery Plan was being managed as part of a working group which would report in via the Primary Care Operational Group (PCOG) and this Committee. There were a number of key areas of focus:

- Supporting practices to improve their 2 and 4 week appointment data, and appointment mapping.
- Establishing self-referral routes in Gloucestershire for falls, musculoskeletal, weight management, community podiatry, wheelchair and community equipment services and eventually, audiology.
- Assisting practices to move from analogue to digital telephony to ensure that practices could meet the NHSE criteria.
- Reduce bureaucracy within the system, by establishing local mechanisms to facilitate the Primary Care and Secondary Care interface, led by Chief Medical Officers (CMOs) across all ICBs, whereby a programme of work will be developed.
- There had been a high uptake in the previous GP Improvement Programme in Gloucestershire and GPs did not feel it necessary to enrol again on a national programme so soon, but this is being examined.
- Patient Participation Groups (PPGs) will be looked at to understand where more could be done to build up these groups.
- Community Pharmacy Services needed to be implemented and there are local and national Communication Plans enabling patients to be signposted and to understand the challenges and the roles within general practice.

7.5 AJ said that feedback on the paper had been given by this Committee before being taken to the Board and felt it was a really good document. AJ said progress had been made and was keen to have this shown in more detail. JW informed members that information would be amalgamated and presented at the next meeting via a dashboard showing performance against the actions.

7.6 OA GP surgeries need support to gain the most impact from direct signposting to other services referencing the self-referral routes and reducing bureaucracy. It was very difficult for GPs to keep abreast of all the changes around all the different pathways and asked for strong communications to be sent out to put information on their websites which would help.

7.7 Practices felt challenged in a number of areas including financial pressures, patient demand and expectation, the Primary and Secondary Care interface and workforce. There was a proposal in place for a Primary Care Liaison Officer which would help. AS spoke about leadership within the Trust and within Primary Care, with plans to take a Charter forward lead by Dr Ananthakrishnan Raghuram. OA said the Primary Care Interface would translate into a culture for change and hoped that in the future there would be more opportunities for face to face consultant GP interactions. AJ said it would be beneficial to have future progress reports on that culture change.

7.8 CAM referenced the statement about patients understanding how practices would function and asked whether patients would have access to the same level of support with standardised services for individuals. If this was not the case CAM felt the ICB could be open to criticism if this were not the case and there was a need to avoid a postcode lottery,

as some practices were not as developed as others. CAM also asked whether there was a communications plan to help patients to understand how they might access services.

7.9 AJ was concerned about how Primary Care could help patients to understand how practices functioned and where there might be disparities within the services being offered, wondering if anything could be done to mitigate this.

7.10 JW responded that there would be local and national communications campaigns which would be run with, for example, the new Additional Roles Reimbursement Scheme (ARRS) roles being explained. The System Delivery Plan was about understanding General Practice, improving access to those services and being more appropriate in doing so.

7.11 HG praised the significant work on the System Delivery Plan that had been done by JW and the team.
In terms of the targets, there would always be unintended consequences in trying to meet targets when looking at performance. The impact would need to be understood if better performance in appointment data was achieved and what that could mean for access but also patient care.

7.12 HG said that financial resilience and sustainability had been hard for practices who were still suffering the effects of cost of living increases. HG had never previously come across such pressure in general practice from a financial perspective. Implementation of the Plan would have to be done sensitively ensuring there were no unintended consequences to chasing any particular targets and understanding individual practice positions.

7.13 HG was pleased to see that community pharmacies were going to be taking up even more opportunities which could help enormously in terms of picking up some of those minor illnesses from a “pharmacy first” approach.

Resolution: ***The PC&DC noted the contents of the Delivery Plan for Recovering Access to Primary Care report.***

8. Gloucestershire Dental Strategy Update Report

8.1 HE gave a verbal update to members on the three areas of the Commissioning Plan, Access, Workforce and Oral Health Improvement for the Committee. This Commissioning Plan had been seen twice previously by the Committee, most recently in August 2023. A fully costed Plan will be brought to the Committee for the meeting in February 2024. However, the Committee were today updated on a number of developments before that meeting.

8.2 In terms of access, the Committee approved an Expressions of Interest letter in July 2023 which had been sent to all 63 practitioners of general dental services in the county in order to provide additional urgent capacity initially out of hours, weekends or evenings and subsequently in hours and interest in stabilisation.

8.3 There were 51 additional urgent care appointments obtained on average per week which was pleasing in terms of additional capacity. This capacity had been signed off and supported by colleagues from the South West Collaborative Commissioning Hub and also by the NHSE Procurement Team in helping to make some of these changes.

8.4 132 stabilisation appointments had been secured per week and it had been proposed that the capacity will be accessed via NHS 111. The pathway for these appointments is in the process of being finalised so that capacity will be available for members of the public to use.

8.5 In terms of workforce, HE was delighted to inform the Committee that a dental strategy clinical lead, Christina Worle, had been appointed and will initially work on a Friday but will increase her hours towards the end of February 2024 and will continue her work in a clinical capacity for the other three days a week. The recruitment panel had been supported by County Council colleagues - a public health consultant, a public health consultant in dental services from NHSE, and NHSE workforce Training and Education colleagues.

8.6 HE described how in Section 3.3 of the paper on oral health improvement, two developments would be undertaken in conjunction with Gloucestershire County Council colleagues who had a statutory duty for the oral health improvement of their population. Both programmes had been commissioned by NHSE prior to delegation to the ICB and will be coming on stream within the county.

8.7 Regarding the Supervised Toothbrushing contract, this was awarded by NHSE to At Home Dental and will be mobilised mid-December 2023, with a go live date of mid-January 2024. A phased roll-out will service will eventually be available in 172 primary school settings across the county, in nursery schools where they are attached to a school, and in special schools. The majority of the services will be prioritised for Indices of Multiple Deprivation (IMD) areas 1 to 6 and further prioritisation would take place in relation to Core20plus2 areas.

8.8 HE explained that First Dental Steps was a programme for all babies at their universal 9-12 month check with an additional component of oral health improvement and for some children, a pathway into the Community Dental Service. The final part of the paper showed the anticipated costs over the next three years of the costs associated with those programmes.

8.9 HE informed that the first dental engagement event was held on 30th November 2023 and the response was very pleasing and there was a good deal of energy in the room. 21 practices had joined the event which had been a great start given the current position.
A survey was handed out to those attending and the response on asking when they would like to meet again was in another six months' time. Feedback was given on retaining associate dentists and increasing the number of training practices in the county, of which there were currently only four that were able to support foundation dentists.

8.10 HG observed that at the event there had been quite a lot of misunderstanding about flexible commissioning before and now and so to dispel the myths there will be a FAQ based on what would need to be done to become a foundation trainer and how rebasing their contracts could be done as well as further work. HG told the Committee that she was so proud of the work her team had done and achieved already, which would definitely pay dividends. The exercise also incorporated the rebuilding and establishing of relationships and the ambitions of the Strategy would not be achievable until trust was there, which can take time.

8.11 MH said she was surprised that capacity had been identified so quickly and this was all credit to the team who had been collaborating with local dentists which had encouraged them to come forward so quickly. It was often difficult to respond to patient complaints but with work like this moving forward this will lead to more capacity for NHS 111 that will meet the immediate needs for people.

8.12 HE believed that the stabilisation appointments would go some way to support people because as well as that initial appointment, the stabilisation period is for 12 months for one

dental issue which gives certainty. Whilst it does not provide a routine dental home for individuals, it does address a particular issue over a period of time.

***Resolution:* The PC&DC noted the contents of the Gloucestershire Dental Strategy Update Report**

9. Primary Care Risk Report

9.1 JW reported that there had been a general Primary Care risk scored at 15 which reflected much of the conversation earlier around resilience and sustainability within Primary Care. This was down to workforce challenges and increased demand around the appointments that practices were offering.

9.2 The risk was listed as being a general risk in that the ICB's requirements of providing Primary Medical Services for practices that were facing resilience challenges, could not be met. It had been identified that there was a risk of harm to patients due to practice staff burnout in particular.

9.3 JW explained that regular Primary Care meetings were held with individual practices to support them when issues were identified. All ICBs did have some resilience funding where non -recurrent support could be given if necessary.

9.4 HE said that the New to Practice programme would help ensure stabilisation of the workforce, not only with recruitment of new partners, but also their retention. The team had supported recruitment into the ARRS roles whilst accepting the financial challenges being faced.

9.5 HG said with the support of Finance the team had been working with a highly qualified Primary Care accountant to really help those practices to understand their financial planning. Feedback about the approach had been resoundingly positive. HG said going forward that there would be a much more pro-active approach around supporting the GP partnership model to become more sustainable and resilient by working out what the best financial budget forecast modelling could be. There was more work to be done but continuing support should not be under-estimated.

9.6 AJ said the Risk Register mentioned addressing the workforce challenges and mentioned a monthly dashboard focus on workforce numbers and AJ asked whether this data could come to this Committee even if it were just a summary showing how numbers were doing. HG added it was hoped that some of the learning and modelling would transfer over into the dental recruitment agenda. **Action: Workforce data from monthly dashboard to come to a future PC&DC meeting to check on numbers.** **HG /HE**

9.7 HE said this would apply around the fellowships and support for under-doctored areas in the county as well as the Health Inequalities fellowships that had been so successful and was something that would definitely be usefully replicated into a programme for foundation dentists to incentivise them to stay within Gloucestershire. HE confirmed that workforce figures could be reported to this Committee in future.

***Resolution:* The Committee noted the content of the PC&DC Risk Report.**

10. Highlight Reports

10.1 General Practice

10.1.1 JW said the Highlight Report, which is shared as regular reporting with ICB Board, gave an overview of all the programmes of work to develop and sustain practices and includes all delegated services around Pharmacy, Optometry and Dentistry.

- All locally commissioned GP Enhanced Services are being reviewed for 2024/2025. A vasectomy contract will be ending in June and a review is underway of the specification and a procurement process which will take place in the new year.
- There was a lot of work going on around digital some of which was linked with the Recovering Access to Primary Care Programme and included the switch on of prospective record access to all patients.
- A Footfall website pilot was taking place and practices are to be contacted with further information on rollout.
- This phase of the Covid vaccination programme was ending and there will be an Evergreen offer. Gloucestershire is one of the top few counties in the country in terms of the amount of vaccinations that had been completed.

10.2 Pharmacy, Optometry & Dentistry (POD)

10.2.1

- The NHSE South West Team continue to work on the transition items identified at the point of delegation. There were statutory groups for Primary care but also for each of the POD groups. The Ophthalmology group tended to link in with the ICB Clinical Programme Group (CPG) and this was working well.
- Work continues around workforce, and HE said that a locum event had taken place recently which had been well attended and supported by around 60 locums. This is an annual event and the locums help to design the agenda.
- Locums were reporting that they had not been able to obtain as much work as they had done previously. However, a review of the Primary Care Flexible Staffing pool revealed that locums worked over 1,800 hours for practices in the county during November 2023. There is 100% sign up from all the practices to the pool and 112 GPs working in it.

AS said that the event had been successful and praised the team for organising it. AS said that there seemed to be less locums this year with the bulk of them being long serving GPs which was good.

10.3 Primary Care Strategy

10.3.1 JW said that work continued on the Primary Care Strategy which was a significant piece of work, and the team were grateful to have a variety of roles across Primary Care and the ICB to support as part of the group which was chaired by Dr. Olesya Atkinson. OA said that a summary was presented today to the PCN Clinical Directors and Business Managers and there was good discussion. The Strategy is expected in April 2024. JW said there is an engagement plan being followed and there would be further engagement from others before anything is finalised.

Resolution: ***The Committee noted the content of the Highlight Reports.***

11. Performance Report

11.1 JW said a new look was being trialled with the Performance Report by looking at all of the Primary Care key indicators which the practices and PCNs were focused on, and those that were coming through as part of the system challenges as well. This would include the IIF and would look at the capacity and access improvement plans which linked with the Recovering Access in Primary Care actions ,.

The report aimed to give an overview of the performance within Primary Care & PCNs including
- Investment & Impact Funding (IIF)
- Capacity and Access Improvement Plans (CAIP)
- PCN Specifications
- PCN Additional Roles Reimbursement (ARR) Scheme.
- Severe Mental Illness Physical Health Checks
- Learning Disability Annual Health Checks
- General Practice Appointment Data
- Selected POD Performance Data.

Overall trends rather than changes month by month would be highlighted. The report will continue to be refined.

11.2 AJ said she had found the report extremely helpful both visually and descriptively. AS said, he had concerns around appointment targets which did not necessarily reflect quality in Primary Care. AJ said she had a comment around IIF indicators and asked whether this was expected performance. . OA said the reason this was still red was due to being only half way into the year.

Resolution: ***The Committee noted the content of the Performance Reports.***

12. Primary Care Quality Report

12.1 MAE updated on the report around safeguarding and was pleased to say that there was a new designated nurse for Children which was a new role and the additional input had been welcomed. This new role will support Primary Care. MAE said that the ICB were working under the guidance of Working Together 18. This was under review and had been out for consultation. It was hoped that in the New Year Working Together 24 would be visible and would reveal changes. MAE said that having education brought in as a statutory partner was a good idea, considering how much time children spent in education. A more informative briefing would follow once this paper had been issued.

12.2 The Executive Partnership for Children's Safeguarding had published their Annual Report which could be found on the Gloucestershire County Council (GCC) website. The ICB Annual Report covered Children and Adults.

12.3 Part of the Enhanced Service for GPs will be to undertake an annual practice Safeguarding assurance process which was also evidence that everything was in place should a CQC inspection occur. The Local Medical Council (LMC) had expressed concerns in that it was onerous for GPs to complete and so the named GP for Safeguarding was working with the LMC to obtain an audit that would deliver that assurance without it being too problematic for Primary Care to complete.

12.4 BP gave some highlights on the Patient Experience and Engagement element of the report. Data had been included in the report around the number of people who were coming through the Complaints and PALS Team. Feedback from NHSE was that Gloucestershire had delivered the best performance in resolving local dental queries which had prevented some formal complaints. The team had been able to resolve a number of these enquiries very effectively and BP thanked the Primary Care team who had provided regular updates.

12.5 An update on Patient Participation Groups (PPGs) had been provided in the report. There were four main ways in which the ICB worked with PPGs. They would often ask for advice and support in the recruitment of new members for their groups and a short recruitment

survey had been developed which had proven incredibly successful. Two practices recently had put out Expressions of Interest to which they had received hundreds of applicants in the region of approximately 300. Part of the role of the team had been to sift the applications that had been sent in and where this level of interest is seen, these people can also be added to a virtual Patient Group.

12.6 The team were also helping PPGs with information and advice about how to manage their PPG such as Terms of Reference and the development of workplans for which good progress had been made.

12.7 The Countywide PPG Network's last meeting focused on the Primary Care Strategy. HG thought the meeting was so good and was the most positive and productive discussion she had ever had at PPG level. HG congratulated BP on this brilliant meeting. The next meeting will examine the cross-cutting themes identified in the Primary Care Strategy.

12.8 Sharing the Power: Get *Involved* in Research to increase diversity in Gloucestershire was going from strength to strength with great work going on with community voluntary organisations and Gloucestershire University with particular focus around mental health amongst people from minority communities. NHSE had provided some funding to support that work.

12.9 MAE had attended the last Research meeting and there had been real energy and enthusiasm in the room with people wanting to become involved and share their ideas. A forthcoming workshop was likely to be beneficial. The first Community Primary Care and Research Group is to take place next week which would hopefully drive forward the research agenda in the Primary Care community.

12.10 JZS said that since writing the Patient Safety update, GHC had finished their part of the policy and had written their plan. A task and finish group will be set up including Primary Care, so that the system investigation and learning could be considered. This will be cascaded to Primary Care colleagues and updates given as this work progressed.

12.11 Work continued with colleagues at Highnam with PPG on Out of Hours and NHS 111. Feedback from patients regarding the signage in the Emergency Department (ED) and the Out of Hours (OOH) GP had led to improvements which had not been previously flagged as an issue, so this collaboration had proved productive.

12.12 The Leg Ulcer Service had now had project management support agreed with the work now sitting under the team of Jane Haros. It was the aim to incorporate some of the good work of Herefordshire colleagues into some of that done locally. The support of designated management support meant this would progress in the New Year.

12.13 Concerns were being raised by Primary Care clinicians around the significant delays and backlog of radiology reports. The ICB planned care leads had been asked by Executives to gain a fuller understanding of the problems with radiology reporting backlogs, specifically relating to GP urgent reporting times. Data presented at the Diagnostic Programme Board, suggested that CT/MRI capacity was being prioritised to ED and some inpatient areas, which could be at expense of GP urgent and 2ww requests. A working group is to examine this to understand the situation and JW thought it was important for this to remain under the Quality agenda.

12.14 MH commented that Gloucestershire ICB had the most capacity in the country for CT, MRI and non-maternity ultrasound scans and thought that this needed to be an accelerated review and addressed immediately. There should be no problem around 2ww for diagnostics. AS said, tests were done on time, but the problem was the reporting which

took 5-6 weeks. The reporting therefore had been outsourced due to this problem. MH asked about the programme of work and Christian Hamilton had been heavily involved with this with Kerry O'Hara. **Action: JZS to follow up radiology reporting backlogs and report back to the Committee.** **JZS**

12.15 Migrant Health Update – JZS reminded the Committee that the Ramada Hotel would be closing on 11th December 2023 and the Prince of Wales Hotel was closing in the third week in January 2024. The Orchard and The Ibis were still full and remained static with no plans to close them. Beachley Barracks in Chepstow will house eligible Afghanistan nationals and their families. They will be flown from Pakistan to four sites in the UK which were Ministry of Defence (MOD) bases that had capacity for residents to live. 4500 nationals were expected before Christmas.

12.16 96 people were on site at Beachley, about 42% of the capacity for the base. The people coming in had complex needs and had very different health needs to those residing in contingency hotels. This would result in a big impact at a Primary Care level. There were a variety of clinical issues that needed to be addressed. From a vaccination perspective the ICB were working jointly with the vaccination team with the biggest issue being MMR and DVT vaccines.

12.17 No notification had been given to the ICB about this and MH had spoken to the Police and Crime Commissioner who had said that there would be no need for any input from health and issues would all go to ED. That obviously was not the case and never would be and MH said it was wrong that this should happen and the ICB not be informed. This would need to be raised formally. JZS said she would be attending a formal MOD meeting and site visit at Beachley. GICB is trying to ensure that Migrant Help and the Home Office were aware of all those who had health concerns when dispersal decisions were being made. MH was clear that the ICB wished to support people whilst also considering those health needs and potential risks around Primary Care of the local population.

12.18 CAM said as two hotels were going to be closing, these people would become homeless and emergency accommodation would need to be found. Four of six districts had responded positively with offers of housing, but this would not be enough capacity. Other options were being examined for those migrants arriving.

12.19 JZS said that as the Forest of Dean was an area of deprivation there could well be a risk for the local population. AJ said this Committee would be able to keep an eye on things if migration were to be placed on the Risk Register. This was a topic that needed to be regularly reviewed. JZS and colleagues were working closely with Public Health colleagues as medicines needed for the migrants would not be the day to day kind normally needed.

Resolution:* *The Committee noted the content of the Primary Care Quality Report.

13. Delegated Primary Care Financial Report – September 2023

13.1 CL explained that at the end of September 2023 the Integrated Care Board's (ICB) Delegated Primary Care co-commissioning budgets were showing a £773k overspend position on a £59,575k year to date budget. The month six forecast position was breakeven, although this position could change as the year progressed and issues were highlighted. One overspend was the IIF of £400k along with a number of other smaller items but these were manageable within the ICB position. Recurrent and non-recurrent funding would need to be examined so that next year's position was understood.

13.2 In terms of POD, there were reported underspends on one of the budgets – Other GP did not have any commitments but in Months 7 and 9 with the national letter and further flexibilities, the dental underspend had now been brought into the ICB and ICS overall financial position which will be shown in future months. There had been some underspend on secondary dental contracts of which some were on a cost per case basis. The underspend for dental was on a non-recurrent basis so was for this year only.

13.3 There was a question about the confidence of underspending on dental in consecutive years. CL said that a range of scenarios were being modelled but based on the trends that had been seen, the strategy had finance from the ICB, and the dental hub had done some modelling and they were very experienced around this so it was with some confidence, predicted that finances will be fine. Obviously, there was more work to do, and HG's team were working closely with the Hub and ICB Finance to ensure that over-commitments were not made recurrently.

Resolution: ***The Committee noted the content of the Delegated Primary Care Financial Report for September 2023.***

14. ICS Transformation Programme & ILPs Highlight Report

14.1 HG drew the Committee's attention to an event held in mid-November on the Locality Work Programme, attended by MH and CAM. HG had found it inspirational, and it was an opportunity for localities and neighbourhoods to demonstrate their Quality Improvement and partnership projects. There was an opportunity for the ICB to submit three case studies, all of which had been moving and inspiring. CAM and AJ said this event had been amazingly vibrant with obvious passion. This will be joined up with the Integration agenda.

Resolution: ***The Committee noted the content of the ICS Transformation Programme & ILP Highlight Report.***

15. Any Other Business (AOB)

15.1 There were no items of any other business.

The meeting closed at 15.30pm

Date and Time of next meeting: Thursday 1st February 2024 - 14.00-16.00pm, Shire Hall Gloucester GL1 2TG

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: PC&DC Committee
Signed (Chair): Ayesha Janjua
Date: February 1st 2024

NHS Gloucestershire System Quality Committee

Thursday 13th December 2023, 2.00–4.25pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Andy Seymour	AS	Chief Medical Officer, GICB
Hannah Williams *(deputising for John Trevains)*	HW	Deputy Director of Nursing and Quality at Gloucestershire Health and Care NHS Foundation Trust
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marion Andrews-Evans	MAE	Executive Nurse & Director for Quality, GICB
Matt Holdaway	MHo	Chief Nurse and Director of Quality, GHNHSFT
Sarah Scott *(Part meeting)*	SS	Executive Director of Adult Social Care and Public Health, GCC
Participants Presents:		
Annalie Hamlin	AH	Senior Nurse Quality and Integrated Commissioning, GICB
Becky Parish	BP	Associate Director, Engagement and Experience, GICB
Christina Gradowski	CGi	Associate Director of Corporate Affairs, GICB
Emily White	EW	Director of Quality, Performance & Strategy - Adult Social Care, GCC
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Julie Zatman-Symonds	JZS	Deputy Chief Nurse, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Sarah Morton	SM	Professional Head of Adult Physiotherapy, GCC
Trudi Pigott	TP	Deputy Director of Clinical Quality, GICB
Vanessa Catterall	VC	Head of Quality and Safeguarding, GCC
In Attendance:		
Dawn Collinson	DC	Governance Administrator, GICB
Ryan Brunsdon	RB	Board Secretary, GICB.
Richard Thorn (Agenda Item 4)	RT	Senior Commissioning Programme Manager, GICB
Amanda Jones (Agenda Item 9)	AJ	Director of Operations for Adult Social Care, GCC
Una Rice (Agenda Item 13)	UR	Associate Director, Digital Transformation, GICB
Helen Ford (Agenda Item 13)	HF	Deputy Director, Integrated Commissioning, GICB
Rebecca Barrow (Agenda Item 13)	RBa	Head of Integrated Commissioning for Continuing Health Care (CHC), 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 John Trevains and Siobhan Farmer. The meeting was declared 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) BP declared that she was now elected Chair of Young Carers, Gloucestershire. JM declared that she was Co-Chair for the Learning Disability Partnership Board (LDPB) and PD&SI and would be raising some issues relevant to these Boards.	
4.	**Minutes of the last meeting held 19th October 2023**	
	The minutes from the last meeting held on 19th October 2023 were approved as an accurate record of the meeting. JSo had two items under Matters Arising, as noted below.	
5.	**Matters Arising & Action Log**	
5.1	**Open Actions:** **18/08/2022 – Item 7.16 - Recruitment Figures, Children in Care and Child Death.** MAE updated that a designated doctor for Children in Care (CiC) was now in post and a designated doctor for Child Death will started on 3rd January 2024. JSo requested that the red risks on the Risk Register be reviewed due to this positive outcome. **Action Closed.** **20/10/2022 – Item 8.1 - Self-harm in Children and Young People.** MAE suggested Rob Mauler (RM) and Trudi Pigott (TP) work on this and bring data back to a future meeting. **Action to remain Open.** **16/02/2023 – Item 11.9 - Quality in Service Level Agreements (SLAs).** TP to bring verbal update to December meeting. MAE had raised this at regional SQC to see if there were other systems in place. EW to discuss with TP. RB to place on agenda for an agreed future meeting. **Action to remain Open.** **12/04/2023 – Item 5.13 - Primary Care quality and metrics.** JZS said to amalgamate wider quality metrics in line with workstreams and add Primary Care element on to that once data intelligence arrived. Ensure Newton work kept separate. Update for meeting in February 2024. **Action to remain Open.** **12/04/2023 – Item 6.6 - Quality and outcome reporting for Newton Europe.** Work not yet completed with Newton Europe. JZS keen to bring in some of this work to SQC re wider issues on governance and quality measures. Primary Care Quality metrics to be kept separate. **Action to remain Open.** **12/04/2023 – Item 6.7 - CQC ICB inspection documents.** Covered in today's meeting. **Action closed.** **12/04/2023 – Item 8.3 - Adult Social Care (ASC) Review Update -** EW updated and said the Peer Report had now been made public and would be brought to February 2024 meeting. **Action to remain open.** **17/08/2023 – Item 6.17 - Primary Care Funding.** This had been discussed with the Chair of the ICB and will form part of future Board Development session. **Action to be closed.** **17/08/2023 – Item 8.4 – Children & Young People's Services (CYP).** JCu had since met with Ann James to discuss. **Action closed.**	

	17/08/2023 – Item 9.3 - Risk Reporting. HH on Maternity leave. Discussions with MAE to look at best way forward with suggestion that a meeting outside of the SQC Committee to discuss the system risks, as has potential to take most of the meeting and bring back to the SQC for agreement. **Action to remain Open.** **19/10/23 – Item 6.4.3 - Learning from Deaths Mortality Data in the GHFT Assurance Report.** Picked up by JSo from last meeting. MHo to bring the Assurance Report to the February 2024 meeting. **Action to remain Open.** **19/10/23 – Item 6.9.2 – Minutes from System Quality Group.** JSo said that these needed to come to this meeting, but they had not yet been sighted on an Agenda or sent with any System Quality Committee papers. TP to send to minutes of October and December meetings to RB for onward for circulation to members. **Action to remain Open.** **19/10/23 – Item 6.4.1 – People Panel Update.** BP to bring a report on People Panel Survey to the December meeting. Covered in December meeting. **Action Closed.** **19/10/23 – Item 5.2.2.** Plan around System Experience Group to be brought to December meeting. Covered in December meeting today. **Action Closed.**	
5.2	<u>Paediatric Audiology Update</u> RT informed the Committee this had been discussed in the System Quality Group last week. There was a national Paediatric Audiology Improvement Group underway which had been brought about by NHS Lothian review issues. Recommendations from that had resulted in immediate actions being taken. NHSE's desk-top peer review exercise examined compliance of national standards and for Gloucestershire, there were local gaps which had resulted in a detailed Action Plan being drawn up with the actions being worked through. More information would be available in February 2024. MHo informed members that this had escaped part of GHFT's governance process and had come back to the System Quality Group last week. A number of actions needed to be addressed internally before being escalated through to the ICB for which MHo apologised. The Gap Analysis and RAG rating had been presented by the Audiology nurses and the action plan was being worked through. This would come through to the System Quality Group and to this Committee, giving a broader picture around any potential assistance requirements. **Action: MHo to bring back a Paediatric Audiology update in February 2024.** JSo asked whether there would be any impacts on accreditation and whether there would be any system level risks coming from that work which would be helpful to know. MAE agreed and said by not having an early diagnosis for children with hearing difficulties could affect their education and personal development, meaning this was an important focus and could have future system-wide implications. MHo said from a system perspective, decisions will have to be made and it would need to be clear what definitely had to be done, and what the programme of work would be around things that also should be followed up and considered. This would be a conversation that would take place in February 2024.	**MHo**
6.	**<u>Risk Management Report Update</u>**	

6.1	TP informed that she had met with the Governance around the System Risk Register and Berkeley House had now been added to the Risk Register. It was noted that there were three risks of 20. CGi confirmed that each Directorate had its own Risk Register which would have a quality perspective attached. RB had pulled together all the risks and had put these onto the system Risk Register which was owned by this Committee. If a certain risk pertained to other directorates, then this could be discussed and decided where risks should be placed.	
6.2	JM raised non-compliance with NICE Guidelines relating to a commissioning perspective and asked whether the ICB were in breach of them and if so, how serious this would be. There was a question then whether such things should be coming to this Committee. JM also noticed that Clinical Programme Groups (CPGs) were going to be feeding into the Chief Medical Officer (CMO) and asked whether they should have the opportunity of being able to flag quality related risks direct to this Committee.	
6.3	CGi explained that CPGs came under Strategy and Transformation directorate, and they placed all their risks on one register, which was drawn together if there was a quality aspect, and then brought to the System Quality Committee. JM said that there was currently nothing from them on the Risk Register. CGi stated that there was a training programme of work being undertaken which would involve each of the directorate's risk leads and senior managers to explain the aspects of risk and how to capture those risks correctly.	
6.4	JSo explained that Risk Registers were being examined so that they could be improved and raised the following: • Risk Registers should be short, concise and focused for different Committees and the Governance team so that updating the Register would be easier, understanding the difference between control and action and giving clear assurance. • Risk discussions should ideally take place at the beginning of Committee meetings, which was generally good practice so that this would inform the rest of the meeting driving any later thoughts, decisions and discussions for that meeting. • A covering paper for every Risk Report would give insights into any changes being presented. • Risk owners themselves should give feedback and input to make any risks more meaningful and explanatory. • Involve system partners with any actions to improve and ensure strategic risks had partner risks mapped on to the face of the Board Assurance Framework (BAF). • CPGs to conduct deep dives to ensure adherence to NICE Guidelines and report back to the System Quality Committee. Work will continue with the Audit Committee and the Governance team on the Risk Register to incorporate an easier and clearer document with less text and thus aiding an easier process around capturing and mitigating risks.	
6.5	*SS joined the meeting at 2.30pm.*	
6.6	SS referred to risk 1077 (risks to the capacity of the care market), which was allocated to BL. There was a statutory duty in the County Council to ensure sufficient provision and quality of care within the county. BL had commissioned a new market position statement of need for care, (the old one being out of date) and Newton Europe had been tasked to put this together. The projection for 25 years showed that the need within Gloucestershire would be very demanding and so SS thought the ICB Board should be briefed around the needs of the older population in a future development session. Future planning was	

	paramount and would be forming a key strand of the Council's strategy in terms of how this would be moving forward and also involving workforce.	
6.7	JCu thought teams could check between themselves as to where risks should be sitting and also understand how to evaluate what was being done and whether it was having an impact to resolve those risks. JCu and JSo agreed to meet at the end of this meeting to discuss current risk and determine whether anything else should be added to the Risk Register.	
	Resolution: The committee noted the update.	
7.	**System Partner Highlight Assurance Reports**	
7.1	GHFT including Maternity/LMNS Quality Report	
7.1.1	MHo updated the Committee on three items not contained in the paper: The Good Governance Institute (GGI) Review had been working with GHFT relating to the review of the governance structure and intended to present their recommendations at a Board Development session tomorrow. MHo and Mark Pietroni were also to make a number of informal recommendations to take forward which linked into the action plan for Well Led from the previous CQC inspections. Daily Incident Response Safety huddles had been running at 8.45 am for two and a half weeks with multi-disciplinary attendance, where every moderate harm incident from the previous 24 hours was reviewed, and decisions made on any immediate safety actions. Feedback had been very positive and good immediate safety actions had been enacted. The reporting of incidents was much better than it had been previously, with senior leads hosting the meetings. CQC colleagues visited Stroud Maternity Unit on 12th December as they were examining stand-alone midwifery led units. Documentation had been uploaded and there was to be initial feedback on 19th December. It would appear that there were no immediate safety concerns and updates to colleagues would be shared as soon as these had been received.	
7.1.2	MHo explained that the CQC had visited Maternity and Surgery at GHFT in April 2023 and reports had now come back on 10th November. Surgery were not rated but noted as having made significant progress with two "must do" and "should do" actions. Maternity were re-rated as Inadequate and issued with a continuing Section 29A at notice regarding the two issues previously highlighted with a single "must do" action and four "should do" actions.	
7.1.3	The CQC had been invited to come back in November 2023 to present them with the action plan and results and significant progress had been made against the open incidents. At that time there were 17 open incidents from a peak of above 200. The safeguarding Level 3 trajectory will be up to 90% compliance from March 2024. The verbal feedback was encouraging but noting nothing more formal had been received from the CQC. MHo said the ICB, and this Committee would be kept fully informed regarding the situation.	
7.1.4	The 14% vacancy rate was improving but circumstances were still challenging for midwifery and obstetric colleagues, which had resulted in the on-going temporary closure of the Aveta Birth Unit in Cheltenham and post-natal beds in Stroud. The Maternity	

	Delivery Group had considered two Options Appraisal papers today which will work through GHFT's governance process to system colleagues in due course.	
7.1.5	The Key Issues and Performance (KIAR) Report had been included in the papers. The Health & Safety Executive had announced an inspection on 6th December, the first part being around violence and aggression and Musculoskeletal Disorders which was being followed up with some table-top exercises. There had been some outstanding actions associated with the Human Tissue Authority (HTA) inspection of the mortuary services, with the aim of closing these by the end of the month. Since the last report there had been no new Never Events, 12 new Serious Incidents, three of which were related to Healthcare Safety Investigation Branch (HSIB) investigations.	
7.1.6	Boarding of patients had increased due to operational pressures and a lot of work was being done around this policy with clear direction from the Board that this needed to be limited and finally stopped. MHo explained that most of this was due to ambulance handover delays and Cat 2 response times, but it would be much more difficult to board people in future and work continues around the improvement process.	
7.1.7	GHFT's smoking status in the Quality Performance Report was astounding due to Shima and her team who had been engaging clinical teams and inpatients who were smokers early on when patients were first admitted. The early smoking cessation work was very effective when started early and continued to be going very well.	
7.1.8	MAE felt that due to pressure on ambulance staff to achieve no handover delays, the boarding numbers and risk to patients would increase. There was real concern that this winter would see this practice continuing. MAE stated that she had seen that all systems in the South West were reporting black this week and there was a huge worry especially around industrial action coming up and the week following Christmas which could well see significant problems in hospitals.	
7.1.9	MHo said that there were over 150 patients in the Emergency Department (ED) at the weekend with 18 ambulances waiting. MHo would like to see swift recovery from this position, but it was definitely very challenging at the moment. There had been some unfortunate instances, due to a rising number of patients, where MHo had been forced into a situation where some abhorrent decisions around reverse boarding of patients had needed to be made, which had been an extremely difficult, unpleasant and upsetting situation.	
7.1.10	JZS mentioned pressure ulcer numbers which MHo said had not dropped, with some of these definitely due to the boarding of patients. With workloads increasing, there would be less nursing time to go round, inevitably leading to harm. HW said data in GHC was revealing that pressure ulcers were a system issue when patients were on trolleys for significant periods of time or did not have access to a pressure relieving mattress, thus resulting in harm. JCu said this was a national issue and asked whether there was anything this Committee could do or support.	
7.1.11	SS said there were huge pressures everywhere and the Working as One Programme together with Newton Europe would help with delivering better care to our population and objectives were being examined where tangible differences could be made around quality, capacity and safety in services. SS thought having some formal feedback from a quality perspective into the Working as One Programme would be useful, so that all the implications of the quality agenda could be taken into consideration.	
7.1.12	MHo said finance and focus had been invested in Newton and he was behind the work, but his concerns were around the ambulances. He was just concerned that delivery would be too late for this winter, although the work was always going to take time. JCu said there would be huge pressure on Government to do something rapidly and to deliver	

	real and sustainable results. JCu said she would feed all this back at her next Board meeting.	
7.1.13	JCu asked MHo to feed back that this Committee concurred with his concerns and did not approve or support boarding, recognising the impact that this was having on staff and the risks to patients, whilst realising that MHo had been forced, by recent unprecedented circumstances, to make some really difficult decisions. The Committee were fully supportive of the work that MHo was trying to manage, particularly the ongoing work with the Working as One Programme and JCu said the Committee were here should he need to draw on them for any further assistance. MHo extended thanks to the Chair and the Committee for their kind support.	
	Resolution: The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).	
7.2	Gloucestershire Health and Care Trust (GHC) Quality Report	
7.2.1	HW started by saying that embedded learning events was becoming business as usual and this was having a positive impact of these on staff. Band 5 recruitment was on track to reach 100% by the end of November – numbers had yet to be confirmed but HW was confident that this would be achieved.	
7.2.2	Charlton Lane were continuing to work on falls reduction and the team were looking forward to showcase their work at some stage. The work is translating into community hospitals and the Falls Improvement Group are beginning to see a shift in the data there.	
7.2.3	It had taken some time to agree funding for inpatient mental health, but it had come through and job descriptions had been written and GHC would be launching their own tobacco management programme in line with NHSE requirements in this area, led by nurse Angela Willan.	
7.2.4	HW said that GHC had a good line of sight on pressure ulcers and she was confident that when a pressure ulcer was recognised, it was managed entirely appropriately. If a person developed a pressure ulcer between 4 and 6 weeks of their death, then this was an indicator of last weeks of life and colleagues had begun to notice this elsewhere. MAE said that this might be helpful from a research perspective and she would be happy to talk about this with HW after the meeting.	
7.2.5	Understanding, awareness and reporting of a closed culture had improved although there was still some more work to be done and a close eye was being kept on this.	
7.2.6	The overall CQC Action Plan following the core inspection now stood at 98% and was on track to be complete at the end of January 2024. Significant improvements had been made around rapid tranquilisation observation at 96% but there are still 4% of patients who have no documentation and this is an important area that colleagues continue to focus on.	
7.2.7	JCu said that she had recently visited Charlton Lane and had been so impressed with the End of Life and Palliative Care teams and she had found this very humbling and wished to extend thanks to the teams for this. AH said she had been impressed with the amount of work having been done at Charlton Lane on falls reduction and had circulated their presentation in order to promote this work and felt that an update at this Committee would be a good idea. HW said she was very proud of their achievements particularly as a	

	mental health nurse had led on this where traditionally mental health nurses did not have much exposure to falls prevention.	
	Resolution: The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Health and Care NHS Foundation Trust (GHCNHSFT).	
7.3	ICB Quality Report	
7.3.1	JZS drew the Committee's attention to the Migrant Health part of the Report which had moved on considerably since it had been written. There was work going on in Beachley Barracks in Monmouthshire in that the ICB had been advised that another 89 Afghan nationals and their families would be arriving over the weekend of 16th December. The Ministry of Defence (MOD) had four sites which had been set up in the UK for nationals and their families which was a two year contract for residents. The impact on Primary Care would be quite profound and it was very noticeable at practice level, in terms of complex needs, that this would sit within family medicine and would also have an impact on provider colleagues.	
7.3.2	To support the people who needed to be registered, the ICB had been working closely with Monmouthshire colleagues with the closest GP practice to the Beachley Barracks being Lydney which would not have capacity to take on that number of new residents. Monmouth also does not have capacity but this would be a joint effort. The provision for additional accommodation was being reviewed in Wales and Scotland so this was an evolving model. The health needs of local residents and those of the Afghan nationals needed to be considered as there were some complex disorders and the medicines required were very different from those seen in the contingency hotels.	
7.3.3	It was important to note that the health provision was at the ICB's discretion and it was not for the MOD to dictate procedures. The offer would need to be managed from an NHS perspective and the high risk issues examined. Throughput would be swift and movements such as this would make it difficult for those trying to manage the situation. Senior MOD personnel had commended the ICB for their work but had offered no further support. Resources such as Health Visitors, School Nurses, management of chronic conditions and mental health issues would need to be considered.	
7.3.4	JM asked whether people who had been dreadfully traumatised were being offered mental health support as she was not aware of anything. JZS said that this was offered for those living in the contingency hotels and there were links for people, but mental health services were already very overwhelmed with demand. There were many children with complex needs on this site and was something that had been flagged. JZS informed the Committee that the team were doing the best they could to understand the needs of the people. Many people would need to have much longer conversations with health professionals in order for their complex health needs to be investigated and treated.	
7.3.6	AH said that the Gloucestershire Action for Refugees and Asylum Seekers (GARAS) grant funding had allowed the number of psychotherapists to be increased, and there would also be support from GHC's mental health teams and talking therapy services. However, it would be more difficult to offer continuous or follow-up treatment due to the swift turnaround of the residents. JCu commented on the many difficulties and risks that this situation was causing and JZS said this had been recognised and fed back to MOD officials.	

7.3.7	MAE said that it had been agreed that the review of leg ulcer services was a priority area for the ICB and commitment had been given to the provision of project management resource for 2023/2024 to support this work.	
7.3.8	The Vaccine Strategy had been published and involved the delegation of the responsibility for the commissioning vaccines to the ICB from April 2025. Currently vaccines were commissioned by a variety of different people and this approach will simplify matters.	
7.3.9	The ICB had been selected as a demonstrator site for the Measles, Mumps, and Rubella (MMR) vaccinations, the uptake of which had been very low in some parts of the county; however, some new approaches are to be conducted in order to encourage better uptake.	
7.3.10	Gloucestershire achieved 71% of vaccination uptake rate which was phenomenal. The South West had 63% and nationally, it was 52%. This was all credit to the system partner teams of GHFT and GHC and other partner providers across the county. There were still three areas in Gloucester City where the uptake rate was worrying and work continues in those areas with GHC's pop-up clinics visiting different areas to encourage people to have their vaccines. People living with a learning disability were being 'phoned about vaccinations and 154 people had been contacted in the last two weeks and this personal touch had elicited a really good response and had made a difference.	
	Resolution: The Committee members noted the verbal update on the Integrated Care Board Quality Report (ICB).	
7.4	Adult Social Care Quality Report	
7.4.1	EW updated on Adult Social Care and started by drawing the Committee's attention to issues with the overseas governance process and people who were often unscrupulously operating from abroad to bring workers over from international countries, purporting to get them work in care agencies and thus leaving them open to possible abuse once they had arrived in this country. The CQC did not regulate those brokers and Adult Social Care did not have a statutory role here either. The provider market needed to enact due diligence around their recruitment processes.	
7.4.2	Registered managers and longevity remains an issue in bed based care and seemed to be a theme coming from stakeholders.	
7.4.3	Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) compliance meant that the Complete Health Improvement Programme (CHIP) team were working closely with the IPC team in the hospitals around discharges where there had been more of a risk than usually seen at this time of year.	
7.4.4	Nursing beds of choice – some nursing homes had been de-registering and there had been some complexity around dementia care in the bed base.	
7.4.5	EW spoke about collaborating with providers outside the county in that some people needed care and support outside the county but mostly Adult Social Care imported more people than were sent out for care. Some providers had quality concerns but Gloucestershire still had a responsibility to those still outside the county.	
7.4.6	SS referred to international recruitment and revocation of licences and said this was currently a hot topic for her as she was involved in this. There was an issue around how	

	revocation of licences were impacting care providers with most doing this well, legally and compassionately. SS was concerned about the weakening of the health and care system and asked JCu if she could perhaps give some information around licences and how they were being issued. SS felt that the minority were affecting the majority of the providers that were doing things properly. JCu said she would be happy to action this. **Action: JCu to raise concerns to senior colleagues in Department of Health and Social Care (DHSC) on the process of the issuing and revocation of licences in health and care providers from international countries.**	**JCu**
7.4.7	An Improvement Plan is to be developed by the County Council which will be shared in a special January 2024 update along with the Peer Challenge Report which will address issues raised by the Local Government Association (LGA) as well as those identified in the Council's self-assessment.	
7.4.8	A Data and Intelligence Strategy and a Quality Strategy were being developed and both are currently in draft and due to be signed off next week. Much of the work will ultimately allow a much more co-ordinated system way of working. Enhanced Health in Care Homes work also continues.	
7.4.9	There were concerns around some care providers looking after people with learning disabilities and a lot of that work was being overseen by the Safeguarding Adults Board but as there was a correlation between safeguarding and quality, visibility was desirable to this Committee in terms of some of the things being seen.	
7.4.10	JCu said she had been surprised by this and JM said she was concerned about the number of places that were supposed to be supporting people with learning disabilities who must be affected badly. Some of the supported living places did not in fact offer more choice and control and would probably have received more care in a residential home. JM wondered if there was a strategy to try to improve the way that care and support was being delivered to those with learning disabilities.	
7.4.11	EW said that the response and support to care providers looking after those with a learning disability and were working age adults, was really good and the gap was in the older people's services as there was not the same oversight and response. Work was being done here and BL had plans in place to strengthen this. EW and BL were working closely on this design and colleagues here had been involved in conversations regarding support to the provider market and what that model should look like. The support for people with a learning disability was really strong.	
	Resolution: ***The Committee members noted the verbal update on the Adult Social Care Quality Report (ASC).***	
7.5	Children's Social Care Report	
7.5.1	VC said she would be happy to take suggestions on what the Committee would like to see in future which would be of benefit to the meeting and JCu said issues that affected the quality of care for children and young people would be of interest to the Committee, such as: Children's Mental Health and Children in placements out of county. **Action: VC to liaise with EW and TP for quality information on Children's Social Care to be brought to the February 2024 meeting.**	**VC/EW TP**

	Resolution: ***The Committee members noted the verbal update on the Children's Social Care Report.***	
7.6	System Quality Group Report	
7.6.1	MAE informed the Committee on the recent System Quality Group meeting: • Berkeley House was discussed. • Mortality and Patient Safety in the Mortality Group with GHFT data being examined. • Patient Safety and Mortality analysis had shown that there was no correlation for those awaiting treatment in this area. • Actions around winter planning and response had been received and examined with leads on various areas identified ensuring quality and safety around the winter plan. • An Audiologist attended and spoke about their view on Paediatric Audiology. • A maternity update and action plans were discussed with feedback from the Local Maternity and Neonatal System (LMNS). MAE said that this report would be sent to, and discussed, at the Regional System Quality Group meeting. MAE explained that if information were brought to this meeting from the System Quality Group straight after their meeting had taken place, it would update this Committee in a much timelier way, but their minutes would of course be shared on approval.	
	Resolution: The Committee members noted the verbal update on the System Quality Group Report.	
7.7.	Countess of Chester Case update – MAE said there had been nothing new of note on this.	
8.	**Commissioning for Quality and Innovation (CQUIN) Report Update**	
8.1	TP drew the Committee's attention to the fact that the attendance of the System Clinical Effectiveness Group had been examined and now that this was going to be under the jurisdiction of the CMO, this would encourage wider attendance which TP had discussed recently with AS and MAE. It was planned to have deep dives into CPGs around NICE compliance. It was hoped that once this had been done, a better report would come to this Committee demonstrating clarity around discussions and up to date scenarios.	
8.2	Gloucestershire took the approach that CQUINs were an improvement programme and not something that providers would be penalised for if they did not achieve some of the CQUINs. Some of these were somewhat weighty and input into some of the systems proved difficult for clinicians, especially during the recent industrial action.	
	Resolution*: *The Committee members noted the verbal update on the CQUIN Report.	
9.	**Audit of Pathway 2 (P2) Beds**	
9.1	AJ presented on this subject and said she had been asked to do a piece of work following a report which was examining case studies in the Discharge to Assess (D2A) beds which were now called Pathway 2 beds which were there to support patients on a short term basis following discharge from hospital. Harm had been identified in the model being used	

	at the time, with consistent issues around patients being in the wrong pathway resulting in 50% more people being sent into bedded units than the national average, half of which could have been sent home. There were also inconsistencies around information in paperwork, with limited access to permissions and community reablement support once a patient was out into a bed, meaning that people stayed in those beds for a longer period of time. Outcomes were poor as many patients then went on to need long term care.	
9.2	At the time of examining this work, there were 170 Pathway 2 beds commissioned by Adult Social Care This did not include any community hospital beds. Average length of stay was 89 days but the longest length of stay at that point was 446 days although short term assessment and reablement beds should have been around 28 days. Main themes for move-on were awaiting assessment, therapy and long term care. Issues arose due to too many beds, and beds being opened which did not have the amount of staff to support people in those units. There was also a practice at the time of purchasing spot beds, which did not have the wrap-around support needed.	
9.3	JM asked whether the model involved purchasing care home beds for use and whether long term care had been used in the rehabilitation and reablement beds. AJ explained that additional beds in care homes had been purchased alongside some block contracted beds, there to support rehabilitation and reablement. There had been provision for long term care from some providers, but others had been commissioned to provide just short term support, thus the model had been mixed at the time.	
9.4	Actions had been taken to end the use of spot purchase beds unless there were exceptional circumstances and all requests had to go through Directors in order to determine whether they were appropriate. Since then, hardly any requests had been made and together with this, a de-commissioning plan had resulted in fewer beds which were more appropriate to meet the needs of people who required short term rehabilitation. More people were also returning home rather than going into those beds, with a real focus action on the Home First area.	
9.5	The total number of beds had now been reduced to 82 (from 170 not including the community hospitals) and all the block contracted beds had a therapy offer and to fulfil that, private rehabilitation therapy had been purchased which would work alongside the social work team to support improved outcomes. The offer was now a lot clearer and some consistency issues were also improving, along with a tracker to monitor the use of beds, (still in development) so that a single version could be shared with ICB colleagues.	
9.6	This work had been incorporated into the Intermediate Care Reablement workstream under the Working as One Programme and trials had been started with the aim of further reduction of the length of stay on Pathway 2 beds. The MDT model was being redesigned, along with the way handover and discharge planning was done and the setting of Smart goals. Early indications were that some gains could be seen in that area. The average length of stay was now around 56 days and work was being done to validate those numbers.	
9.7	SM informed the Committee that her colleague Srikesavan (Sri) Sabapathy was to be the lead therapist for rehabilitation and had been involved in conversations regarding this. AJ said Sri had been really helpful so far and continued to be involved in the development of this service. SM asked whether it was the intention to continue with private provision or whether discussions could be widened around the intermediate care workstream and how some of those potential models might look like. AJ said appropriate work had been included in the workstream which would explore how the ultimate model would be presented.	

9.8	SS reflected that the team had done very well in reducing the number of beds and harm had been done to people in the past due to the model in place at the time. SS said that people needed to hold their nerves with the work around Newton because the culture needed to be changed in the system which she felt was really important. JCu also felt that lessons had been learnt about the impact of some of the funding that had previously been issued for short term beds, with this approach being best in order to bring about outcomes of the highest quality for our population. AJ was thanked for her helpful and informative presentation.	
	Resolution: The Committee noted the verbal update on the pathway audit of the P2 beds.	
10.	**Patient Safety Incident Response Framework (PSIRF) Update**	
10.1	RM was pleased to update the Committee that the two biggest providers to the ICB, GHFT and GHC were next month finalising their plans and policies around PSIRF and would be submitting them to their respective Boards in January 2024 and then on to the ICB in February 2024. RM had assisted with the shaping of their plans.	
10.2	RM had been pleased to see the direction of travel around culture and how the Trusts were focusing on key elements of safety. New ways of working were being demonstrated such as the hub approach and once provider Boards had signed off those plans, they would be presented to this Committee along with the ICB plan for ratification, as would other plans for smaller providers. PSIRF would then be enabled as from 1st March 2024 and then the hard work would begin, with a great deal to work through. At the time of the switch over, the ICB would cease to take responsibility for signing off incidents, as Trusts would move to self-determination and hold sovereign accountability for themselves, just as the ICB did when moving from the CCG with NHSE stepping away in places. The ICB would continue to be a supportive and critical friend and start to work on system-level investigations. The next meeting in February would see more paperwork around ratifications.	
10.3	JCu said this would be helpful to see and good to have implemented. JCu asked about timescales and expectations, referring to 1st March 2024. RM said that everybody was going to commence switch over at slightly different times and the ICB were one of the later organisations but region had been kept up to date on Datix issues so knew what was going on here. **Action: RM to bring papers for ratification on PSIRF to the February 2024 Committee meeting.**	**RM**
	Resolution*: The Committee noted the verbal update on PSIRF.*	
11.	**Implementation Plan for System Experience Group**	
11.1	BP updated in the chat that the intention was to align the Terms of Reference (ToR) for the System Experience Group with the System Safety and System Effectiveness Groups. BP was keen to have a Lay Chair for the System Experience Group and to hold six meetings a year, with focussed discussions on scheduled Insight priorities, for example in July 2024, Primary Care experience post publication of the national GP Survey (including questions on Dentistry and Pharmacy). Regarding Staff Experience, which was covered at a recent People Committee meeting, BP recommended one shared meeting per annum to discuss Insight from both groups.	

	Resolution*: The Committee noted the verbal update on the Implementation Plan for the System Experience Group.*	
12.	**People Panel Update**	
12.1	BP gave an update today in that the Patient Engagement team had already received 238 completed surveys; over a 20% response in a week which had been hugely successful. JCu was pleased about this and said it was also good to have seen movement on the Patient Experience Group.	
	Resolution*: The Committee noted the verbal update on the People Panel.*	
13.	**Policies for Approval**	
13.1	Non-Emergency Patient Transport	
13.1.1	Minor changes had been made to the policy to improve clarity and reference new patient choice options.	
	Resolution: ***The Committee approved the Non-Emergency Patient Transport policy following review and update.***	
13.2	Digital Clinical Safety Policy	
13.2.1	There had been clarification of the Board role added to this policy, allowing a review and update to be undertaken.	
	Resolution: ***The Committee approved the Digital Clinical Safety policy following review and update.***	
13.3	Multi-Agency Mental Capacity Act Policy	
13.3.1	There had been revisions made to assessment of capacity and introduction of the new Mental Capacity Act assessment and Best Interest form.	
	Resolution: ***The Committee approved the Multi-Agency Mental Capacity Act policy following review and update.***	
13.4	Personal Health Budgets Policy	
13.4.1	Flowchart and process guidance notes had been co-developed to support the Personal Health Budgets Policy which had been circulated prior to the meeting.	
	Resolution: ***The Committee approved the Personal Health Budgets policy following review and update.***	
14.	**Meeting Review, Items for Escalation to the Risk Register and Any Other Business**	
14.1	JZS said it was probably worth reiterating the number of migrants being seen at Beachley Barracks in Monmouthshire and in terms of what that means for Primary Care colleagues.	**JZS/JCu**

	Action: JZS to do a brief paper for the next Board Development session and JCu will request migrants be placed on the Agenda for that session.	
14.2	Annual Committee Survey Review	
14.2.1	CGi will be sending Committee members some questions and reflections on how well the System Quality Committee was working. JCu reflected that the Committee was not where it was desired to be at the start, and through workshops had taken place and changes made, honest feedback would be appreciated. JCu felt personally that the workshops had been a valuable medium through which to take learning and ideas forward.	
14.2.2	JSo felt sections could be added in around insight and value. It would also be helpful for Committee members to have opportunities to develop and also whether anything could be done for the Committee collectively as well as individually. CGi said this questionnaire would go out electronically and would be anonymous. There would be comment boxes at the end of each question and there was a Committee Plan for the year ahead which would be sent to the Chair. Suggestions for different topic discussions could enable the Plan to start to be programmed. **Action: CGi to bring the Annual Committee Survey Review Plan and the survey results to the February 2024 Committee meeting.**	**CGi**
	The meeting concluded at 4.25pm.	

Time and date of the next meeting:
Thurs 15th February 2024 – 2.00-5.00pm
Shire Hall, Westgate Street, Gloucester GL1 2TG

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 26th October 2023, 14.00 – 16.00pm

Canton Room & virtually at Shire Hall, Westgate Street, Gloucester, GL1 2TG

Members Present:		
Prof Jane Cummings (chair)	JC	Non-Executive Director, Committee Chair
Amanda Jones	AJ	Director of Operations for Adult Social Care, GCC (Deputising for Sarah Scott)
Dr Andrew Seymour	AS	Chief Medical Officer, ICB
Deborah Evans	DE	Chair, GHFT
Dr Marion Andrews-Evans	MAE	Chief Nursing Officer, ICB
Mary Hutton	MH	Chief Executive, ICB
Tracey Cox	TC	Director of People, Culture and Engagement, ICB
Participants Present:		
Christina Gradowski	CG	Associate Director of Corporate Affairs, ICB
Claire Radley	CR	Director of People & OD, GHFT
Jossette Jones	JJ	Retention Lead, ICS
Neil Savage	NS	Director of HR & OD, GHC
Sophie Elizabeth-Atkins	SEA	People Programme Manager, ICS
In attendance:		
Karen Clements	KC	NED, ICB
Nikita Davis	ND	HR and Governance Project Officer, ICB
Ryan Brunsdon	RB	Board Secretary, ICB
Amabel Mortimer *(Agenda Item 11)*	AM	Strategic Lead/ Programme Director - Arts, Health & Wellbeing, University of Gloucestershire
Nick Oxlade *(Agenda Item 11)*	NO	Strategic Lead Partnerships & Projects, University of Gloucestershire

1 Introduction & Welcome

1.1 JC welcomed the attendees and invited KC to introduce herself.

1.2 KC explained that she is going through the onboarding process to become a Non-Executive Director (NED) for the Integrated Care Board (ICB) and will take over responsibility for chairing the People Committee. KC outlined in her current role she is head of a couple of divisions within an international, commercial property firm, but the majority of her career has been spent leading organisational transformation and understanding how to deliver change through people. KC added that she has a particular passion for diversity and inclusion, is leading this group within her current organisation, and authored their strategy of the same name.

2 Apologies for Absence

2.1 Apologies were received from Sarah Scott.

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 20th July 2023 were approved as an accurate record of the meeting.

4.2 TC provided an update on item 10 from the previous meeting (strengthening our approach to careers & engagement) and stated that approval for funding had been granted by the Joint Commissioning Partnership Executive (JCPE) to expand the service offer as previously discussed.

4.3 NS advised that provider Trusts had received notification of a ballot from the British Medical Association (BMA) which will be sent to BMA members on Monday 6th November, and so further planning and work around business continuity will be required.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **12.01.2023, Item 6.11 –** Exit data. This action was requesting closure. TC and JJ gave an update on this during the meeting. **Action closed.**

5.1.2 **27.04.2023, Item 7.1 –** Workforce Intelligence and Programme Highlight. This action was requesting closure. ICS Workforce Plans on a Page circulated to People Boards. **Action closed.**

5.1.3 **27.04.2023, Item 11.2 –** Menopause Policy. This action was requesting closure. Policy has been amended to include effects of menopause on men's health. **Action closed.**

5.1.4 **27.04.2023, Item 9.6 –** Draft People Strategy Report. This action was requesting closure. Strategy signed off by Board on 27th September 2023. **Action closed.**

6 Integrated Care System (ICS) People Function Summary Report

6.1 TC gave an overview of the people function summary report, highlighting that at the time of writing the next stage of the industrial action had not been announced. There have been 60 days of action to date in 2023, which had been difficult and will continue to impact on temporary staffing spend, productivity, and achievement of wider performance requirements and expectations.

6.2 TC summarised the national and local workforce position relating to vacancy numbers and whilst there has been an overall reduction since June 2022, the number of vacancies between March and June 2023 have increased both nationally and regionally.

6.3 TC recognised progress that had been made by the Integrated Care Board (ICB) in signing the Armed Forces Covenant (AFC) and the support from colleagues in other local organisations, particularly GHC, in helping the ICB taking the commitments forwards. The ICB intends on progressing towards becoming a silver and subsequently gold-award recognised employer over the next couple of years.

6.4 AS advised that the Royal College of General Practitioners (RCGP) run a veteran accreditation programme for practices to sign up to and are aiming for at least 40% of

practices nationally to be signed up. In Gloucestershire there are now only two Primary Care Networks (PCN) that are not signed up which is a large increase from only having 30% signed up a year ago.

6.5 TC reported the ICB had been awarded £40,000 from NHS England (NHSE) for a new initiative to target individuals who have been in care and supporting them into employment either in the NHS or into social care. TC added that the proposal aligns with work and initiatives already being undertaken locally by Vikki Walter's team.

6.6 TC shared a social care sector workforce infographic highlighting positive data relating to a decrease in vacancies and a significant increase in international recruitment to the social care sector. TC also advised that Skills for Care would be producing a workforce plan for social care and JJ indicated the timescale for completing this was by summer 2024. TC summarised that it is important to ensure parity between health and social care and reporting as much data as possible from the social care perspective.

6.7 TC offered to share the infographic with the Committee and explained that it is an interactive document so further detail can be seen by clicking on certain parts. **TC**

6.8 JC commented that she would be chairing the RCN (Royal College of Nursing) RCN Foundation Annual Lecture which this year is based on social care and would feed back any relevant information to the Committee.

RESOLUTION: The People Committee noted the content of the ICS People Function – Summary Report.

7 Workforce Intelligence & Programme Highlight Report

7.1 SEA reflected that agency expenditure continues to be challenging as the forecasted agency spend for 2023/24 (£32.177m) is higher than the NHSE cap (£25.609m) but recognised that both Gloucestershire Hospitals NHS Foundation Trust (GHFT) and Gloucestershire Health & Care NHS Foundation Trust (GHC) have comprehensive action plans in place and there has been a slight decrease in use of agency staff and increase in use of bank staff. SEA reported that since July 2023 GHFT have made agency booked shifts visible to bank staff so there has been an increase in bank staff taking up these shifts. CR reported that between July and September 718 shifts had been converted from agency to bank.

7.2 SEA reported that in relation to E rostering systems, providers have linked in with the Procurement team and are working at a system level to maintain and work together on potential joint approaches when contracts come to an end.

7.3 Other methods for increasing bank and reducing agency spend are being explored with NHS Professionals and also Allocate's cloud tool. Conflicting advice and outstanding queries are being examined with other systems who currently have them in place, such as whether, with NHS Professionals, staff would be classed as bank or agency spend.

7.4 SEA conveyed information from the Southwest Regional team who advised that Gloucestershire are plateauing with regards to agency use, but a decrease is needed to offset the increased usage at the beginning of the year.

7.5 SEA highlighted the new metrics dashboard view and advised that they are working towards making it interactive. Current vacancy rates are as follows:

- 13.6% across the ICS.
- 8.2% across the Trusts.
- 19.1% across social care.

7.6 Regarding the Systems Thinking Masterclass SEA reported there were 96 applicants for cohort three, which had 24 places, so cohort four will be run at the same time; funding has also been established for a fifth cohort in the new year. SEA added that there is a lot of interest in the programme so within the Organisational Development (OD) Steering Group there are ongoing discussions about where the training could go in the future and the possibility of "train the trainer" options to be able to provide the training in-house, thus eliminating the expenditure to an external provider.

7.7 Cohort two of the Inclusion Allies Programme had recently concluded with no further cohorts planned; SEA stated that feedback had been good. The Reciprocal Mentoring Programme is part-way through with the first cohort and they are looking at running a second cohort in the new year.

7.8 NS remarked that, whilst not part of the system development programmes for this year, the feedback from the Flourish Leadership and Development Programme had generated high Net Promoter scores, for example 50 from the ethnicity cohort and 57 from the disability cohort and proposed that further work be undertaken in order to see the longer-term viability of the programme and return on investment.

7.9 CR agreed that the programme was well received and that, in general, there needs to be more follow-up with attendees to get a complete picture of the programme's success and application, not just during the training but after. CR added that this wrap-around approach had been considered and built into the OD Steering Group plan on a page.

7.10 SEA advised that a long-term evaluation process had just been undertaken with the Flourish cohort and the results presented to the OD Steering Group. The next step is to decide how it fits with other ongoing Equality, Diversity, and Inclusivity (EDI) initiatives such as Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the five high impact actions.

7.11 JC reflected that, particularly within the EDI agenda, people complete many development programmes and courses, sometimes even degrees, but still struggle to get ahead or see real-life change from taking part so showing the impact is important.

7.12 TC relayed that 42% of the Flourish Programme participants either agreed or strongly agreed that it had helped them advance their career.

7.13 CR suggested the focus be on two or three things programmes that are done really well and doing them deeply because that is where value is going to come from. CR added that whilst 42% is a great starting point, the focus should be on seeing it through rather than loading more actions in.

7.14 SEA provided some additional positive feedback from the Flourish evaluation:

- 76.2% of participants agreed or strongly agreed that the programme helped them to take on new challenges and responsibilities.
- 66.6% of participants agreed or strongly agreed that the programme helped them make a positive impact in the organisation.
- Slightly less at 42.9% and scored mostly agree, not strongly, was the score relating to individuals having meaningful career conversations with their line manager, so there is work to do on this aspect. SEA explained that a manager's

course had been run parallel to the Flourish course which had been less well received and attended so the lower result was expected.

7.15 KC queried whether specific population groups could be looked at with line managers in relation to progression, for example whether people nominated to go on training courses are representative of the cohort that they come from or how many people nominated for promotion are representative of the layer below. TC responded that they are able to see distribution of staff by ethnicity, grade, sexuality etc., if it is declared, across pay bands, and through some of the WRES standards can track progression over time but acknowledged that there is a consistent under-representation at senior level. TC explained that WRES has been ongoing since 2015 so trends can be seen in the data since then.

7.16 KC sought clarification on whether the data is visible to line managers who are then challenged on and held accountable for it, or if the data is just monitored by HR and OD functions. TC clarified that, for the ICB, they can scale the information down to directorates.

7.17 CR advised for GHFT whilst there is a wealth of data available, almost too much, it is not being utilised to its' full potential, and added that the agenda is not being owned across the organisation, nor is there enough divisional ownership of the data. CR stated that they are working towards this and concluded that some divisions are now starting to access the data.

7.18 SEA highlighted the following funding updates:

- £145,000.00 in funding has been received for support of Allied Health Professionals (AHPs).
- The Advancing Practice Lead funding has been extended for a year.
- Workforce Development funding has been approved in principle by NHSE and projects are starting to be delivered.

7.19 JC queried what areas were being looked at in relation to the workforce development funding. SEA reported that there was a lot of focus on Primary Care (PC) and upskilling in diabetes, health and well-being mindfulness support and the personalisation agenda. PC had separate funding of £40,000.00 so ran a conference on personalisation and were trying to promote nursing as a first career within PC. SEA added that there were also infrastructure costs included in the generic workforce development funding, which it has been confirmed will not be available next year from this funding stream.

7.20 TC gave an update on the Be in Gloucestershire campaign, which is initially focussing on GPs in Gloucestershire, and advised that the branding material is now being developed. TC added that the level of interest from GPs in supporting the narrative development and responding to baseline questionnaires had been phenomenal. The campaign will be launched after Christmas, but there will be a micro-site that is heavily branded with testimonials and videos to sell the virtues of being a GP in Gloucestershire, with the overarching materials being used to support other recruitment campaigns.

7.21 TC advised that there are ongoing discussions across health and social care about doing some targeted work in children's services as there are vacancy challenges with many roles. Along with Helen Ford they will be looking to develop a fast, follow-on to the campaign in relation to children services.

RESOLUTION: The People Committee noted the content of the Workforce Intelligence & Programme Highlight Report.

8 **Deep dive: Workforce Retention**

8.1 TC emphasised the importance of focus on retention over the next few years which is reinforced through the aspirations of the NHS workforce plan and sets out an expectation that over the span of the plan's lifetime the ICS will prevent 130,000 staff from leaving. TC advised that the ICS had been given funding for one year, until quarter one 2024/25, to conduct deep-dive diagnostics and analysis into retention challenges and to identify areas of focus. The ICS Retention Lead, JJ, was introduced and invited to provide an overview of the work being done in this area.

8.2 JJ presented the staff retention report and began by stating that the Gloucestershire ICS leaver rate, 7.8%, was slightly more favourable than the position in the Southwest, 8.2%. JJ explained that the peak in leaver numbers depicted around June 2022 had been attributed to staff not leaving during Covid but resigning after once the pandemic had started to settle, and also due to a number of fixed term contracts in different sectors coming to an end. JJ highlighted that work/ life balance was given by 25% of the workforce in Gloucestershire as their reason for leaving.

8.3 There are two areas in Gloucestershire where the ICS data sits in the fourth quartile nationally, which are midwifery and clinical support services. Gloucestershire is currently the worst performing ICS for retention of midwives with an 8.9% leaver rate, compared to 6.1% nationally. Support to clinical staff is at 10.8% with a national average of 11%, however when broken down into support categories, support to nursing and midwifery leaver rate is at 11% and support to trainees in healthcare sciences sits above at 12.1%.

8.4 JJ acknowledged input from NS that the re-banding of staff from two to three is expected to have a positive impact on retention as seen in other systems where this has been implemented. JJ relayed conversations with North Bristol Trust (NBT) and University Hospital Bristol (UHB) in which UHB reported a reduction in leavers in January when staff had to be employed to qualify for their back pay but following this the number of leavers had risen to the same levels as before. NBT reported a reduction also but attributed this to UHB having more band two's moving up to band three than they did, so whilst Bristol ICS initially saw a reduction it hasn't been sustained.

8.5 CR advised that around seven years ago, GHFT had a very high sickness absence rate amongst healthcare assistants, so the decision was made to remove sick pay, so there are a range of different contracts amongst this staff group. This is being resolved at the same time as the work upgrading band two staff and is why it has taken the organisation longer to sort but may have a positive impact in terms of leaver data.

8.6 AHPs were featuring in the fourth quartile nationally but a recent decrease in leavers to 6.6% now places this data in the second quartile, with the national average being 6.8%. There has also been a decrease in the number of leavers in administrator and nursing positions. In PC JJ noted an increase in leavers in all staff groups apart from GPs which had a slight decrease.

8.7 The national turnover figure in Adult Social Care (ASC) is 28% and ranges from 18.8% to 40%; the turnover rate in Gloucestershire is 32%. JJ added that ASC use turnover rates as opposed to leavers rates so there isn't a direct comparison. GCC reported a peak in turnover earlier in the year, which is now decreasing, but the number of leavers within first12-months is on the rise again. ASC have identified five factors which packaged as a bundle they believe are key to retaining staff. JJ emphasised that retention

is not just about pay, that there is more around the health and well-being of staff that needs to be considered, so ASC have identified the following five points, that Gloucestershire is currently performing around average in compared to national data:

- Being paid more than the national minimum wage
- Not being on a zero-hour contracts
- Being able to work full time
- Access to training
- Having a relevant qualification

8.8 JJ followed that the first high impact actions identified by the NHS, completion of nursing and midwifery self-assessment tool, was being replaced with flexible working. The additional actions are:

- Legacy mentors
- National Preceptorship Framework – all Gloucestershire organisations now have the gold quality mark.
- Pensions
- Menopause

8.9 Other retention actions that are being looked at within Gloucestershire ICS are:

- Rotational posts, particularly for nurses but perhaps extended to AHPs. Royal United Hospitals (RUH) in Bath and Derbyshire have good programmes established so both are being looked at to see if it could be extended across Gloucestershire.
- Professional advocacy. JJ stated that there is a challenge finding funded places to put staff on as regionally there are not enough places to send people take the course.
- International recruitment. JJ highlighted an app that is aimed at supporting internationally recruited staff which social care are very interested in and JJ is looking at from an NHS perspective.
- Be in Gloucestershire campaign.
- Core induction programme for health and well-being.
- Staff accommodation
- Widening participation

8.10 JJ posed the question of what could be done as a system rather than as individual organisations and outlined some examples such as legacy mentors, flexible working, pensions, and menopause.

8.11 NS commented that there should be importance placed on working with staff to identify and have conversations with those who may be thinking about leaving before they actually do. Earlier this year GHC hired Cheryl Haswell, previously a senior Infection Prevention Control Nurse at GHFT and also senior matron, on a retire and return basis to lead on a retention programme for nursing and who has been running “itchy feet” clinics. NS reported that these have given GHC greater opportunity to steer people and work on ironing out identified problem areas. NS summarised that they have had an initial evaluation and are looking to roll the clinics out to other professions.

8.12 JJ concurred and explained that this will form part of the remit of the legacy mentors and that these conversations have been ongoing in the medical division at GHFT for the last couple of years. JJ explained that the difference between the model in the medical division and model for legacy mentors is that the latter look to support staff in their first couple of years post qualification, whereas the medical division support mentors also support new band sevens who don’t have experience so have a broader remit. JJ added

that they are looking at how to evaluate the legacy mentor service as it is important this is done properly.

8.13 CG stated that she has run partial retirement and retire and return sessions with some Continuing Healthcare (CHC) nurses because they tend to be an older workforce nearing retirement, and there had been a lot of interest from them in staying on and working flexibly for perhaps two or three days. CG added that there had been a lot of queries around pensions which had been difficult to answer so more work and expertise is required on that part of the offer. JJ agreed that the confusion around pensions is reflected nationally, and clearer information is needed.

8.14 CR described the monthly starter/ leaver data for GHFT as interesting to review as turnover can be very quick, and that it had been reported as part of the staff survey last year that the experience of staff in their first three months is quite poor. A taskforce has now been set up to look at to addressing this issue. CR added that the turnover rate for admin and clerical staff is one of the most concerning and continuing to increase so they are now looking into this as well as part of their workforce sustainability programme.

8.15 CR reported that the staff experience improvement programme is one of GHFTs biggest pieces of work and that the proxy measure for success of the workstreams is retention of staff. The overarching workstreams are aimed at:

- Team and leadership development, and staff experience of working in teams.
- Addressing discrimination.
- Raising confidence in speaking up.

8.16 MAE discussed the experience of nurses who, following completion of the preceptorship programme remain at a band five so decide to leave to find band six posts elsewhere. There have been discussions amongst nurse directors about whether it could be cost effective to upgrade nurses to a band six after a certain period of time and experience gained, so staff are aware and not look to leave, similar to how midwives are uplifted to a band six immediately following completion of their preceptorship programme.

8.17 CR commented that the issue about whether professions are paid at the right band for the right work is common and the general consensus is that they are not, so would be interested to know whether any systems across the country have been able to calculate what the return on investment would be for such an exercise and how long it would take to show.

8.18 JC stated that the Royal College of Nursing (RCN) has a particular focus on why most other professions have an automatic progression post-qualification and why nurses don't, and offered to contact the Chief Nurse at the RCN to see if there is evidence of a positive impact on retention and savings if implemented.

8.19 AJ advised that ASC have a dedicated recruitment and retention team who are exploring consistent implementation of "stay interviews" to understand what will keep staff and what they are looking for and will be looking at the feedback from staff survey for more information on this. AJ highlighted employee voice groups, supervision, and PDR process as other mechanisms to identify ways of retaining staff but reflected that triangulating the information to come up with a plan is where they need to improve. ASC also have an OD programme that will be doing targeted team charter work in areas where retention is an issue and also bespoke work where needed should trends arise in teams that were unexpected.

8.20 AJ further added that ASC are focussing on apprenticeships and growing their own staff, particularly in the social work staff group as there are national challenges and shortages within this area. ASC have agreed to backfill people who participate in apprenticeships and will offer those who complete the course a post at a higher grade, even if it is a post that is at risk or doesn't yet exist because there is enough turnover to be able to do so, thus hopefully retaining staff.

8.21 JC outlined that she chairs a charity who commissioned the King's Fund and Michael West to do a piece of work that looked at the experiences of newly qualified nurses and midwives and are holding an event in November to feedback some of the experiences. Any members of the Committee who would like to attend can contact JC directly. JC also detailed a longitudinal study that is to be conducted by Northwest London Trust over three years on the experience of internationally recruited nurses and midwives, and finally will feedback to the Committee the results of an ethnographic study undertaken by Kings College London and University of Cardiff comparing England's staffing approach to Wales's.

8.22 TC emphasised the need to take evidence-based interventions and reiterated JJ's point that it will take a wide range of activities to make a difference in retaining staff.

RESOLUTION: The People Committee noted the content of the Workforce Retention report.

9 NHS Workforce Plan - Implications for the ICS

9.1 TC outlined that the long-term workforce plan had been issued at end of June 2023, but organisations are still waiting for clarity on the funding flows that are attached to it and what it might mean in practice. 200 actions have been associated with the delivery of the plan, which NHSE have organised into 22 priorities that have been outlined in the Committee report. TC questioned whether the order of priorities ascribed was appropriate given the current challenges around clinical workforce.

9.2 NHSE have identified priority areas that are important for the Southwest to work collaboratively on which includes undergraduate expansion, apprenticeships, medical reform, and retention. TC highlighted productivity as one of the areas that has historically been difficult to evidence when demonstrating how growth in staffing numbers translates to higher outputs, and suggested this could be displayed through use of new technology and innovations.

9.3 TC informed the Committee of four upcoming workshops that will cover two themes per session and explained that NHSE had first canvassed views to determine what organisations felt was the order of priority, with the first workshop focussing on supply and retention. TC speculated that the workshops could start initial conversations about sharing best practice and will give an update at the next meeting on the two that will have been run by then.

9.4 CR observed that the NHS Human Resources (HR) and OD Futures report very clearly identified the priority actions and then articulated what the national, regional, Health Education England (HEE), systems and then local HR teams needed to do and stated a similar approach to the long-term workforce plan would be useful and advocated doing this as a system if it doesn't come from the NHS.

9.5 JC agreed and queried if time would be better spent focussing locally on the agreed outputs of the approved One Gloucestershire People Strategy as it was already aligned with the national plan.

RESOLUTION: The People Committee noted the content of the NHS Workforce Plan - Implications for the ICS report.

10 <u>UoG Arts, Health, and Wellbeing Centre</u>

AM and NO joined the meeting.

10.1 JC welcomed AM and NO from University of Gloucestershire (UoG) to the meeting. TC outlined that at the end of 2021/22 the ICB allocated a grant to work in partnership with UoG to create a dedicated Arts, Health and Wellbeing Centre within the new city centre School of Health and Social Care. Building works are ongoing but in the background progress is being made on the vision and ambitions for the centre.

10.2 TC presented the update and outlined the vision for the centre, which was shared with the Committee prior to the meeting, and identified the initiatives and endeavours that could be undertaken through the facility could form part of the value proposition to staff in relation to retention and setting NHS Gloucestershire apart from other areas and institutions.

10.3 The core business of the centre would be to provide all professions with a space to:

- Conduct research and education.
- Test out new technologies, interventions, and therapeutic approaches.
- Complement the work provided by NHS and Social Care providers.

10.4 TC introduced the potential for creating additional opportunities around placement capacity through service innovation and intervention-based projects, acknowledging that this would not completely solve the difficulties around placement capacity but could contribute towards it. TC highlighted UoG's strong ambitions around growing its research capability and extending the level of research innovation across Gloucestershire through connecting students with academics and researchers.

10.5 TC presented a breakdown of how the funding has been allocated. Just under a third of the funding has been used to support building the facility, and the rest has been allocated to invest in kick-starting intervention-based projects and various continuing professional development (CPD) initiatives.

10.6 MAE explained that as part of the funding some money was set aside to support two PhD students to complete doctoral studies in order to raise the profile of research in Gloucestershire. The topics advertised are around the relationship of arts and creativity in relation to health and well-being, and then any project that relates to the priorities of the ICS, so workforce or digital transformation ideas are of particular interest. MAE reported 16 expressions of interest from a range of ICS teams, adding that there will be future opportunities for research with funding for around eight studies.

10.7 MAE further added that some of the CPD money has been used to commission UoG to deliver a research skills course starting in January 2024. There are 20 funded places with further money set aside for another 20 places if it becomes a popular programme.

10.8 TC advised that a task and finish group has been set up to explore a curriculum for CPD focussed on positive risk-taking to upskill staff in this area, particularly around the urgent and emergency care transformation space.

10.9 TC described the facilities that will be available for booking at the centre:

- Two treatment and four consultation rooms that can be used for research and testing new ways of working.
- There is space for an immersive suite where simulations can take place.
- A large group room where activities can take place.

10.10 When discussing the governance and current membership of the centre's steering group, TC queried whether the GHFT representation was appropriate and asked Committee members to feedback any reflections on membership to the steering group.

10.11 TC summarised the next steps for the group relating to releasing some of the funds to make an offer to the system to support intervention-based projects, what these might look like, and highlighted the need to identifying ongoing funding streams to secure sustainability for future projects and research.

10.12 AM commented that there had been lots of positivity around the centre, particularly from PhD's, and advised that there is a static page on the UoG website with some basic information about the centre that AM can share the link to.

10.13 MH queried how much scope there was for developing placement capacity, and debated whether there was potential to link in with GHFTs Med Tech Innovation Centre which will be next door. AM confirmed that they are working closely with Claire Richardson, who is working on the Health Innovation Lab project, and that there could be scope for students to be able to work with the lab as well.

10.14 Regarding placements NO stated that there could be opportunity for expanding placement capacity for some of the allied health programmes but highlighted that there isn't a lot of clarity on the facilities going into the centre or what it will be filled by, so we need to realistic about the potential for increasing placement capacity.

10.15 NS brought attention to a new partnership careers hub opened in partnership between City College Plymouth and University Hospitals Plymouth and suggested that it would be useful to see what the results are over the next year relating to the number of people who went on to gain employment as a direct result of engagement with the hub. AM thanked NS and confirmed this was on their radar.

10.16 CR stated the update was very helpful and suggested Anna Gleghorn as an appropriate deputy from GHFT for the steering group. CR continued that the ICS is currently looking at redesigning the operating model for staff health and wellbeing and posed the idea of using the centre as a professional space for this.

10.17 AM welcomed the suggestion, adding that there is a need for the centre to generate money and so the potential and scope for using the centre out of hours could be limitless. AM emphasised the importance of engaging and working with the community and staff groups to understand what they need and what is going to help them, so are very open to ideas like this.

10.18 TC thanked AM and NO for joining the meeting and recommended that a further update be given to the Committee in around six months.

AM left the meeting.

10.19 TC invited NO to give a brief update on the School of Health and Social Care. NO provided an update as follows:

- Across all programmes UoG have converted nearly 100% of all offers made into actual enrolments which is the highest conversion rate for a number of years.
- Nationally nursing numbers are down, and for the first time in a few years UoG are reopening applications for paramedic science due to not meeting the target figure.
- A number of students have opted not go to university this year because of the cost-of-living challenges.
- The National Education Training Survey (NETS) is out so UoG are emphasising its' importance to students and will share any relevant data.
- A new Head of School, Rakhee Aggarwal, has been appointed and will be starting next week. UoG have also appointed a new Head of Quality who is starting in January 2024.

NO left the meeting.

RESOLUTION: The People Committee noted the content of the Arts, Health and Wellbeing Centre update and agreed revisit the item in six months.

11 People Committee Risk Register

11.1 TC outlined the seven areas of identified risks that are rated 15 and above, highlighting the last two which are new:

- Inadequate Workforce Supply (risk score 16 – no change)
- On-going industrial action (risk score 16 – no change)
- Band 2/3 HCA pay issue (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)
- Loss of workforce development funds in 2024/25 (risk score 16 – new risk)
- Loss of CPD funding for nursing and AHP staff from 2024/25 (risk score 16 – new risk)

11.2 SEA debated whether there was a risk that HEE merging with NHSE will mean less autonomy and flexibility in how funding could be spent, as NHSE funding streams have always been more directive. SEA asked if this could be flagged at the NHSE workshops or added to the register.

11.3 JC agreed that this should be flagged with NHSE and commented that there would be some future thinking about how to make the funding work to suit the system if funding streams were operated in that way.

RESOLUTION: The People Committee noted the content of the People Committee Risk Register.

AS left the meeting.

12 Policy Updates

12.1 CG gave some background to the Reasonable Adjustments policy and Health Passport explaining that a recommendation had been made to the ICB to be more transparent about what reasonable adjustments are and to give clarity to managers on the procedure for agreeing them. CG added that both had been approved at the Staff Partnership Forum (SPF) and was being presented to the Committee for approval.

12.2 *The People Committee approved the Reasonable Adjustments Policy and Health Passport and Guidance.*

12.3 CG explained that there were a couple of edits to make to the Zero Tolerance policy as an incident reporting mailbox had now been set up which the HR team are responsible for monitoring. CG highlighted that the policy had been reviewed by the Continuing Healthcare (CHC) team as one of the teams most likely to receive the kinds of abuse described within the policy and had also been presented at SPF.

12.4 *The People Committee approved the Zero Tolerance – Abuse of NHS Staff policy.*

12.5 The Social Media policy had been updated to the ICB policy format and the definitions recommended at the previous Committee meeting added.

12.6 *The People Committee approved the Social Media policy.*

RESOLUTION: The People Committee approved the Reasonable Adjustments policy along with Health Passport and Guidance, Zero Tolerance and Social Media policies.

13 Any Other Business

13.1 JC thanked the attendees for their time and contributions. There was no other business, but JC clarified that KC would chair the next meeting.

The meeting closed at 16.06pm.

Date and Time of next meeting: Thursday 8th February at 2pm in Shire Hall.

Minutes Approved by: People Committee
Signed (Chair):Karen Clements
Date:8th February 2024

NHS Gloucestershire System Resources Committee

Held at 1.00pm on Tuesday 16th January 2024

Hybrid Meeting via MS Teams and ICB Canton Room, Shire Hall Gloucester

Members Present		
Prof Jo Coast	JC	Non-Executive Director, Chair
Cath Leech	CL	Chief Finance Officer, ICB
Ellen Rule	ER	Deputy Chief Executive Officer, ICB
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Participants Present:		
Chris Buttery	CB	Finance Programme Manager, ICB
Jaki Meekings-Davis	JMD	Member, GHFT
Kat Doherty	KD	Senior Performance Management Lead, ICB
Mark Golledge	MG	Programme Director – PMO & ICS Development, ICB
Shofiqur Rahman	SR	Deputy Chief Finance Officer, ICB
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking notes)
Ryan Brunsdon	RB	Board Secretary, ICB
Siobhan Farmer	SF	Director of Public Health, GCC
Haydn Jones	HJ	Associate Director Business Intelligence, ICB

1. Introduction and Apologies for Absence

1.1 The Chair welcomed members, participants, and attendees. Apologies were received from Julie Soutter, Karen Johnson, Steve Brittan, Sandra Betney, Angela Porter, and Ian Quinnell.

2. Declarations of Interest

2.1 There were no interests declared.

3. Minutes of the Previous Meeting

3.1 The minutes of the meeting held on 17th November 2023 were approved as an accurate record of the meeting.

4. Action Log & Matters Arising

4.1 Action Log

4.1.1 **Action 23** –MG was asked to liaise with the Corporate Governance team to move risks that were not within the ambit of the System Resources Committee. MG liaised

with the Corporate Governance team. RB from the Corporate Governance team appeared before members to provide an update on system risk review and the remodelling of risk management tools. **Item closed.**

4.1.2 **Action 24** – Julie Soutter (JS), MG & ER were asked to support preparation for the next Board Development session on the follow-up from the Health Economics Session. Jess Yeates (JY) prepared a record which evidenced fulfilment of such arrangement. **Item closed.**

4.1.3 **Action 25** – CB and JY were asked to circulate the Integrated Performance report, including the M7 Finance report. The reports were circulated. **Item closed.**

4.1.4 **Action 26** – Members committed to reviewing the draft Planning Principles and sending feedback to MG. Members reviewed the principles and requested an update. MG presented an update of the Planning Principles before the Committee. **Item closed.**

4.2 Matters Arising: Review of Committee Terms of Reference

4.2.1 JC suggested a need to revisit and review the Committee's terms of reference. JC emphasised on need to address issues that limited the effectiveness of risk mitigation and efficacy demanded in resource management. JC raised a concern regarding setback arising from absence of some members of the Committee who represented critical sectors and cohorts within the Integrated Care System (thereafter "the ICS").

4.2.2 CL acknowledged the work pressures faced by members, but she emphasised that from a commissioning perspective it was important for quoracy to be representative of interests within the partnership as this would give Gloucestershire Integrated Care Board (thereafter "the ICB") a comprehensive appreciation of system resource needs. JC requested a review of the Committee terms of reference. **Action: JC and MG to review the terms of reference and report to members.** **JC & MG**

4.2.3 JMB stated that it was necessary for members who were unable to attend due to other commitments to update themselves on issues covered in their absence and get the earliest opportunity to contribute their views whenever practicable. JMD suggested that members should hold two meetings. One meeting would focus on the ICB perspective of resource planning and allocation whilst the other meeting would focus on the ICS needs.

4.3 Matters Arising: Planning Principles

4.3.1 MG described planning principles as a guide to effective resource use and he emphasised that the development of the principles was a collective effort from teams across system. MG explained that competing needs created competition for resources and exposed partners to conflict. The principles would help support outcomes favouring equity and reduction of health inequality in local communities.

4.3.2 MG added that the approach to planning favoured by the ICB sought to nurture a sense of personal and collective ownership of health delivery programmes. MG further described how the planning principles would help create a commissioning environment conducive to aiding efforts which identified areas of cost savings and promoting equitable allocation of resources.

5. Performance Report

5.1 Operating Performance

5.1.1 MW presented the operational performance covered in the January 2024 report. He highlighted areas of achievement and areas requiring further attention. MW stated that demand for Primary Care services continued to increase. MW also explained that endoscopy required more investment, and he cited the slight deterioration in cancer performance. MW commented that the system showed resilience during doctors' strikes and it also demonstrated resilience in Urgent and Emergency Care.

5.1.2 MW explained that Elective recovery continued to meet national targets and future projections appeared favourable. MW highlighted that local vaccination programmes were performing well but radiology remained an area requiring more focus. MW however reassured that efforts to reverse slippage in radiology appeared to be producing promising results. MW described the pressures impacting on hospital bed capacity since Christmas period. He reassured that corrective efforts were progressing well.

5.1.3 ER emphasised the ICB's commitment to improving outcomes. She highlighted the strong performance in domiciliary care and described the support packages designed to enable patient turnaround from hospital beds to domiciliary care. ER explained that Pathway1(home-based care) comparatively outperformed Pathway 2 (hospital-based care) and reversal of Pathway 2 slippage was receiving priority.

5.1.4 CL concurred and confirmed that Pathway 2 previously experienced bed capacity pressures amounting to £3.8 million due to the commissioning of extra beds. MW stated that GHFT patients were waiting longer than 65 or 78 weeks for elective treatment due to pressure caused by industrial actions. MW clarified that slippage in this area was not only local but extended beyond Gloucestershire County boundaries. MW cautioned that missing nationally set standards could negatively impact on funding opportunities.

5.2 Learning and Reflections

5.2.1 KD presented a survey report which gave feedback on performance. KD explained that the survey highlighted areas requiring deep diving and emerging issues. KD stated that the outcome of performance reports was key to reducing inequality, supporting proactive risk management and improving strategic priorities.

5.2.2 KD presented a summary dashboard which was still at a developmental stage and explained that the dashboard's key metrics aligned with the Three Pillars in ICS strategy. The metrics provided an oversight of system performance measured against national standards. ER commended the strong link between the dashboard metrics and the Three Pillars.

5.3 Shared Outcomes Framework

5.3.1 MG presented and explained that the report was significantly influenced by the Hewitt report. MG highlighted the importance of having an overarching framework incorporating both long term and short-term elements. JC stated that the Integrated Locality Partnerships (ILPs) could be used as a tool to advance shared target outcomes. MG stated that an overarching framework should have underlying subsets constituting Clinical Programme Groups (CPGs) and pathways such as dementia, respiratory, amongst others. Whilst members appreciated the framework employed to inform intelligence gathering, they discussed other models of delivering outcome.

5.3.2 ER pointed out a need to capture a wider cross-section of views on critical matters. SF expressed a concern that a wider information catchment area could result in more pressure to intelligence gathering channels. ER acknowledged the potential pressure arising from the processing of a huge amount of information but she focused on need to develop skills to sift through pertinent issues. ER emphasised the importance of bringing the Board's attention not to every problem but the most critical issues.

5.3.3 ER added that there would be a need to analyse providers' performance if there was reasonable belief that providers' performance impacted the ICB outcomes. ER reiterated the value deriving from pulling comparative data from a cross section of health delivery systems. KD concurred that extending the intelligence gathering catchment area would increase committees' capacity to assess system risks. MG reiterated that the cross-systems approach would encourage a shared view of risk trends and outcomes.

RESOLUTION: The System Resources Committee noted the Performance report.

6. Planning

6.1 MW presented the Joint Forward Plan, the Operational Plan and the medium-term Financial Plan and he stated that the plans were only provisional and as the ICB was still waiting for further guidance from NHS England. MW stated that the guidance was expected before December 2023 hence the slippage in reporting. **Action: MW, KD and CL to produce and present substantive plans by 7th March 2023.** **MW, KD&CL**

RESOLUTION: The System Resources Committee noted the Planning report.

The Chair agreed with members to adjourn the meeting from 2:30 – 2:40 pm.

7. ICS Capital Financial Framework

7.1 CL presented the report and gave a draft summary of a rolling ICS overarching 5-year Capital Plan which would be subject to 6-month reviews and updates. CL clarified that the overarching plan constituted joined-up partner capital plans which were not random but aligned with strategic system planning. CL emphasised that planning should be proactively risk scanning. JMD stated that the challenge faced by members was how to equitably match the partners' specific capital needs with integrated system plans.

7.2 CL concurred but expressed a need to sell the idea of prioritising resources on critical matters. CL stated as an example, a possibility of prioritising GHFT estates maintenance requirements over some of new capital projects of partners to an extent such action would not prejudice the partners' key strategic programmes.

RESOLUTION: The System Resources Committee noted the ICS Capital Financial Framework report.

8. Investments and Benefits Review

8.1 CL, MG and HJ presented the report. CL explained that in October 2023, each ICB in the South-West was asked by NHS England to assess benefits deriving from material investments made starting from 2019 and use this to inform future investment strategy. This resulted in an investment log being created for updating decisions made across the system. MG updated that the ICB and its partners were reviewing their respective investments, focusing on future investments and evaluating schemes for prioritisation.

8.2 JC enquired as to whether the partners were using standard tools in the evaluation of investments priorities. MG responded that the partners were using identical tools and similar principles for evaluating investments. MG added that the tools were advanced enough to address the unique nature of each scheme. MG gave as an example the application of the tools and principles in as far as they applied to the respiratory scheme. MG added that the newly established Evaluation Advisory Group would provide advice and input prior to schemes being brought before members for scrutiny and assurance.

RESOLUTION: The System Resources Committee noted the Investments and Benefits Review report.

9. Urgent & Emergency Care (UEC) - Benefit and Savings Plan

9.1 ER presented the report and described UEC transformation programme which was premised on exploiting the benefits deriving from Realisation Approach to achieve efficacy and cost effectiveness within the UEC environment. ER emphasised that outcomes in terms of mitigating cost pressures and maximising benefits in UEC

required strong partnership. JC requested more details on arrangements made between partners to drive the UEC transformation programme forward.

9.2 ER reassured that there were processes in place designed to support the transformation programme. ER explained that there was a Benefits Realisation Board in place, and she added that other forums to support the transformation process were being considered. ER stated that her team was looking into developing transformation tools and models with capacity to project benefits to be realised and proactively mitigate cost pressures.

9.3 ER reiterated that allocation of resources appeared to currently favour Secondary Care. ER stated that support from members was critical to the re-mapping and re-designing of equitable resource allocation mechanisms for the ICS. CL added that it would be idle for partners to guarantee as practicable as possible that the benefits already deriving from transformation programmes should not be lost when reallocating resources in pursuit of equity.

RESOLUTION: The System Resources Committee noted Urgent & Emergency Care (UEC) report.

10. M8 Finance Report and Whole Time Equivalent Workforce Review

10.1 Whole Time Equivalent (WTE) Workforce Review

10.1.1 CL presented and stated that workforce expenditure accounted for approximately 70% of the local ICS cost base thus making it a significant driver of expenditure and financial performance. CL explained that the ICB was asked by NHS England to review Gloucestershire Hospitals Foundation Trust (GHFT) and Gloucestershire Health & Care (GHC) workforce expenditure based on budgeted WTE figures. CL stated that available evidence indicated that workforce related productivity had been deteriorating over time, with the slippage being more pronounced in Outpatients and Theatres in the case of GHFT.

10.1.2 CL stated that the decrease in productivity was driven by mismatch between activity and workforce costs. CL cited Bank work contracts and Agency work as significantly increasing productivity costs. CL explained that the ICB was committed to contributing to reversal of workforce related slippage both in the GHFT and GHC. The ICB was thus assisting with the building of workforce controls to improve outcomes. JC commended the efforts put in developing staff controls and observed that urgency spend was beginning to go down.

10.2 M8 Finance Report

10.2.1 CL explained that partners continued to focus on achieving breakeven position across the ICS. CL gave an overview of ICS capital programmes and discussed pressure from industrial action affecting GHFT, and pressure emanating from Section 117 affecting GHC. CL stated that the early findings for M9 pointed toward

continuing pressure arising from industrial action and the projection for M10 pointed toward a similar trend.

10.2.2 CL clarified that the M8 Capital expenditure showed a small underspend against budget for the year, but the position was expected to subsequently shift from underspend to overspend. CL stated that pressure on capital programmes would be exacerbated by the capitalisation of finance leases (IFRS16) and constrained funding conditions. CL reassured that there was ongoing work across the system to ensure that ICS capital expenditure remained within the system resource allocation. CL also reassured that efforts were being made to mitigate funding constraints.

RESOLUTION: The System Resources Committee:

- **Noted the Whole Time Equivalent (WTE) Workforce Review.**
- **Noted the M8 Finance Report.**

11. Committee Risks

11.1 RB presented the report and stated that the ICB was moving from a generic risk management platform to a more friendly bespoke platform. RB further stated that the ICB risk management process was being redesigned to support both operational and system level outcomes. RB explained that a Task and Finish Group had been set up and was currently seized with the task of remodelling risk tools to improve effectiveness of risk management efforts.

11.2 RB added that the Task and Finish Group was developing the user-friendly risks tools after engaging and receiving feedback from Risk Owners and Risk Leads. RB stated that BAFs and user-friendly dashboards would be used to provide succinct information to committees and decision makers. RB highlighted that a training programme was being rolled out for the purpose of upskilling Risk Leads, Risk Owners, and those charged with providing assurance.

11.3 RB emphasised that responsibilities over system risks extended to committees of the Board to an extent generally not exceeding their respective areas of focus. RB clarified that being committees of the Board, such committees would not necessarily preoccupy themselves with operational matters but would provide assurance and oversight over matters of system risks. RB reiterated that the Task and Finish Group was tasked with mapping process and resource planning. RB gave timelines for the project life cycle.

RESOLUTION: The System Resources Committee noted the Committee Risks report.

12. Any Other Business

12.1 It was suggested that a session on how the ICS spends its money and where money should be invested would be beneficial.

The meeting ended at 3:45pm.

Date and Time of Next Meeting: 7th March 2024 at 2:00pm (Hybrid).

Minutes Approved by: System Resources Committee Signed (Chair):Prof Jo Coast Date:7th March 2024