Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 29th May 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: *Mary Hutton, Mark Walkingshaw, Sarah Scott, Kevin McNamara, Ann James, Pete Bungard & Martin Holloway*	Information	**Chair**
2.	2.02 – 2.02pm	**Declarations of Interests** The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	**Chair**
3.	2.02 – 2.04pm	**Minutes of the meeting held 27th March 2024**	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 (Community Pharmacy)**	Discussion	**Lucy Bird Healthwatch**
7.	2.30 – 3.00pm	**Community Pharmacy, Optometry and Dental Services in Gloucestershire**	Discussion	**Helen Goodey Dr Raghuram Ananthakrishnan**
8.	3.00 – 3.10pm	**Chief Executive Officer Report**	Discussion	**Ellen Rule**
9.	3.10 - 3.20pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.20 – 3.45pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Ellen Rule Tracey Cox Marie Crofts Cath Leech**
		Decision items		
11	3.45 – 3.50pm	**Primary Care & Direct Commissioning Committee Terms of Reference**	Decision	**Ayesha Janjua**
12.	3.50 – 3.55pm	**System Resources Committee Terms of Reference**	Decision	**Prof Jo Coast**
		Information items		
13.1	3.55 – 4.10pm	**Chair's verbal report from the Audit Briefing** held on 9th May 2024.	Information	**Julie Soutter**
13.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** held on 4th April 2024 and approved minutes from 1st February 2024		**Ayesha Janjua**
13.3		**Chair's verbal report on the System Quality Committee** held on 3rd April 2024 and approved minutes from 15th February 2024		**Prof Jane Cummings**
13.4		**Chair's verbal report on the People Committee** held on 16th May 2024 and approved minutes from 8th February 2024		**Karen Clements**
13.5		**Chair's verbal report on the Resources Committee** held 2nd May 2024 and approved minutes from 7th March 2024		**Prof Jo Coast**
14.	4.15pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 26th June 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 27th March 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
Julie Soutter	JS	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 and Chair of Health & Wellbeing Partnership Board
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHSFT
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Ingrid Barker	IB	Chair, Gloucestershire Health & Care NHSFT
Mark Walkingshaw	MW	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Richard Smale	RS	Interim Director of System Co-Ordination, NHS England – South West
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
Gemma Artz *(Item 6 on the Agenda)*	GA	ICS Clinical Programme Director, NHS Gloucestershire ICB
Oonagh Wilson *(Item 6 on the Agenda)*	OW	Clinical Lead for Nursing, Therapies and Quality Projects, Gloucestershire Health and Care NHS Foundation Trust
Jo White *(Item10 on the Agenda)*	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
Caroline Smith *(Item 11 on the Agenda)*	CS	Senior Manager, Engagement & Inclusion, NHS Gloucestershire ICB
Mark Golledge (*Item 12 on the Agenda)*	MG	Programme Director - PMO & ICS Development, NHS Gloucestershire ICB

David Porter *(item x on the Agenda)*	DP	Associate Director - Contracting & Procurement, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 The Chair welcomed members to the meeting. Apologies were received from Mark Cooke, who had requested that Richard Smale deputised for him today. The meeting was declared to be quorate.

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

2. Declarations of Interests

2.1 The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)
There were no new declarations of interest for this meeting.

3. Minutes of the Public Board meeting held on 31st January 2024

3.1 The minutes from the Public Board meeting held on the 31st January 2024 were approved as an accurate record.

4. Matters Arising and Action Log

4.1 DE had raised an issue related to Min. 8.9 about an End-of-Life visit which referenced choice of place to die and Continuing Health Care. It had been agreed that further work would be conducted but there was not an update on the Matters Arising.

4.2 ER responded that a number of actions had been undertaken by ER and BL following the conversation about End of Life and CHC. A meeting had been held with Dr Tanya de Weymarn, End of Life (EoL) Clinical Lead for this Clinical Programme Group and Jane Haros, Deputy Director of Integrated Commissioning where it was agreed that:

- An Action Plan would be presented to the Quality Committee of the Board incorporating a deep dive analysis on the work programme which was underway in EoL CPG.
- The EoL Team had been invited to attend the Integrated Flow Hub to review all patients with No Criteria to Reside (NCR) who have indicated that they should be on an EoL pathway.

ER explained that whilst there were good and swift processes in place for people who needed to be fast-tracked, there was an identified need around patients who were not identified as fast-track within the Continuing Health Care (CHC) criteria. Issues to be resolved include staff training initiatives, education and better identification of patients who were at EoL. These were some of the areas that were being addressed.

4.3 The Chair recommended that the EoL report on completion should be sent to DE and IB once it had also been presented to the Quality Committee. It is noted that this report would be submitted to the June Quality Committee.

4.4 The Chair then referred to the Action Log where four items were indicated as requesting closure and three items which needed to be brought back. KM referenced Action 21 (Item 10.12 – LMNS functionality) and requested that the narrative be clearer in the Action Log,

to reflect the need for further clarity of the membership. This was subsequently rectified on the Action Log so that the narrative corresponded with that of the minutes.

5. Questions from members of the public

5.1 The following questions were received from members of the public. Full responses were read during the ICB Board meeting and were included in a log on the ICB public website https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/

Responses were also directly sent to those who had submitted questions.

The Chair stated that those who had asked questions would be offered a meeting in some instances, where further in depth answers and discussion could be offered at that time.

6. Patient Story - Integrated Care Partnership (ICP) Contract

6.1 The Chair explained that this patient story linked in with the work of the Integrated Care Partnership, which was the statutory group responsible for helping to set the strategy for the ICB. The work of the ICP to date, clearly demonstrated how the ICP had the potential to greatly impact the health of the people of Gloucestershire.

6.2 GA introduced herself and OW from the Outreach Team. She explained how cardiovascular disease accounted for a quarter of all premature deaths in England. It accounted for 20% of the life expectancy gap between the least and most deprived areas, which rose to 30% for men in Gloucestershire.

6.3 GA explained that high blood pressure could often lead to heart attacks, strokes and kidney disease, all of which impacted mortality and the quality of life for those experiencing and surviving those events and conditions. Through various groups, a range of projects were being undertaken to support the identification of people who either had undiagnosed blood pressure or were not treated, within the normal blood pressure range.

6.4 There were approximately 11,000 patients in Gloucestershire based on national prevalence data that needed to be identified and treated to reach the national standard of 80%. Awareness had been raised via the community Outreach work which offered the opportunity for blood pressure checks in non-traditional settings.

6.5 There had been recent community focused events where blood pressure checks had been part of the offer as well as the Know Your Numbers Campaign, which toured the county in the information bus in September last year and January this year. These events led to an additional 663 blood pressure checks in the community. Information was uploaded via SystmOne onto the patient's GP records enabling follow up. 140 people to date had been signposted to other resources and health support.

6.6 OW informed the Board that as part of the national Covid vaccination strategy, the GHC Outreach Vaccination and Health Team had come up with more ideas about making every contact count, and after setting up a system, were also able to offer basic health checks. OW informed the meeting that the team had conducted a further 80 clinics in a variety of locations including warm spaces, food banks, church halls, libraries, livestock markets etc. A survey conducted had revealed that topics the public would like more information on were:

- Monitoring blood pressure at home
- Lifestyle changes and smoking cessation
- Stress, anxiety and mental health issues

- Skin lesions
- Vaccine eligibility.

6.7 OW described the patient story, for which the patient had been anonymised and had given full consent to share. Rebecca's story was documented from the start of her receiving a Covid booster and being offered a free health check to then finding out that her blood pressure was high. Her blood pressure was borderline and she received a call to see her GP the following day. She was seen by her GP and reported feeling generally unwell, and was then sent for a chest radiography, which revealed she had an enlarged heart. Her GP prescribed 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.

6.8 Rebecca said: "If I had not taken up the offer of that initial blood pressure check I would have had 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 am now receiving the treatment I need."

6.9 ER thanked both colleagues for sharing the inspiring story and asked whether there would be an opportunity for taking some of these checks into workplaces. GA responded that one example was the visit to Gloucester City Homes where 8 out of 27 people checked, were identified as having high blood pressure and were followed up. The Chief Executive of that organisation let the staff know that conversations had also been generated about health in general. This included the benefits of having had those health checks, where people would have remained in ignorance of potential problems should these checks not have taken place. Further conversations with Rikki Moody and the Outreach Team will examine whether these Health Checks could be made available to the independent care sector more generally.

6.10 The Chair stated that the Forward Plan intended to address the issue of Health Checks for the workforce of the two NHS partners and the County Council, which would be a significant achievement.

6.11 HG supported this valuable work but observed that as Primary Care conducted more blood pressure checks, more issues would be found and would have an effect on General Practice regarding the workforce capacity, access and availability for patients to be followed up. It would be important to keep a watch on that. The Chair responded that Bob Hodges was the new incoming chair of the Local Medical Council (LMC) and was also the Clinical Director of the Gloucester Primary Care Network and his inclusion in these schemes would be very beneficial.

6.12 SF stated that it was fantastic news that things were gathering momentum through the Partnership. SF informed the Board that Pharmacy First, which was now in place, would also be able to offer blood pressure testing and would help with capacity and access in Primary Care. Work with partners had been undertaken to ensure that they were aware of where offers were available. This message will also be promoted within communities to make people more knowledgeable about where blood pressure checks could be conducted. Blood pressure monitors were also available relatively cheaply online. Early identification would definitely bring preventative health benefits to the overall population, which was why this was so important.

6.13 DE thought that the offer to the NHS partner trusts was a good one because there were many people from lower socio-economic and ethnically diverse groups, where there may

be blood pressure issues. The NHS in Gloucestershire was also the most ethnically diverse employers, so it would enable the organisation to best meet the needs of those communities. DE stated that it was a good idea to offer this opportunity to social care provider staff for the same reason in that there were working in a very pressurised environment, and were lowly paid staff who may not find it easy to access services in a mainstream way due to work pressures/shift work etc. DE also understood the very challenging demands currently being made on Primary Care.

6.14 JB noted the points made about workplace testing and rolling out those opportunities was really welcome. However, JB noted that the Pharmacy First scheme was not likely to relieve the pressure on General Practice, due to community pharmacists being unable to prescribe and not having other pertinent information to hand about a particular patient. Although the programme was welcome, it would need to generate additional resources in order for need to be met, mostly from General Practice where the necessary patient information was available.

6.15 JCu agreed with the aforesaid comments and also wanted to be positive about the patient story in recognising that the patient was contacted very swiftly by her GP at a time when nationally there had been negativity around waiting times and the outcome had been extremely positive. This was to be celebrated together with addressing the longer term impact of the programme. By identifying problems early on, this would prevent significant need and intervention at a later stage so balancing this was obviously very important. JCu extended thanks for the work that had been achieved thus far.

6.16 OA raised the visibility of data and would like to see more collaborative work with PCNs to enable them to improve their databases. OA had noticed that her PCN was one of the lowest for early diagnosis for in the South West for cardiovascular disease (CVD), necessitating changes across practices. This data was not thought to be visible to practices and PCNs particularly for those who were outliers. The 2023/2024 contracts no longer included CVD as part of the PCN targets, so this would need to be addressed.

6.17 OA would like to work with the Circulatory Team to help PCNs to map the changes that had been made and how much diagnosis of blood pressure had increased. Specific changes had also been made for Core20PLUS5 areas in terms of engagement. There was an intention to work together outside the meeting with OA already having forward plans around this.

6.18 GA described how a much more detailed data analysis had been completed which would be shared with OA. The plan was to have Cardiovascular Disease (CVD) Champions across Primary Care with one Champion per PCN so that they could also assist with data collation. Community work to determine why people were not be coming forward, for follow up after they had received blood pressure checks from the Outreach Team, was being undertaken. People could then be engaged with differently to encourage treatment uptake. GA informed the Board that this data was broken down by ICP districts, thereby allowing easier interpretation and would be sent to OA.

6.19 MC commented that if people were going to take their own blood pressures at home, they would need to know when intervention was needed. MC asked OW whether clinics were based in areas where there was greatest health inequalities. OW replied that NHSE had some say in this and GA confirmed that data on health inequalities was used to target the areas where the Information bus should go, which was central Gloucester and West Cheltenham.

Resolution: The Board noted the content of the patient story from the GHC Outreach Vaccination and Health Team.

7. Health & Wellbeing Partnership Update

7.1 CAM introduced the update as Chair of the Health & Wellbeing Partnership, subsequently named the one Gloucestershire Health and Wellbeing Partnership (HWP). The Partnership was established in July 2022 with the statutory formation of the Integrated Care System Board. The Department of Health and Social Care tasked each Integrated Care Partnership (ICP) to develop the Integrated Care Strategy. There had been a strong history of partnership working in Gloucestershire which provided a very strong base from which to commence this work. The update today would give an overview of what had been achieved so far and future plans.

7.2 MW explained that collaborative work was taking place with system partners within an agreed broad framework. System partners focused on patient centred programmes that worked at the community level. There was commitment in the partnership to work to the best possible evidence and this was apparent in some of the blood pressure work referenced earlier.

7.3 The three exemplar themes for this year were around employment, smoking and blood pressure. The Partnership had demonstrated many times that a small amount of funding could go a long way to help communities whilst encouraging investment from external sources into the system. Data sharing across system partners had been of benefit and many challenges around this had been overcome to ensure that clear measures were available in order to track system delivery.

7.4 A year after the publication of the Interim Integrated Care Strategy, the Partnership had held a development session to discuss the experiences of the last 12 months and what the Partnership's focus should be for the coming 12 months. The Integrated Care Strategy was agreed as an interim, but more time together was needed to allow the Strategy to act as a roadmap for action across the Partnership. A light tough refresh of the Strategy was planned in 2024, exploring areas of strength, progress, gaps or challenges.

7.5 SF explained that open space events for exemplar themes would give the Partnership opportunities to listen to communities about any concerns and to identify some of the barriers. Tewkesbury would be the first area to be offered this approach, which if successful, could be taken this forward to other districts.

7.6 Employment inequalities in the county had been discussed at a recent event with five ideas coming from that:

1. Creating a pilot for greater joint working with a priority cohort in the area and to share accountability across the partnership for that piece of work;
2. Mapping the overall provision to inform how services were better commissioned and to lessen unhelpful competition between providers;
3. Clear pathways to ensure system visibility enabling support for those wishing to return to employment;
4. Speaking with one voice to businesses and creating a product to highlight how social value was important to link work and health;
5. Seeking further opportunities to engage with schools and families to create quality work which was rewarding for people in the county.

7.7 Proposals had been developed around insights in communities and what factors and barriers might affect changes in behaviour. Working with organisations, community groups and Integrated Locality Partnerships (ILPs) to examine the blood pressure data would

continue to take place, as previously referenced. SF commented that blood pressure data was part of the pack today, should members of the Board wish to view it.

7.8 There was a specific ask of ICS partners to take up the offer from the blood pressure exemplar theme, to work in collaboration around developing a sustainable approach to offer blood pressure checks for the collective workforce of over 28,000 people in health and care. CEOs were in discussion with their HR Directors about the feasibility of this.

7.9 The Chair thanked those involved in the presentation, noting that there were some good opportunities available that had not been previously explored. GHC had a very good Occupational Health service and if that could be made available to more employers in County, it could help to reduce sickness and increase productivity. The Chair stated that this presentation did not cover the financial resources associated with this work. This was due to Gloucestershire having been committed to joint commissioning for a long time, as such there was a separate mechanism which dealt with some of the interchange of funds for health and care, which was the Joint Commissioning Board, thus the money aspect did not to appear in the ICP presentation as there was another place for those conversations.

7.10 MC commented that there had been significant success around getting people with mental illness back to work using a model that had come from NHSE which was linked to health inequalities and she wondered whether a team was addressing this. DB responded that the IPS (Individual Placement and Support) team performance were working on this and so far, had achieved good results. JCu commented that during a recent visit with IB and DE, they had met the IPS team and the impact they were having on getting people back into employment in Gloucestershire was very commendable. The Chair recognised that further inroads needed to be made with Learning Difficulties and the other part that linked into this work was the Physical Health Checks where further work was being undertaken in this area.

7.11 SF highlighted to the Board that two programmes were being run in tandem in each of the trusts; every person admitted in GHFT had their smoking status recorded, so that people could be identified and offered support to stop smoking if they were smokers. While GHC focused on smoking cessation particularly inpatients smoking with 50% of patients being smokers. Each local authority nationally had been given a share of £70m funding for smoking cessation services, every year for the next five years of which Gloucestershire's share was approximately £730k. A decision on how this would be spent would be taken to Cabinet. Options would be explored with Primary Care along with other existing models in place.

7.12 **Resolution: The Board noted the Health & Wellbeing Partnership update, specifically the exemplar theme to work in collaboration to develop a sustainable approach to offer blood pressure checks to the collective workforce of over 28,000 people.**

8. Chief Executive Officer Report

8.1 MH reported to the Board on the following topics:

Social Prescribing Day

Various organisations supported and helped people to understand what was available on the Social Prescribing Day, which proved that this was thriving in Gloucestershire and was very successful.

Arts and Health

The National Centre for Creative Health (NCCH) has been working in partnership with NHS England Personalised Care Team and a number of Integrated Care Systems (ICSs) of which Gloucestershire was one. https://creativehealthtoolkit.org.uk/ It was fortunate for

Gloucestershire that there was a Creative Health consortium who were encouraging more things to be done in this space and a broad range of offers had been built up for people in the county.

Action: Creative Health Consortium to be placed on a future Agenda for discussion around a Patient Story. **CG**

First National GP Leadership Event

Dr Olesya Atkinson attended the first national GP leadership event in London on 31st January 2024. The meeting brought together single GP leaders from each of the 42 systems representing general practice. There would 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.

System Operational Planning 2024-25

A high-level submission of key metrics was completed at the end of February 2024. Full national guidance was expected imminently, however, significant changes were not expected. It had been hard work this year and there was a good suite of performances for Gloucestershire, having achieved some quite significant improvements. Plans next year would be more ambitious. The plan would continue to be refined over the coming weeks in readiness for the full and final submission at the start of May 2024, with further updates to the Board to follow with the results of the work. It was noted that an update would be provided in the May board papers.

National Staff Survey 2023 Results

The ICB had an improved response rate of 76.8% compared to 74% in 2022. The ICB did well with regard to staff who would recommend the ICB as a place to work, 74.8% (compared to 80.6% in 2022 and was equivalent to the 'Best', (ICB average was 51.7%).

In GHFT all People Promise elements had shown statistically significant improvement in their score. 56 out of 87 questions (64%) which were directly linked to the People Promise themes, had seen a statistically significant 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).

GHC had come first in the Staff Survey overall rating across South West Provider Trusts (tying again with Dorset Healthcare University Trust) and had the fifth highest rating nationally for being recommended as a place to work in England (Mental Health, Learning Disability & MH/LD/Community Provider Trust benchmark group).

8.2 KM stated that GHFT had arrested the decline but there was still a lot of work to do regarding the improvement of scores and KM wanted to manage expectations. Part of the challenge that the Trust had been tackling was that a fair amount of resource had been tied up in a very small number of workforce issues. It was hoped now to focus on the bigger issues and to discuss these further with the People Committee.

8.3 The Chair recognised that the Trust had had to deal with the massive impact of the pandemic and it had cast a very long shadow over the NHS in all organisations. KM observed that a huge amount of changes had taken place within the Trust over the past couple of years. This showed that the Trust had the capacity to change at any one time, knowing when to push forward with service improvements and when to pull back, as well as taking the right people on the journey.

8.4 DB commented that GHC had been pleased to see that staff had recommended the Trust as being a good place to work which was a pleasing result. This however was not a consistent position across the whole organisation and there would be a focus on examining things that were not right, particularly around the rise of racial harassment and discrimination, which was currently a significant focus.

8.5 The Chair spoke on behalf of all Board members saying that everybody would be feeling uncomfortable about the Workforce Race Equality Standard (WRES) data across the whole of the NHS and about the WRES data locally. The same applied to the Disability data both nationally and locally. The focus was therefore about what tangible changes could be made across the system to improve this, with the People Committee leading on this. The Chair stated that the Board needed to acknowledge that this was simply not good enough and everybody needed to address these issues both individually and collectively.

Resolution: The Board noted the Chief Executive Officer Report.

9. Board Assurance Framework

9.1 TC informed the Board that the Board Assurance Framework (BAF) had been updated and reviewed extensively since last presented at Board in November 2023. The key changes to the BAF had been summarised. It included three new additional strategic risks, one was to examine what the system was doing collectively to pay attention to some of those challenges, this also included the WRES metrics. New risks relating to the estates infrastructure and cyber security had also been added. Three particular risks rated as 20 and above related to workforce, the challenges to the sustainability and resilience of Primary Care and the financial risk. The new risk included on Cyber Security was rated as a high red risk (20) in line with system partners.

9.2 The full BAF was also presented at the March 2024 Audit Committee and Strategic Executive. The Audit Committee commended the work that has been completed to re-align the BAF. Each sub-committee was responsible for the oversight, scrutiny and challenge of high rated risks on the Corporate Risk Register and BAF which related the committee's role and remit for example the Quality Committee reviewed risks related to the quality of services.

9.3 JS recognised the hard work that had gone into the BAF to improve it and she thanked colleagues for their support as well as the risk leads within directorates. The Audit Committee would continue to work on refining and improving the BAF particularly around the descriptors used for controls, assurance and actions. Individual directorates would be invited to attend an Audit Committee meeting to give a presentation around their assurance mechanisms and controls. Examination of other organisations and how they present their risk reports to the Board and sub-committees would also be reviewed to improve risk reporting within the ICB.

9.4 The Chair commented that due to system partners being involved in the Audit Committee, this offered transparency around the BAF throughout the system which was important to recognise. The Chair also noted that there was an incredible wealth of data and work that had gone into the refreshed BAF. The Chair thought that later in the year some time should be spent at the beginning of a Board meeting to go through this in greater depth and to close off all the work that had been completed in relation to key actions. .

9.5 KM referenced 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". This* was rated at a score of 10 having reduced from 15. KM raised the issue

that the score reduction did not reflect the challenges across the system, including Primary Care dentistry, which was a very fragile area where there was a great deal of work to implement the dental strategy. The Chair recommended that this be reviewed at the next iteration of the BAF.

9.6 DB referenced BAF 1 "The failure to promote and embed *initiatives* on health inequalities and prevention." He thought that" initiatives" should be changed to "an overall approach" and the wording updated. The Chair recommended this be reviewed at the next iteration of the BAF.

Resolution: The Board members noted the update on the refreshed Board Assurance Framework.

10. Integrated Finance, Performance, Quality & Workforce Report (IPR)

10.1 MW drew the Board's attention to this month's report which was split into 2 sections, the Integrated Performance Report (Part A) and the Delivery Plan for Recovering Access to Primary Care Update (Part B). The Strategic Executive had also reviewed the Primary Care Delivery Plan at its meeting held on 21st March 2024.

10.2 The IPR report this month also included a detailed section on Outcome Measures. This followed the Board development session in February 2024; when the session looked at the inequalities framework which linked in part to the next agenda item 11 and how the ICB was able to evidence outcomes for the population.

10.3 MW stated that the British Social Attitude Survey released today made sober reading around the results with the key message being around the importance that patients placed on timely access to all services. The regional and national focus continued to be on a subset of the national measures around Urgent and Emergency care, access to the 4 hour performance standard, the ambulance handover performance and cancer and diagnostic access standards.

10.5 MW referenced the Health Outcomes dashboard which was still under development. A Board Development session a few weeks ago had focussed on agreeing a framework around the approach to identifying and responding to health inequalities. A commitment was made that this should start to feed through into the Board reporting. It had been recommended that old measures should be removed prior to adding new ones.

10.6 Examination of the dashboard revealed the stark challenges being faced by the population in Gloucester City, which were influencing some of the Board's decisions, particularly around targeted investment to meet the needs of that population.

10.7 MW informed the meeting that the new Integrated Flow hub was going some way towards delivering targets against national standards, and was starting to make a significant difference to the daily drive to aid flow across the system. MW stated that it was pleasing to note the opening of the brand new Diagnostic Centre which was a fantastic facility and offered over 80,000 diagnostic appointments each year to the population.

10.8 There was a new national requirement for every hospital now to maintain a minimum of 76% performance against the 4 hour standard and so the regional team would be reporting daily results to the national team. Waiting lists continued to be of concern, particularly in oral surgery, ENT and orthopaedics, but there was confidence that as of 31st March, the elective recovery targets would be met by GHFT which was important both in

demonstrating the commitment as a system in reducing waits along with the expectation of additional investment into the system through the national Elective Recovery Fund.

10.9 Recovery of performance targets for cancer waiting times continued to be a focus, in particular waiting list initiatives across Urology, Lower GI and Breast were in place to support recovery against the 28 day and 62 day standards. The additional activity would continue into 2024-2025 as part of the operational plan.

10.10 JW gave an update on the Primary Care Access Recovery Programme, informing the Board that The National Delivery Plan had two central ambitions:

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

There were four elements to this (see Slide 3 of the presentation):

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

10.11 Good progress had been made around data, infrastructure and workforce challenges in a time where significant increases in workload were being seen in Primary Care.

10.12 TC updated on the workforce element of the report.

- There had been industrial action from junior doctors last week so a careful watch would be kept on anything resulting from this.
- There would be potential for the ICB to develop a staff housing support service for health and social care staff across Gloucestershire, working in collaboration with two other systems in the South West. Accessing high quality accommodation was a particular issue for international recruits and other staff.
- There was an improving and positive trend around vacancies and the retention position.
- It is planned to hold some Leadership Conferences across Gloucestershire with the opportunity to bring colleagues together across the system to hear about progress and priorities in the county. There was a long list of potential topics for discussion and more on this will follow for diaries later in the year.
- A Systemwide Conference for coaches would be held on 25th April 2024 for all system partner's coaches to attend.

10.13 MC updated on Quality:

- The System Quality Committee (SQC) would be looking at the BAF next week.
- Patient Safety Incident Response Framework (PSIRF) – this was a good opportunity to learn across the system in terms of themes.
- Berkeley House – updates would be given at the SQC meeting next week.
- Various places had received Care Quality Commission (CQC) inspections and an accuracy check was being run on the report by GHFT.
- Significant work had been undertaken on migrant health to ensure that there will be adequate health care provision for around 1000 Entitled Persons at Beachley Barracks.
- MC was leading, with others, a review of the membership of the function of the Local Maternity & Neonatal System (LMNS) and MC had been in discussion with

the NHSE South West Region about the Perinatal Review about what that might look like. Feedback from other areas and system would be useful.

- A single Maternity Action Plan was being pulled together – the plan was less important than the actions underneath it. A Quality Improvement Group will review the top 20 actions to tackle.
- The Workforce Race Equality Standard (WRES) data was discussed and MC concluded that GHFT needed to be congratulated on the Black Maternity Matters programme. There were four senior leaders for the programme and the first session of that programme was held recently, proving to be very inspiring.
- System Mortality Group – AR and MC with other system partners would be exploring a piece of work around weekend mortality.

10.14 OA noted that in the performance metrics (Page 118) there were two or three areas which were showing red, one was hypertension mentioned earlier. OA asked if there was any way of demonstrating how much the ICB were below the national average, as if we were some way off in a particular area, this would give extra focus and an indication that this was an area which needed more focus. MW responded to OA's question stating that there was some modified colour coding around statistical significance which could be further developed.

10.15 KM mentioned the two aspects of the report referring to dentistry and long waits in oral surgery, which was a big issue, noting that there needed to be a focussed conversation on oral surgery. KM also noted that the Performance Report lacked community information and data and wondered whether this should be a focus going forward.

10.16 MW responded to KM by saying that although there was a limited set of community measures with the focus being on the national measures, community was making an enormous contribution to deliver against national measures which were sometimes termed as Acute Measures. MW stated that he would look into the matter further and how this could be reflected in the IPR.

10.17 HG responded to KM's query about dentistry and oral surgery and stated that there had been a recognition that GHC had capacity for oral surgery resulting in Primary Care having changed that pathway to ensure that there were opportunities to send patients back to general dentists. Capacity had been maximised in GHC and Primary Care Oral Surgery was also being explored. It was recognised as being a real issue but steps had been taken to address this.

10.18 The Chair commented that a longer session on dentistry the opportunities and challenges facing Gloucestershire would be organised for a future board meeting. Also, that there would be time on the agenda for a more in-depth discussion on the IPR at the May board.

10.19 JCu observed that a report and data had yet to be received from the South West Commissioning Hub. RS confirmed that he had also spotted this and assured the Board that it was being addressed by a colleague of his.

10.20 A question was raised as to how it was known that initiatives were working given the distributed nature of GP practices. JW stated that digital elements had been, and continue to be, put in place to collate certain data. OA commented that the way patients perceived Primary Care was indicative of the responses from patient surveys which was also key in monitoring those initiatives.

10.21 CL updated on the Finance element of the report.

- In terms of the 2023-2024 position, a surplus of just under £500k was being reported as a system, which was a significant achievement given some of the

system pressures having been seen during the year. Quite a number of those pressures were recurrent and were being built into the 2024-2025 financial position which was a work in progress.

- Capital against the system Capital Departmental Expenditure Limits (CDEL) was reporting a break-even position but there was an underspend against the national capital programmes and in terms of the International Financial Reporting Standard of 16 Leases (IFRS 16) issue, this was a forecast of break-even due to NHSE having allocated contingency funding.
- Good progress had been made to reduce agency spending over the financial year and GHC was on track to deliver the target of 3.7%. GHFT was slightly off target with the February 2024 spend being slightly higher. However, the overall rolling trend was showing downwards. The target for next year was £3.2%and there were plans in development for both organisations to hit that target.

The Chair extended thanks to CL and her team who were working incredibly hard towards year end and acknowledged how fortunate the organisation was to have them.

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

11. Progress Report – Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS)

11.1 This was presented by TC and CS. The PSED included a requirement that the ICB would publish equality information about both the communities being served and the staff employed by the ICB. It also required ICBs to have one or more published equality objectives, which were specific, measurable and covered a period of up to four years.

The report set out our response to these requirements and evidenced the process the ICB had undertaken to review its 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

This report would need to be published on the ICB's website by 31st March 2024 enabling evidence to be demonstrated around compliance with the PSED. The report indicated that strategic objectives should be examined further, with more detailed work required. It was proposed that this should be conducted over Q1 in partnership with system colleagues and a request would be made for volunteers to assist with this. The Board members were fully supportive of this approach with commitment to assist with the work required with some people already actively involved in the work.

11.2 JCu extended thanks to all involved in the work and asked whether there were any other ICBs who had self-assessed as being in a higher bracket and if so, would it be possible to understand how they had achieved this. TC responded that she was unsure even though she had asked other colleagues about this but, probably region might have some of the answers to this. The Chair commented that she would expect other regions such as West Yorkshire to be at the top of the ratings due to having extra resources. TC confirmed that she would discuss with the South West region to see how Gloucestershire ICB compared to other ICBs around the PSED scores and would report this to the People Committee. Minutes of the People Committee would be reported to the Board.

Resolution: The ICB Board members:

- **Noted the content of the ICB Progress Report – Public Sector Equality Duty and the ICB's response to the Equality Delivery System;**
- **Noted and approved the improvement actions;**
- **Noted publication of the EDS assessment on the ICB website on 31st March 2024.**

12. <u>One Gloucestershire Joint Forward Plan 2024-2029</u>

12.1 MG presented this and explained that ICBs and their partner trusts had a duty under the Health and Care Act 2022 to develop 5-year Joint Forward Plans (JFPs) before the start of each financial year.

12.2 This second Joint Forward Plan (2024-2029) was setting out a renewed commitment to the delivery of the ambitions within the Integrated Care Strategy. The Plan was formed of a main document (reflecting the ICB's 10 Strategic Objectives), and an Appendix that set out, for each of our ICS Transformation Programmes, an overview of what had been achieved in 2023/2024 and future plans.

12.3 The Plan would sit alongside the Annual Report that would be published over the course of the next few weeks which would reflect achievements over the last year. The Joint Forward Plan was more of a forward view of what would be delivered together over the next few years. The Annual Report and the Joint Forward Plan would be used by NHSE for their annual assessment of ICBs.

The Chair commended the Plan which showed the system was thinking about the long term investments and to make Gloucestershire a place to be proud of. The Plan read well, was coherent and it had been pleasing to see it constructed in such an organised way.

<u>Resolution</u>: The ICB Board members:

- **Approved the 2024-2029 Joint Forward Plan**
- **Agreed 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.**

13. <u>ICB Interim Procurement Strategy</u>

13.1 MW introduced DP as Head of Procurement for the ICB to present the Procurement Strategy. The paper was being presented to seek approval from the Board for the introduction of a revised interim strategy for the Procurement of Healthcare Services following the introduction of the Provider Selection Regime from 1st January 2024. This was a positive development as it should in some instances simplify the procurement process for services.

DP explained that the strategy incorporated a Market Management Strategy and Representation (Disputes) Resolution Policy from 1 April 2024 to 31 March 2025.

13.2 JS had met with MW and DP to look at the policy and what it meant. JS informed the meeting that the Audit Committee did have a report on Procurement at every meeting and thought the Terms of Reference (ToR) for the Audit Committee could be examined to

enable this type of paper to be robustly discussed at that Committee before being presented to the Board. **Action: JS and CGi to examine the incorporation of Procurement items into the Audit Committee ToR. A flowchart to demonstrate where CSU fitted in would also be helpful.** **JS/CGi**

13.3 **Resolution: The ICB Board approved the introduction of an Interim Strategy for the Procurement of Health Care Services (incorporating Market Management Strategy and Representations / Disputes Resolution Policy*).***

14. Committee Updates

14.1 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.

14.1.1 There were no further updates to add to the papers circulated prior to this meeting.

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.

14.2.1 There were no further updates to add to the papers circulated prior to this meeting.

14.3 Chair's verbal report on the System Quality Committee meeting held on 15th February 2024 and approved minutes from 13th December 2023.

14.3.1 There were no further updates to add to the papers circulated prior to this meeting.

14.4 Chair's verbal report on the People Committee meeting held on 8th February 2024 and approved minutes from 26th October 2023.

14.4.1 There were no further updates to add to the papers circulated prior to this meeting.

14.5 Chair's verbal report on the Resources Committee meeting held 7th March 2024 and approved minutes from 16th January 2024.

14.5.1 There were no further updates to add to the papers circulated prior to this meeting.

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

15. Any Other Business

15.1 The Chair wished to raise that the processes being undertaken around the next procurement for the Out of Hours (OOH) service would be completed earlier than expected and had a very tight implementation period. It was the intention to set up an Exceptional Meeting over the 7-10 days in order to accelerate the decision. Colleagues would be in touch with members around potential dates.

15.2 The Chair brought the Board members' attention to the fact that it IB's last Public Board meeting and wanted to publicly acknowledge how important IB's input had been to the system in Gloucestershire, and how she had been a significant part of the many positive changes that had come about in the county.

The meeting concluded at 16.32pm

Time and date of next meeting

The next Board meeting will be held on Wednesday 29th May 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 – May 2024

Open actions only

Meeting Date Raised	Reference	Action	Due	Updates	Status
31/01/2024	**Min 8.18 P2 beds/EoL**	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	**July 2024**	**May 2024:** A discussion has been included on June agenda for the System Quality Committee with regards to EOL.	**Action to be Closed.**
31/01/2024	**Min 10.12 LMNS membership**	MCr to examine membership of LMNS.	**May 2024**	**May 2024:** Following the further unannounced inspection of maternity services in March 2024 the CNO has established a Quality improvement Group as part of the National Quality Board framework of surveillance. The group will focus on the top 5/10 priorities including CQC Must do actions and immediate concerns. The review of the LMNS is part of this process but has not yet been completed. The regional CNO is advising the ICB CNO on this.	**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**	**May 2024:** A detailed paper will be submitted to the July ICB Board on Migrant Health	**Action to be Closed.**
27/03/2024	**Min 8.1 Social Prescribing, CEO report**	Creative Health Consortium to be placed on a future Agenda for discussion around a Patient Story.	**Autumn 2024**	**May 2024:** This topic is on the list of patient stories for the Autumn 2024	**Action to be Closed.**
27/03/2024	**Min 13.2 Interim Procurement Strategy**	A review will be undertaken of the Audit Committee ToR to see if changes need to be made to ensure that Procurement items including the Strategy can be reviewed by the Audit Committee prior to coming to the Board for approval	**September 2025**	**May 2024:** The ToR will be reviewed and any changes will be reported and agreed by the Audit Committee in July to submit if required to the ICB Board in September .	**Action to be Closed**

Agenda Item 7

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 2024

Report Title	**Community Pharmacy, Optometry and Dental Services in Gloucestershire**					
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**		
			Strategic Executive	16th May 2024		
Executive Summary	The purpose of this presentation is to give an overview of the progress we have made since 2023 (against the 3 pillars of the Integrated Care Strategy) and highlight the core set of priorities we are now seeking to deliver across these services. Pharmacy, Optometry and Dental (POD) Services were delegated to ICBs on 1st April 2023 from NHS England South- West. Managing these services locally, gives us the opportunity to ensure that we can design services in a way that ensure they meet the needs of the local population.					
Key Issues to note	This presentation sets out how we will deliver against the 10 strategic objectives contained within the Joint Forward Plan which relate to the three pillars. The presentation provides an overview on how the ICS will: • Promote the opportunities that POD provision can have in enabling people to self-care and promoting Making Every Contact Count. • Promote the range of provision that is available across the County e.g. community pharmacies • Improve equity in access and outcomes across POD services • Attract new talent into these services as well as supporting the existing POD workforce • Address the sustainability of service provision such as Community Pharmacy, and ensuring safety in prescribing • Improve accessibility and access for patients in services such as Dentistry. The last slide details the shared priorities going forward for: **Dentistry** • To increase access to dentistry services across the population • To maximise the opportunities of collaborative working with primary care **Community Pharmacy** • To sustain community pharmacy provision across Gloucestershire (including in light of challenges associated with national funding of community pharmacy) • To ensure a timely and safe provision of medication for patients plus access to assessment and advice for low acuity conditions **Community Optometry** • To support reduce the burden of growth on ophthalmology services across Gloucestershire And across all services to support the development of the workforce.					

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There are detailed risks related to each of the key workstreams contained in local plans.			
Management of Conflicts of Interest	There were no conflicts of interests with producing this presentation.			
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)	The ICB is required to work within the delegation framework set out for POD and primary care as detailed in the MoU between NHSE and the ICB.			
Impact on Health Inequalities	See Slide 4 – Dental Decay in Gloucestershire with regard to oral health projects targeting deprivation. See Slide 5 Local Pharmacies and blood pressure checks, smoking cessation, vaccinations etc. See Slide 7 Reducing Inequalities – Homeless Eye Care Project, Eye Care Liaison Officers on Care of The Elderly Wards and a domiciliary low vision pilot.			
Impact on Equality and Diversity	Those areas of high deprivation correlate with a greater diversity of residents and workers so programmes that targets at areas of high deprivation also have an impact on equality and diversity.			
Impact on Sustainable Development	The service will be offered locally patients			
Patient and Public Involvement	The programmes of work within this presentation are informed by patient and public feedback see the Patient Story Agenda item 6.			
Recommendation	**The Board is requested to:** ▪ Discuss the pharmacy, dental and optometry programmes of work being implemented ▪ Note the Presentation			
Author	**Helen Edwards** **Sian Williams** **Adele Jones**	**Role Title**	Deputy Director of Primary Care and Place Gloucestershire ICS Clinical Lead - Community Pharmacy Integration	
Sponsoring Director (if not author)	**Helen Goodey, Director of Primary Care & Place** **Dr Ananthakrishnan Raghuram, Chief Medical Director**			

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 Gloucestershire

Agenda Item 7

Pharmacy, Optometry and Dental

Helen Goodey / Dr Raghu

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Context

- Pharmacy, Optometry and Dental (POD) Services were delegated to ICBs on 1st April 2023 from NHS England South- West. Managing these services locally, gives us the opportunity to ensure that we can design services in a way that ensure they meet the needs of the local population.

- The purpose of this presentation is to give an overview of the progress we have made since 2023 (against the 3 pillars of the Integrated Care Strategy) and highlight the core set of priorities we are now seeking to deliver across these services.

1. Making Gloucestershire a better place for the future	2. Transforming what we do	3. Improving health and care services today
• 1.1 Improving Oral Health across the Gloucestershire population • 1.2 The role of Community Pharmacies in Health Promotion	• 2.1 Transforming Pharmacy Provision (including delivery of Pharmacy First) • 2.2 Transforming Ophthalmology Services (including Community Ophthalmic Link) • 2.3 Developing the One Gloucestershire Workforce for Pharmacy, Optometry and Dental Services	3.1 Improving Access, Reducing Wait Times & Tackling Inequalities in Access: - Dentistry Access; including rapid commissioning of 10,000 additional UDAs in West Cheltenham, 2500 in Forest of Dean and plus additional access in Gloucester city as part of the new access site/ Centre of Dental Excellence - Pharmacy and Optometry Access 3.2 Safe and Cost-Effective Prescribing

Pharmacy, Optometry and Dental Services in Gloucestershire

The provision of Pharmacy, Optometry and Dental Services across the County is as follows:

Community Pharmacy

- Last year +14 million prescription items were dispensed in Gloucestershire.
- Majority of prescriptions by the 105 Community Pharmacies in Gloucestershire
- Gloucestershire has 2.6 Pharmacies per 10,000 GP patients (England average is 2.9 – range is 2.1 to 3.5)
- The number of hours provided by Community Pharmacy has been declining in recent years – from 6,178 hours in 2021 to 5,457 in 2024
- Over 80% of patients live within a 20-minute walk of their Pharmacy. Crucially access is greater in areas of higher deprivation.

Optometry

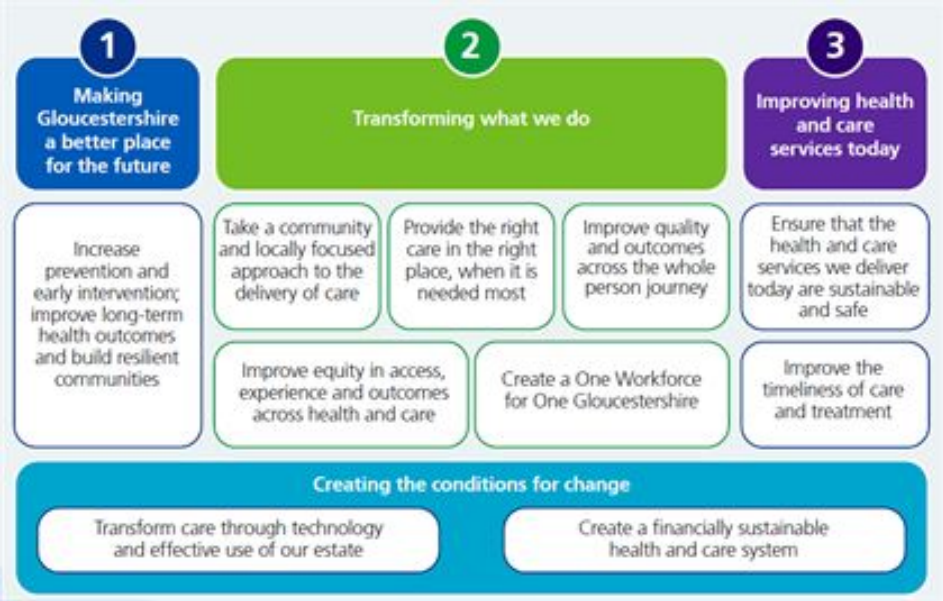
- There are 68 Optical Practices across Gloucestershire.
- There are 1.16 practices available per 10,000 population which is the highest in the South-West.
- 20% of the Gloucestershire adult population access free sight tests under the General Ophthalmic Services Contract.
- Gloucestershire has more optical practices in areas of deprivation than the rest of the South-West.

Dental

- 62 primary care dental contracts and 11 primary care orthodontic contracts.
- 30% of dental contracts are delivered from a site in a Core20PLUS5 area (patients receiving care may not be living in proximity of the practices).
- 68% of contracted Units of Dental Activity (UDA) were delivered in March 2024.
- The change in total annual contracted UDAs from March 2019 to March 2024 is 29,202 lower. However, 52,500 UDAs will be commissioned in 24/25 in areas of greatest deprivation.
- Orthodontic contracted activity remains consistent.
- 25.9% of Adults saw an NHS dentist in Gloucestershire (Jan 2024) – the second lowest access rate nationally across all ICBs & the lowest in SW.

Delivering our strategic objectives

Across Pharmacy, Optometry and Dental Services, we are delivering against the 10 strategic objectives agreed within our Joint Forward Plan.



In practice, for Pharmacy, Optometry and Dental provision this means:

- Promoting the opportunities that POD provision can have in enabling people to self-care and promoting Making Every Contact Count.
- Promoting the range of provision that is available across the County e.g. community pharmacies
- Improving equity in access and outcomes across POD services
- Attracting new talent into these services as well as supporting the existing POD workforce
- Addressing the sustainability of service provision such as Community Pharmacy, and ensuring safety in prescribing
- Improving accessibility and access for patients in services such as Dentistry.

One Gloucestershire
Transforming Care, Transforming Communities

Gloucestershire

1. Making Gloucestershire a better place for the future

The ICB is working closely with Gloucestershire County Council who have a statutory duty for oral health.

1.1 Improving Oral Health across the population including children and young people

- **16.8% of 5-year-old children in Gloucestershire have dental decay**, which varies across the county. Dental decay is strongly associated with deprivation – those in the most deprived areas experience decay.
- In response, we have mobilised a new **Supervised Toothbrushing Service** enabling children in early years education settings (particularly areas of higher deprivation) to brush their teeth with supervision from staff. 71% of the 172 schools identified have so far signed up to the programme with further work taking place to increase participation.
- A new **First Dental Steps Programme** has launched offering parents oral health advice at the point Health Visiting Teams carry out 9-month and 12-month reviews for babies.
- We are developing a new **Oral Health Promotion Service t**o enable care home residents to access dental care when it is needed.
- We are continuing to promote **Making Every Contact Count** so that there is increased promotion of the importance of good oral health.

Transforming Care, Transforming Communities

NHS Gloucestershire

1. Making Gloucestershire a better place for the future

We remain committed to long-term prevention and self-care. We are delivering this by:

1.2 The role of Local Community Pharmacies in Health Promotion

Community Pharmacies are playing an important role across Gloucestershire in health promotion. This includes:

- **CVD detection through enhanced Blood Pressure Check Service** carried out in community pharmacies for people over 40 years with the aim of reducing risk of heart attack and strokes.
- The **Pharmacy Contraception Service** enables initiation and continuation of contraception medication and wider sexual health advice.
- Support **local Smoking Cessation** programmes by enabling 'free of charge' Nicotine Replacement Therapy (NRT) via voucher schemes, behavioural support and very brief advice for stopping smoking.
- Pharmacy teams pivotal in improving public's health and offer a range of **Vaccinations** to prevent ill-health such as flu, COVID etc.

Transforming Care, Transforming Communities

NHS Gloucestershire

2. Transforming what we do

We are transforming the way we are delivering health and care services. We are achieving this through:

2.1 Transforming Pharmacy Provision (including delivery of Pharmacy First)

- We launched **Pharmacy First** in Gloucestershire in early 2024 (part of a national initiative) to make better use of clinical skills of community pharmacists and support people to self-manage their health.

Pharmacy First includes:

- Electronic referrals from Practices and NHS 111 for minor, low acuity conditions allowing assessment by a pharmacy in a consultation room.
- Electronic referrals from NHS 111 or Online for emergency repeat prescriptions.
- New clinical pathway consultations for 7 conditions including electronic referrals from Practices and NHS 111 as well as walk-ins.

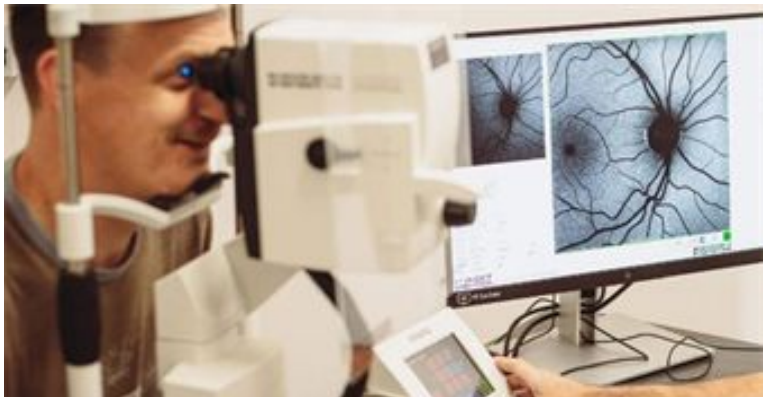
Pharmacy First is an important part of the Primary Care Access and Recovery Plan.

2. Transforming what we do

We are transforming the way we are delivering health and care services. We are achieving this through:

2.2 Transforming Ophthalmology Services (including Community Ophthalmic Link)

The **Eye Health Clinical Programme Group (CPG)** is playing a critical role in transforming eye health services across the County. Ophthalmology is the largest outpatient specialty in the NHS and referrals into secondary care ophthalmology are increasing by 2.92% per annum due to an ageing population.



Patients who wait too long to be seen or followed up are at risk of preventable sight loss.

In response, three priorities have been identified:

- **Reducing Inequalities** – Homeless Eye Care Project, Eye Care Liaison Officers on Care of The Elderly Wards and a domiciliary low vision pilot.
- **Digital Transformation** – Community Ophthalmic Link, which provides community optometrists with access to the hospital eye care record including data, referrals and images.
- **Investing in our Workforce –** Providing community optometrists with access to higher education training in glaucoma, medical retina, low vision and independent prescribing to better care for patients in the community.

2. Transforming what we do

We are transforming the way we are delivering health and care services. We are achieving this through:

2.3 Developing the One Gloucestershire Workforce in Pharmacy, Optometry and Dental Services

It is important that we support and develop the Pharmacy, Optometry and Dental workforce.

Community Pharmacy

- We want to harness the skills and capabilities of Community Pharmacist Independent Prescribers (IPs).
- We are increasing Community Pharmacist IPs by supporting study at University and learning in a prescribing environment. ½ of trainees currently working in pharmacies in areas with high health inequalities.
- The expansion of Pharmacy Technician roles is emerging with national changes planned to support further transformation and support recruitment and retention.

Optometry

- Many stable eye conditions could be care for by primary care optometry.
- We have a long history of offering enhanced services that enable this e.g. Urgent Eyecare Services.
- To continue this, the Eye Health CPG has identified that optometrists with the right qualifications could provide care on the high street rather than in secondary care.
- We are investing £67k national funding in higher education qualifications to support this.

Dental

- Developing a Gloucestershire Dental Workforce strategy & Centre of Dental Excellence in Gloucester City.
- Focusing on retention in Dentistry through incentive schemes and increasing training courses for the range of dental professionals.
- Supporting new recruitment into Dentistry through Dental Fellowships (with a particular focus on Practices in Core20PLUS5 areas) and increasing Educational Supervisors for Dentists and Therapists.

3. Improving health and care services today

We also recognise there are challenges today that we are actively addressing. We are doing this in the following areas:

3.1 Improving access, reducing wait times & tackling inequalities in access: Dentistry

We recognise that improving access across POD (particularly Dentistry) is a core priority. Our current performance is on average 68% of contracted UDA activity. As of January 2024, 25.9 % of adults (within last 24 months) and 46.3% of children (within the last 12 months) of the population of Gloucestershire accessed an NHS dentist.

For Dentistry, we are aiming to achieve this through….

- Building relationships with Gloucestershire contractors and increasing engagement to better understand local challenges & opportunities.
- Increasing Urgent Care appointment from 9 to 50 per week since December 2023 and aiming to increase this further along with over 200 stabilisation sessions a week (where a course of treatment is required), having had no uptake previously through the regional pilot programme.
- Targeting increases in primary care dentistry in areas of greatest deprivation- including in Gloucester City as part of a new access site/ Centre of Dental Excellence plus 10,000 UDAs in West Cheltenham and 2500 UDAs in the Forest of Dean.
- Developing clinical pathways (via the Dental Clinical Lead) into NHS Stabilisation appointments for medical priority patients and those not known to a local dentist.
- Investing in Intermediate Minor Oral Surgery.

NHS Gloucestershire

3. Improving health and care services today

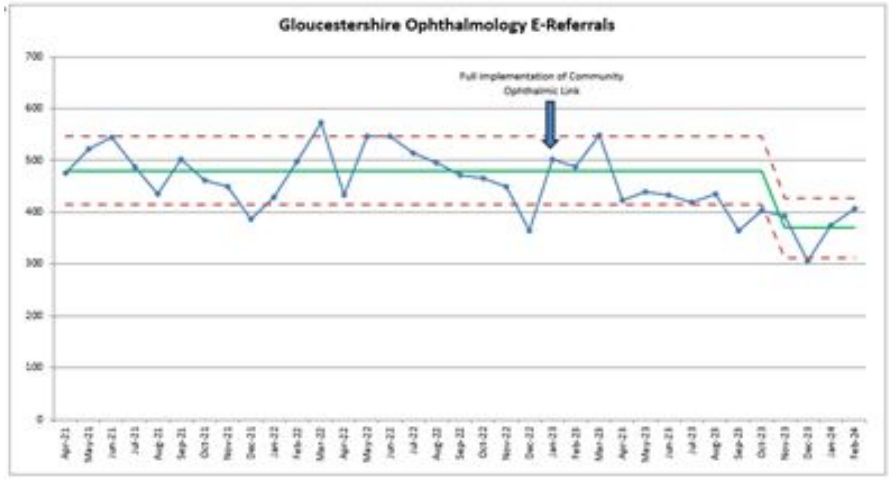
We also recognise there are challenges today that we are actively addressing. We are doing this in the following areas:

3.1 Improving access, reducing wait times & tackling inequalities in access: Pharmacy & Optometry

For Ophthalmology we are promoting the use of community optometry and improving information sharing between community and secondary care.

- The roll out of Community Ophthalmic Link (COL) has seen a statistically significant reduction in Ophthalmology e-referrals (a 24% mean reduction since January 23) and a corresponding reduction in the number of people waiting for a first outpatient appointment (a mean reduction of 16%).

We are also continuing to promote the use of Community Pharmacies (e.g. through referrals from GP Practices) whilst supporting the long-term sustainability of provision in the County.



COL has an annual cost of £140k per annum and an annual benefit of £173k in reduced first appointments. An in-year ROI of 24%

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

3. Improving health and care services today

We also recognise there are challenges today that we are actively addressing. We are doing this through:

3.2 Improving the overall provision, safety and cost-effectiveness of prescribing

- Community Pharmacy staff, GP Practice Pharmacists and ICB are actively working together to **address medication shortages** through monitoring local stock and advising on alternatives when they arise.

- The ICB Medicines Optimisation team is working with GHC on an initiative to **reduce waste and unnecessary prescriptions** by implementing a new way for GP Practices, Care Homes and District Nurses to obtain dressings.

- Work is **reducing hospital re-admissions** by making local Community Pharmacies aware of discharge and medication changes for specific patients (known as the Discharge Medication Service).

- We are continuing the focus on **reducing antibiotic prescribing and overprescribing** – e.g. engagement with Community Pharmacies to reduce prescribed opioids for chronic pain and ensuring community pharmacies only supply antibiotics as part of Pharmacy First under strict criteria.

NHS Gloucestershire

Our shared priorities going forward….

Our priorities going forward for Pharmacy, Optometry and Dental Services are:

Dentistry

- To increase access to dentistry services across the population
- To maximise the opportunities of collaborative working with primary care

Community Pharmacy

- To sustain community pharmacy provision across Gloucestershire (including in light of challenges associated with national funding of community pharmacy)
- To ensure a timely and safe provision of medication for patients plus access to assessment and advice for low acuity conditions

Community Optometry

- To support reduce the burden of growth on ophthalmology services across the Gloucestershire

And across all services to support the development of the workforce.

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 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. There is a special focus this month upon the wide range of Patient and Public Engagement work undertaken across Gloucestershire. This includes our work with our voluntary sector partners to engage people in their local health and care services.						
Key Issues to note	This report covers the following topics: • **Patient and Public Engagement update on work programme** • **Cancer Care Programme Group update** • **Respiratory Care Programme Group update** • **Prostate Cancer Awareness Week** • **Celebrating International Nurses Day** • **New Maternity and Neonatal Independent Senior Advocate Role pilot** • **Dying Matters Week** • **Community Wellbeing Service & Social Prescribing** • **Integrated Urgent Care Service for Gloucestershire patients** • **NHS encourages over 40s to get free blood pressure checks** • **Dental update** • **System Operational Planning 2024-25**						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The report references 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)	The ICB constitution includes specific requirements for the ICB to engage and involve its local communities in health services and has specific duties with regard to the public sector equality duty. s. 1.4.5(e) The public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35). s.1.4.7(f) section 14Z45 (public involvement and consultation).
Impact on Health Inequalities	N/A
Impact on Equality and Diversity	See article on Cultural Competency training (3.2); work of Gloucester University on Diversity, the work of the Partnership Board on the Autism film and composition of the Partnership Board as well as the Information Bus tours and topics.
Impact on Sustainable Development	N/A
Patient and Public Involvement (PPE)	See item on PPE with a full range of reports on how PPE is working across Gloucestershire to engage and involve people in their local health and care services.
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

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 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. Patient and Public Involvement

2.1.1 **Sharing the Power: Research Engagement Network (REN) increasing diversity in research in Gloucestershire**

Last year, One Gloucestershire set out to build a sustainable and evolving research engagement network reaching people and communities in Gloucestershire who want to be involved in health and care research and facilitating codesign of inclusive research. Funded through a competitively won grant from NHSE, this has been approached through collaborative working between NHS Gloucestershire ICB, University of Gloucestershire, National Institute for Healthcare Research, and three VCSE organisations that are trusted and embedded within some local underserved communities.

2.1.2 **What has been delivered in the first six months?**

- A Sharing the Power REN Steering Group has been established and met bi-weekly since October 2024. Meaningful relationships have developed with everyone being fully involved and having the capacity to participate. This connection has set a new tone that is broader than research, successfully moving beyond short-term conversations.
- Each VCSE partner (Inclusion Gloucestershire, The Friendship Café and Music Works) has designed and hosted (or will have) cultural competency training*, with additional colleagues beyond the Steering Group attending, thereby extending reach within the communities of interest.
- A stocktake of current and planned involvement in research amongst underserved communities experiencing health inequalities.
- Supported the evaluation of the Community-based Participatory Research (CPAR) Project facilitated by researchers from University of Gloucestershire (UoG), focussing on mental health amongst the South Asian Community in Gloucester.

- Attended CPAR community celebration events, strengthening connections across and between partners, furthering the cohesion of research initiatives across the county. As a result of the opportunities created by REN, further funding has been secured for CPAR, supporting its sustainability.
- Informed the first Research, Evaluation and Audit Strategy for One Gloucestershire Integrated Care System.
- NIHR and Inclusion Gloucestershire REN partners have trained research champions from a Muslim women's group from The Friendship Café to promote involvement in health and care research. The champions will now be holding their own events.

2.2 **Cultural Competency Training**

2.2.1 Sharing the Power Research Engagement Network members have completed two cultural competency training sessions in April 2024: Disability Awareness hosted by Inclusion Gloucestershire and Muslim community awareness hosted by, and at, The Friendship Café. The third REN VCSE Partner, The Music Works will be hosting their cultural competency training focussing on inclusive approaches and strategies to engagement and challenging behaviour when working with young people.

2.2.2 **Next Steps for the REN**

NHSE's Research Team have recently confirmed additional funding to extend the Gloucestershire REN for a further three months. Activities planned during this time include:

- A workshop for REN members to discuss development of online information to promote research in Gloucestershire with Research 4 Gloucestershire (countywide research steering group) and ICS communications/web developers. Workshop objective to consider coordination and presentation of information on existing online platforms for different audiences such as clinical researchers and community researchers and public participants from diverse and often underserved communities.
- A full day, independently facilitated, workshop focussing on reward and recognition for public participation, including in research, across the One Gloucestershire ICS, including Local Authority partners. Workshop participants will review current practices within Gloucestershire and consider national statutory and VCSE guidance. Workshop objective to develop ICS principles for reward and recognition.
- **University of Gloucestershire:**
    - Phase 2 Community Participatory Action Research (CPAR): Developing resources by commissioning Unit1 films to create a film which reflects the narratives of trauma, mental health resulting from displacement, through

journeys of reorientation and towards re-belonging. Develop the illustrative resource into physical materials, such as cards and posters, to support information sharing about mental health within diverse communities.

- Developing the Diverse Ethnic Research Alliance (DERA) identity - creating badges and lanyards, a logo and leaflets so that DERA can share their mission with the community. Also, consideration of the need for social media and an internet presence to facilitate communication and hope to connect this with the online information workshop activity above.
- Developing the method - planning a further day of training with the community researchers so they can assimilate their shared understanding into a programme or framework for a Circle of Enquiry that they can take into their communities. This would involve mentorship skills, creative and inclusive methods, and developing the circle to create trust and balance. The UoG researchers plan to evaluate this training to create a model for sharing that could be used by other community groups and researchers.

A further round of Research Champion training has been commissioned, as previously provided at the Friendship Café by NIHR and Inclusion Gloucestershire colleagues. The second round of training will focus on a group of people with learning disabilities.

The focus of the REN during this period will also be on securing sustainability with members investigating funding options. VCSE REN members agree that it is great that through the REN they: *"…have been invited to the party and asked to dance, the next question is: what's the music?"*

2.3.1 **Get Involved in Gloucestershire (GIG): New projects added:**
https://getinvolved.glos.nhs.uk/ GIG is our online participation platform where people can share their views, experiences and ideas about local health and care services.
Two new sections have recently been added to GIG:

- **Cancer:** https://getinvolved.glos.nhs.uk/cancer
  This space has been created with the help of the Gloucestershire Cancer Patient Reference Group (PRG), a group of people with lived experience of cancer. The PRG is an advisory group to the Cancer Clinical Programme Group. The space includes Useful Links and information about the PRG, Frequently asked questions such as: I'm worried about cancer: What should I do?; Where can I go for local support?; Where can I find out more about cancer? The space also features a Discussion Board for visitors to post comments and questions for the PRG to respond to.
- **Gloucestershire's Partnership Boards:**
  https://getinvolved.glos.nhs.uk/gloucestershire-partnership-boards

Gloucestershire's Partnership Boards bring together people with lived experience, families and carers, and a wide range of organisations from different sectors. This space introduces the six local Partnership Boards and the Collaborative Partnership Board, which brings together the co-chairs from each of the Partnership Boards together with representatives from the NHS, social care, and other public, voluntary and community sector partners. A new video produced by the Autism Partnership Board https://getinvolved.glos.nhs.uk/gloucestershire-partnership-boards/widgets/91281/videos/4667 was posted on the space in March 2024 and there are Useful Links to information about all of the Partnership Boards individual on the GCC website. The GIG Partnership Board space also features a News Feed https://getinvolved.glos.nhs.uk/gloucestershire-partnership-boards?tool=news_feed#tool_tab which has recently been used by the Physical Disability and Sensory Impairment Partnership Board to advertise their new Facebook page.

2.4. **Joining Up Insight in Gloucestershire (JIG): Online Insight Reports Library Version 1 is now live**

2.4.1 JIG is a central hub for collating and storing Insight gathered from people in Gloucestershire by health, care, statutory and voluntary organisations and groups. JIG has been codeveloped by members of the JIG Steering Group, which draws expertise and experience from across the One Gloucestershire ICS and the VCSE. JIG is hosted on the NHS Futures platform and is accessible to anyone who wants to join the workspace (requests to join are monitored by the ICB Engagement Manager). It holds (non-sensitive) data as themes or topics, including the source of that information. It is easily accessible to a wide range of professionals, to inform decision-making. It is open, giving wide access with the aim of increasing understanding and reducing duplication

2.4.2 It is straightforward to add an entry to JIG; with the methodology having been codesigned and tested by JIG Steering Group members. The following are examples of the information required: Document title, Organisation/Author, Publication date, a Brief summary of the document and Key recommendations. Most importantly, so that visitors can search for and find reports relevant to their search criteria, a taxonomy has been developed informed by Healthwatch England's approach, which provides a selection of choices under a series of headings including *service area* e.g. community mental health; *key themes* e.g. continuity of care , *location* e.g. Tewkesbury and *involvement method* e.g. structured interview.

2.4.3 Eight entries have recently been added to the JIG catalogue, these include: Activity on Referral: Report 2022/23 - Supporting children and young people in Gloucestershire to be more active for their wellbeing produced by Active Gloucestershire; Collaboration

between GL11 Community Hub & NHS Gloucestershire ICS Living Well With Pain Programme produced by GL11 and the ICB; Supporting people to stay healthy and well as the cost of living rises - What are the challenges and what support will make a difference? produced by Healthwatch Gloucestershire; and Community Health and Wellbeing Day at The All Nations Club in November 2023- Evaluation Report produced by the ICB.

2.5 **Information Bus – Where the Bus has visited in April and May 2024**

The One Gloucestershire Information Bus has had a very busy few months. Since 1st April 2024 it has supported the following activities:

- Fairer Contributions Policy GCC consultation at Gloucester Cross, Cheltenham High Street, Stroud CoOp, Cirencester Market and Tewkesbury Morrisons
- Know Your Patch at Coleford Clock Tower
- Wellbeing Tour at Cirencester Market Place, Stow Market Place and Moreton-in-Marsh
- Pride On Tour at Cheltenham High Street
- Bowel Cancer Awareness at The Livestock Market and Cheltenham High Street
- Carers Hub at Stratford Park in Stroud, Asda in Gloucester City, Tewkesbury Leisure Centre, Cinderford Tesco, Dursley town centre, Lydney Tesco and Bishops Cleeve Library
- Go Volunteer Gloucestershire at Tewkesbury Dobbies Garden Centre and Three Shire Garden Centre in Newent
- Sandhurst Traveller site: The Willows
- Biker Meet in Tewkesbury
- Emergency Services Volunteer Recruitment Event at Gloucester Docks
- Heart Failure Awareness at Tewkesbury Morrisons, Cirencester Livestock Marker and Lydney Tesco
- World Asthma Day at Cheltenham High Street, Dursley High Street and Gloucester Cross
- Polish Heritage Day at Gloucester Park
- Dementia Awareness Week at Cinderford, Stow-on-the-Wold, Tewkesbury and The Willows Traveller site
- Cheltenham Pride at Imperial Gardens, Cheltenham

3. Cancer Care Programme Group (CPG) update

3.1.1 Gloucestershire's Cancer Patient Reference Group comprises sixteen individuals with personal experiences of cancer, who are dedicated to improving future care and support for example collaborating with Macmillan Next Steps Cancer Rehabilitation Service and NHS professionals, they design courses and workshops for those completing cancer treatment or on long-term regimens. Meanwhile, Cancer Masterclasses, held periodically,

unite GPs to learn from specialists and patients, enhancing understanding and compliance with tumour site pathways. Notably, 63% of GP practices have attended, with over 250 views of recorded sessions.

3.1.2 Primary Care Cancer Early Diagnosis QI Projects, funded across the county, support initiatives for early diagnosis, such as a successful Facebook live "Prostate Education" session followed by a "Prostate Saturday" event, engaging over 200 men. Additionally, Cancer Community Awareness & Engagement efforts target diverse communities through various events and awareness sessions, aiming to address inequalities in early diagnosis outcomes. Looking ahead, initiatives like the Targeted Lung Health Check and Multi-Cancer Blood Test Programme aim to achieve early and faster cancer diagnoses, aligning with the goal of diagnosing three out of four cases at stages 1 or 2 by 2028.

3.2 Respiratory Clinical Programme Group (CPG) update

3.2.1 The Respiratory Clinical Programme Group planned visits to different areas of the county to support World Asthma Day. The day aims to raise awareness of asthma, talk to members of the public about their experiences of respiratory care, and dispel asthma myths such as asthma is a trivial condition that it is not serious. The team used the opportunity to give out information on exercise, breathlessness, smoking cessation, COPD and other lung conditions but asthma was the primary focus.

3.2.2 The team were able to offer advice to people regarding the expectation for their care, talk about the prevalence, morbidity and mortality from asthma, and signpost members of the public towards reliable sources of accurate information. The team also did some testing (peak flow rate and FeNO) and were able to talk more broadly about healthy lifestyle habits.

4. Prostate Cancer Awareness Event

4.1 Patients from across the TWNS PCN and further afield recently tuned in for a special Prostate Cancer Awareness event hosted on Facebook. Urology Consultant Mr Edward Tudor and GP Dr Jeremy Welch discussed the mixed messages and natural concerns regarding the prostate. The event explained what the prostate is, PSA testing, the symptoms and what happens when referred on to the hospital. A follow-up drop-in clinic was held on 11 May at the Devereux Centre in Tewkesbury for men registered with a TWNS practice who were interested in learning more or wanted a PSA test. A total of 203 men attended. A recording of the Facebook Live session is here.

5. Celebrating our talented and highly skilled General Practice Nurses on International Nurses Day

5.1 International Nurses Day was celebrated on 12 May to coincide with the birthday of nursing pioneer Florence Nightingale, so it was fitting to pay tribute to our practice nurses who play such an important role in the delivery of local healthcare services. Read more here. General Practice Nurse (GPN) and Nurse Partner Nichola Winstanley from Drybrook Surgery explains *here* why she's so passionate about being immersed in the community whilst Lisa Stoddart, Lead Practice Nurse at Aspen Medical Practice in Gloucester explains *here* why being a General Practice Nurse (GPN) is a rewarding and dynamic career choice.

6. New Maternity and Neonatal Independent Senior Advocate Role pilot launched

6.1 A new role being piloted in Gloucestershire is supporting families who have experienced an adverse outcome during their maternity or neonatal care. The Maternity and Neonatal Independent Senior Advocate (MNISA) will ensure the voices of families who have experienced an adverse outcome are listened to, heard, and acted upon by their maternity and neonatal care providers. Details are here.

7. Dying Matters Week

7.1 We know it can be hard to talk to loved ones about death and preparing for the end of someone's life. It is a conversation which is so easy to put off for another day, but communicating your wishes early can really make a difference. Dying Matters Week aims to normalise conversations about death, and to mark this week, the NHS in Gloucestershire launched a new digital resource to help families, carers and those facing End of Life Care. Read more here.

8. Community Wellbeing Service and the future of social prescribing

8.1 NHS Gloucestershire and Gloucestershire County Council have carried out extensive engagement and evaluation of the Community Wellbeing Service (CWS) and the wider social prescribing offer in Gloucestershire over the last 18 months to understand how it is working in practice and to inform future developments. Using this feedback and following an options appraisal, we have concluded that a new social prescribing model is required to meet the needs of local people. We will therefore not be recommissioning the CWS when the contract ends on 30 September 2024. The decision is based upon an evaluation of the service and the changing context of wider health and care options, with more one to one support available through other similar services. Read more here.

9. Integrated Urgent Care Service for Gloucestershire patients

9.1 Gloucestershire Health and Care NHS Foundation Trust has been awarded the contract to provide an Integrated Urgent Care Service (IUCS) for local patients from November 2024. IUCS includes NHS 111 (telephone and online), a local Clinical Assessment Service offering patients access to general and specialist advice from clinicians where appropriate and the Primary Care Out of Hours service. IUCS will play a key role in helping people to get timely, joined up advice and the right service to meet their needs, 24 hours a day, 7 days a week. Services delivered by community pharmacies, GP surgeries, dental practices, community minor illness and injury units and A&E departments in the county will continue to be provided. Read more here.

10. **NHS encourages over 40s to get free blood pressure checks**

10.1 To mark World Hypertension Day on 17 May 2024, Gloucestershire's pharmacies have reminded people over 40 about the importance of having regular blood pressure checks. The theme of the awareness day is to "Measure Your Blood Pressure Accurately, Control It, Live Longer"**,** a message which aims to get people across the world to think about how accurate blood pressure readings can help to reduce their risk of stroke, cardiovascular disease and kidney disease.

11. **Dental Update**

11.1 On 7th February, Department of Health and Social Care published its Dental Recovery Plan with the ambition to make dental services faster, simpler, and fairer for our population. The vast majority of the schemes included within the recovery plan were already encompassed within the ICB's Dental Commissioning Plan which was approved by Primary Care and Direct Commissioning Committee members during their meeting in April.

11.2 Access to NHS dentistry is a key priority for the ICB. To date we have commissioned in excess of 50 urgent appointments and 200 appointments for stabilisation (a course of treatment following an urgent issue) each week for people who do not have a dental home. Patients with an urgent dental need can access the urgent appointments via NHS111. In addition, our Dental Clinical Lead, who took up post in December, has developed clinical pathways into the stabilisation appointments (for patients who require a dental review prior to specific medical treatments). Our next step is to secure new routine access in the most deprived parts of the county including but not limited to a Centre of Dental Excellence in Gloucester City. Whilst the Dental Recovery Plan promotes the short-term use of a dental van to improve access, in this county we would prefer to utilise funding to secure sustainable access for patients.

11.3 To support access in the longer term, we are developing a Dental Workforce plan for the county which will encompass the range of Dental Care Professional (DCP) roles. In the interim we have offered an incentive grant with the aim of retaining dentists in county to deliver NHS activity as they come to the end of their foundation training year. This is in addition to the Golden Hello referred to in the Dental Recovery Plan, the details of which are being worked through currently. Work is being undertaken with the South West Deanery to increase the number of Dental placements and to introduce Dental Therapist placements.

11.4 Improving the oral health of the population in Gloucestershire is a statutory duty of the County Council and we work closely with our colleagues in Public Health to do this. The recently commissioned Supervised Toothbrushing programme is operational in county. Schools were selected to participate in the two-year programme based on their geographical location and an assessment of need, with priority given to schools in the Core20 areas. The programme is aimed at schools, nurseries attached to schools and special schools for children aged 3 to 5 years old. 71% of the 172 identified schools have agreed to host the programme. Toothbrush packs have been delivered and training is being carried out in the schools, together with talks on oral health and question and answer sessions for parents delivered in person.

11.5 In addition, Health Visiting teams in the county are delivering First Dental Steps. First Dental Steps is a new offer in Gloucestershire which forms part of each baby's health and development review at 9 to 12 months of age, undertaken by the health visiting team. Language and learning, safety, diet and behaviour are included as part of the review, together with oral health advice and the provision of a dental pack. These packs are currently being distributed to health visiting teams. The programme also includes a pathway for referral to the Community Dental Service for some specific groups of children (namely for Children in Care, those with a Child Protection Plan, those with Special Educational Needs or for children where an older child in family has had an extraction under General Anaesthetic).

11.6 Whilst our focus to date has been primary care dentistry, we do acknowledge pressures in secondary care and plan to bolster capacity in Intermediate Minor Oral Surgery imminently. We continue to engage with dental primary care contract holders in county and are hosting our second engagement event in June.

12. System Operational Planning 2024-25

12.1 Further to the detailed briefing provided to the Board at our last meeting, on the 2nd of May we submitted the final version of the Gloucestershire system Operational Plan for 2024/25.

12.2 This is a response to specific areas of focus determined by NHS England through the publication of the annual Operational Planning Guidance and sits alongside the other system plans. Publication of this year's planning guidance was delayed until the end of March, with the knock-on impact of this delay resulting in submission of the full plan being required on 2nd May.

12.3 Our Operational Plan for 2024/25 has been developed collaboratively by system partners and reflects the 2024/25 priorities for our ICS and the national priorities set out within the 2024/25 planning guidance. The submitted plan makes a series of system commitments to strong performance across a range of measures including; cancer performance, reduction and elimination of 65 week waits by September, with no patient waiting 78 weeks for elective care, improving Mental Health and Learning Disability & Autism standards and community services.

12.4 Gloucestershire ICB also plans to exceed the national performance objective for 62-day cancer pathways (62 days or less from receipt a referral of suspected cancer to initiation of treatment). The national guidance stated that by the end of the financial year ICBs should seek to ensure 70% of confirmed suspected cancer referrals receive treatment within 62 days of referral. Our plan commits to stretching this target to ensure that in 75% of cases treatment is started within 62 days.

12.5 We have also committed to improving urgent and emergency care pathways, improving performance against the '4-hour target' (arrival to treatment in an urgent setting) to 77% by June, and maintaining this position through the rest of the year, improving to 78% in March.

12.6 Stretching performance objectives in the planning guidance, combined with the aim to achieve continual improvement in the quality, performance and productivity of services must always be balanced with affordability. This year's planning round has been especially challenging in this regard, with increased pressure resulting from (amongst others) the impacts of inflation and industrial action.

12.7 Despite substantial progress being made through the planning round to reduce the size of the financial deficit, the submitted plan as at 2nd May contained a system deficit position of c.£15m (in the context of an overall annual budget of c.£1,100m). This financial position also includes significant savings plans for both the ICB and providers which have to be delivered. These represent a significant financial risk to the system if there is slippage or non-delivery of the schemes.

12.8 Since the submission of the 2nd May plan, work has continued at pace in order to identify further savings to deliver a balanced position for 2024/25 and we have now submitted a plan which shows breakeven but requires more work to finalise all savings plans. Despite the pressures, we continue to invest as system in key areas to support performance delivery and service transformation, for 2024/25 examples of this include:

Investment	Performance expectation
Angiography	Angiogram, angioplasty and pacemaker backlog clearance at GHFT. Supports reduction in long waits overall and removes pressure on urgent angiography procedures.
Endoscopy	Additional endoscopy staff to support backlog clearance at GHFT. Supports reduction in long waits for diagnostic tests and long waits on the RTT list. Helps to support delivery of cancer waiting time standards.
ENT	Additional theatre lists and outpatient activity at GHFT – to assist in reduction of long waits for elective care.
Oral Surgery	Additional capacity via locums at GHFT – to assist in reduction of long waits for elective care.
FIT testing	Provision of FIT testing in primary care – supports prioritisation of urgent cancer cases and assists in the management of patients with Lower GI symptoms.
ARI Hubs	Acute Respiratory Infection Hubs – to reduce demand on UEC services and primary care in the management of patients with respiratory conditions (supports UEC target delivery and primary care capacity).
MIIU Triage line	Supports UEC services with patient access to the right service at the right time and helps increase patient usage of MIIUs (GHC).
Elective Care Hub	Patient Access Support Team – linking patients to appropriate services such as social prescribing while waiting. They can also escalate their case to an appropriate clinician if their condition has deteriorated or remove patients from the waiting list who no longer wish to proceed with treatment.

12.9 The planning guidance also requires that a workforce cap should be applied, set at month 7 of 2023/24 for systems forecasting a deficit position. Changes during months 8-12 of 23/24, and our MHIS, ERF and other changes for 2024/25 (such as recruiting to vacancies within the budgeted establishment) result in our submitted plan not being compliant with the workforce cap. We have explained our rationale in relation to this as part of our submission.

12.10 A final submission will be made to NHSE in June and Operational Planning formal closedown letters are expected to be received from NHSE towards the end of June. We will report our progress in delivering against the commitments set out within the plan as part of our normal reporting arrangements to the Board and the key sub-committees.

13. Recommendation

13.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 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	07/05/2024 14/05/2024	Strategic Executive	16/05/2024			
Executive Summary	The BAF was refreshed in October and November to align with the three pillars, updated strategic objectives and the key priorities. A number of key changes were made following board members feedback at the ICB Board in November, January and most recently in March. Feedback has been obtained from system partners at the Audit Committee meeting in March and Quality Committee in April as well as the Primary Care & Direct Commissioning Committee in April. The feedback obtained from the committees has resulted in a review of key risks related to EPRR, Quality and Recovery as well as Primary Care. Below provides a summary of those changes. The next iteration of the BAF will be updated to reflect the 10 key strategic objectives aligned to the three pillars in the Joint Forward Plan.						
Key Issues to note	**Key issues to note** • **BAF 4 Quality Risk** has been reappraised by the Chief Nursing Officer & Chief Medical Director the risk scored 5x2 = 10 in March 2024 and has been reviewed and rated 4x4 = 16 following a meeting with GHFT CNO and a review of GHFT quality risks. The actions have been updated, risk alignment with other corporate risks, partner risks and a full Director's update is provided. • **BAF 7 Recovery / productivity risk** has been reappraised following the Audit Committee & Quality 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. There have been significant updates made to the actions and a comprehensive Director's update. **Other changes since March 2024 report** • BAF1 Health Inequalities risk has been significantly updated with updates to the controls, actions and Director's review. There is no change in the risk score since the March report. • BAF2 community and locality transformation has been re-aligned with the Director of Primary Care & Place, the actions and Director's progress report updated. There is no change to the risk scoring since the March report. • BAF 3a People and Culture risk, has been reviewed, key priorities have been updated; the controls, actions and Director's update have all been reappraised and have been significantly updated. There is no change in risk score since the March report. This risk has been reviewed by the People Committee on 16th May 2024.						

	• BAF 3b Equality, Diversity and Inclusion will be further updated at the People Committee which takes place on 16th May, in the meantime the controls, actions and Director's update have been updated to reflect recent progress. There is no change in risk score since the March report. • BAF 5. Urgent and Emergency Care risk, has been reviewed with updated controls and actions (see 1 and 2) and a review and update of the Director's comments (1,3 and 5b). There is no change in risk score since the March report. • BAF 6. Primary Care risk had been rearticulated and updated with an increased risk rating from 16 to 20, this followed on from a PCDC Committee meeting held on 1st February. This risk has been reviewed and actions and Director's progress report updated; the risk rating of 20 remains the same as last reported in March 2024. • BAF 8 Mental Health services; this risk has been reviewed with significant updates made to the controls, gaps in controls, assurances and KPIs. The risk score remains unchanged since the March report. • BAF 9 Financial Sustainability risk; this has been reviewed and updates made to the alignment of this risk with risks on the corporate risk register; the actions and Director's report have been updated. The risk scoring remains unchanged since the March report. • BAF10 Estates Infrastructure risk this has been reviewed and updates made to the alignment of this risk with risks on the corporate risk register; the actions and Director's report have been updated. The risk scoring remains unchanged since the March report. • BAF 11 EPRR is included as the ICB is a Category 1 Responder. There is an update on gaps in controls and the Director's report has been updated. The current risk rating remains unchanged and will be reviewed for the next iteration of this report. • BAF 12 Cyber Security risk has been reviewed and actions updated; the Director's report has also been updated. The risk scoring remains unchanged since the March report.
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 All risk scoring has been reviewed and the target risk (impact) now aligns with the current risk impact.
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 is a risk pertaining to health inequalities within the BAF see BAF 1.
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 and review the changes made to the quality risk and recovery risk. • 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 MAY 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	02/05/24	Dir Operational Planning & Perf	**4x3=12**	**4x3=12** ***(unchanged)***	**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	30/04/24	Director of Primary Care & Place	**4x3=12**	**4x3=12** ***(unchanged)***	**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	23/02/24 ***(next review at People Committee 16/05/24***	Dir of People, Culture & Engagement	**4x4=16**	**5x4=20** ***(unchanged)***	**5x1=5**	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	23/02/24 ***(next review at People***	Dir of People, Culture & Engagement	**4x3 = 12**	**4x3=12** ***(unchanged)***	**4x1=4**	People Committee

		inclusive, diverse and engaging culture for staff we employ		***Committee 16/05/24)***					
	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	13/05/24	CNO & CMO	**5x3 = 15**	**4x4 =16** ***(increase and reappraised risk)***	**4x1=4**	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	14/05/24	Deputy CEO / Dir Strategy & Transformation	**5x4=20**	**4x3=12** ***(unchanged)***	**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	30/04/24	Director of Primary Care & Place	**4x4=16**	**5x4=20** ***(unchanged)***	**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	02/05/24	Director of Operational Planning & Perf	**4x4=12**	**4x4=16** ***(increased)***	**4x1=4**	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	19/04/24	Director of Integration	**4x3=12**	**4x3=12** ***(unchanged)***	**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	17/04/24	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16** ***(unchanged)***	**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	17/04/24	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16** ***(unchanged)***	**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	13/05/24	Chief Nursing Officer (CNO)	**4x3=12**	**4x4=16** ***(unchanged)***	**4x1=4**	Quality Committee Audit Committee (IA report)
	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	13/05/24	Chief Clinical Information Officer	**5x4=20**	**5x4=20** ***(unchanged)***	**5x2=10**	Audit Committee

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

Key changes since March 2024 report

- **BAF1** Health Inequalities risk **has been significantly updated with updates to the controls, actions and Director's review. There is no change in the risk score since the March report.**
- **BAF2** community and locality transformation has been re-aligned with the Director of Primary Care & Place, **the actions and Director's progress report updated. There is no change in the risk scoring since the March report.**
- **BAF 3a** People and Culture risk, **has been reviewed, key priorities has been updated; the controls, actions and Director's update have all been reappraised and have been significantly updated. There is no change in risk score since the March report. This risk will be reviewed at the People Committee on 16th May 2024.**
- **BAF 3b** Equality, Diversity and Inclusion **will be further updated at the People Committee which takes place on 16th May, in the meantime the controls, actions and Director's update have been updated to reflect recent progress. There is no change in risk score since the March report.**
- **BAF 4** Quality Risk has been reappraised by the Chief Nursing Officer **the risk scored 5x2 = 10 in March 2024 and has been reviewed and rated 4x4 = 16 following a meeting with GHFT CNO and a review of GHFT quality risks. The actions have been updated, risk alignment with other corporate risks, partner risks and a full Director's update provided.**
- **BAF 5.** Urgent and Emergency Care risk, has been **reviewed with updated controls and actions (see 1 and 2) and a review and update of the Director's comments (1,3 and 5b). There is no change in risk score since the March report.**
- **BAF 6.** Primary Care risk had been rearticulated and updated with an increased risk rating from 16 to 20, this followed on from a PCDC Committee meeting held on 1st February. **This risk has been reviewed and actions and Director's progress report updated; the risk rating of 20 remains the same as last reported in March 2024.**
- **BAF 7** Recovery / productivity risk **has been reappraised following the Audit Committee & Quality 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. There have been significant updates made to the actions and a comprehensive Director's update.**

- **BAF 8** Mental Health services; **this risk has been reviewed with significant updates made to the controls, gaps in controls, assurances and KPIs. The risk score remains unchanged since the March report.**
- **BAF 9** Financial Sustainability risk; **this has been reviewed and updates made to the alignment of this risk with risks on the corporate risk register; the actions and Directors report has been updated. The risk scoring remains unchanged since the March report.**
- **BAF10** Estates Infrastructure risk **this has been reviewed and updates made to the alignment of this risk with risks on the corporate risk register; the actions and Directors report has been updated. The risk scoring remains unchanged since the March report.**
- **BAF 11** EPRR is included as the ICB is a Category 1 Responder. **There is an update on gaps in controls and the Director's report has been updated. The current risk rating remains unchanged and will be reviewed for the next iteration of this report.**
- **BAF 12** Cyber Security risk **has been reviewed and actions updated; the Director's report has also been updated. The risk scoring remains unchanged since the March report.**

NB. Target risks aligned to current risk impact.

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 a health inequalities and prevention approach.** **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**	⟷ ***unchanged since March report***
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:**	**2 May 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. • Health inequalities is a standing item at the Planned Care Delivery Board. • Integrated Locality Partnerships take a place-based approach to identify priorities for addressing the root cause of health inequalities. • Consideration of health inequalities as part of service development and change through application of Equality and Engagement Impact Assessments.	• 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. • No routine or consistent collection of evidence or reporting of how successfully interventions are addressing health inequalities.	• 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. • Lack of clear governance and accountability structures in place for the prevention and health inequalities agendas.

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 of health inequalities reporting including of annual published report on Health Inequalities across programme areas in line with our legal duties on Health Inequalities is currently in progress. 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).	**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. This has informed the development of a Prevention Framework for the ICS. 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 Health Inequalities Framework for the ICS has been developed and was adopted by members of the ICB Board in February. This will be used as a mechanism for programmes to report on their contribution to addressing health inequalities. 5. Development of a reporting template to enable partners to report the work that they are doing in relation to the framework, allowing us to track outcomes and guide priorities. 6. 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).

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. 9. Stocktake of prevention and health inequalities initiatives (has been completed) allows identification of gaps and opportunities 10. System representation at Regional Inequalities Group and links with local and regional networks. 11. . 12. Insights Hub being developed. 13. Project to increase and improve engagement with underserved communities in Gloucestershire around research is soon to be completed. 14. EAC-I is being re-established and will provide governance and oversight of work taking place across the system to tackle health inequalities. 15.	7. 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. 8. 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. 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. 10. 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. 11. We are holding a Leadership Development session on 28th June with senior leaders and practitioners from across the system to promote our strategic approach to addressing health inequalities in Gloucestershire and embed it into business as usual.
	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.

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 challenges in 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**	⟷ ***unchanged since March report***
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	Risk of instability and resilience in general practice.				
Committee	**Quality Committee**	**Last Review & Updated:**	**30th April 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 health & care workforce and the introduction of new models of care • UEC prevention workstream adopting a population health approach to support those at greatest need and risk of deterioration.	• Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. • Sufficient change management resource to deliver sustainable change across the ICS in the timeframe required. • Permission & time for operational staff to actively engage.	• Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG) • Reporting through the UEC prevention programme. • Ongoing monitoring	• Further development of the performance and benefits realisation trajectories required.

• Working with BI colleagues to understand our cohorts. • Supported by 24/25 PCN Network Contract Specification - *A PCN must contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission, by risk stratifying patients and offering care in accordance with the guidance. This must be done as part of INTs, with the aim of reducing avoidable exacerbations of ill health, improving quality of care and patient experience, and reducing unnecessary hospital admission*. Pg43. • Three pilots will help further evaluate the Whiteboard.			

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• Board development session at end of October agreed an approach to support integrated working using the prevention of frailty as a worked example. • GNTG members to promote approach with individual organisational Boards to endorse this way of working and give permission for staff, at Neighbourhood level, to work differently. • A proposal on implementation together with a roll plan and timeframes presented at GNTG meeting in January. • Oversight and assurance of UEC prevention workstream through UEC Transformation Board & Steering Group	• Support from One Gloucestershire Improvement Community in place. • Two workshops for first three Neighbourhoods took place in February and March. Opening remarks from CEO of GHC giving permission for staff to work differently and encouraging staff • Project managers identified for each of the first three Neighbourhoods • Support for Neighbourhood estates solutions available from Community Health Partnership (CHP). • Integrated Locality Partnership (ILP) work plans aligned to focus interventions to support pre frail and mildly frail people. • Proactive care strategy drafted.

	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					
24-25 key priorities: Increase staff retention, provide good training and development opportunities 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 key staffing groups **Impact**: Increased pressure on existing staff, impacting staff morale and wellbeing, and impacting on bank and agency targets for 2024-25.	**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**	**5x1=5**	↔ ***unchanged since March report* (see director's update)**
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	**GHFT SR16** Inability to attract and recruit a compassionate, skilful and sustainable workforce (risk rating 20) **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 further 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:**	**16 May 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 all available resources from NHSE monies for Continuing Professional Development and leadership development to support staff training & development • Some leadership learning and development programmes in place	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	• 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. • Reduced funding for workforce transformation and remaining uncertainty relating to 2024/25 funding mechanisms to sustain targeted work.

• People Promise Leads in both Trusts focusing on all aspects of People Promise elements and best practice • System level delivery plans focusing on agreed priority areas for action in 24/25 for each Steering Group. • Robust organisational plans in place for EDI, retention and temporary staffing spend reduction. • Colleague Communications & Engagement • System-wide careers and engagement team (2 year FTC) focused on promoting careers in health and care	across ICS and make an assessment of needs and gaps)		
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. Appointment of People Promise Leads in both GHFT and GHC. 2. System wide EDI actions focusing on 3 areas, data, anti-discrimination & recruitment/career progression 3. Collective focus on agency and temporary staffing spend in response to revised 3.2% target for 2024/25, zero off-framework usage from July 2024 and no revenue non-clinical agency usage from April 2024 4. On-going recruitment activities at organisational level Roll out of system wide recruitment promotion campaign "Be in Gloucestershire" 5. On-going focus on health and wellbeing initiatives for staff including development of pilot new starter induction and staff housing hub		1. Appointed leads start in May 2024 2. ICS workforce analyst supporting re-presentation of EDI, aim for completion by end of May 3. 3.7% cap met in GHC at March 24. Actions plans for 25 being further developed. 4. Campaign branding approved, Be a GP In Glos nearing completion. 5. HWB strategy drafted, pilot new starter induction planned 9th May, 6. Regional conversations to establish housing hub ongoing, Homeshare element continues to be provided (by Age UK) 7. The People Committee (held on 16/05/24) discussed the importance of keeping the focus on workforce and noted that the high risk score of 20 was in recognition of the many and emerging risks facing the system. However, the positive work undertaken on reducing agency spend, reducing turnover and new initiatives such as We Want You were acknowledged.	
	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 and • 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**	**4x1=4**	↔ ***unchanged since March report***
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	**GHFT SR16** Inability to attract and recruit a compassionate, skilful and sustainable workforce (risk rating 20) **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** 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)				
Committee	**People Committee**	**Last Review and Updated:**	**23 February 2024 (next review date 16 May 24 after paper distribution)**		

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**
• Reporting through the ICS People Governance Groups • 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 task and finish group	Lack of system wide improvement targets for • Recruitment • Movement between pay bands • Insufficient frequency in metrics related to engagement and staff experience • Significant volume of data but more granular analysis required to support improvement plans	• Reporting to the People Board, People Committee & relevant Committees of providers • Reporting to the ICB Board • Audits undertaken by Internal Auditors	People Committee requested further system wide focus and commitment to discuss improvement trajectories.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
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 6. System wide commitment to support agenda prioritising: o Data collation and presentation, o anti-discrimination policy and practice & o recruitment/career progression		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 July People Committee. 2. EDS2 Assurance Report to March Board and published on ICB's Board website 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).	
	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.		

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**	**4x4=16**	**4x1=4**	***Increase in score from last reporting period (March 24) from 5x2 =10 to current score 16 (see director's update)*** ↑
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) **GHFT SR1** Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System (risk rating 25) **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** Maternity services recent inspection March 2024 - GHFT issued with a Section 31 letter of intent related to safety and learning including Women unable to access first trimester antenatal screening or growth scans; Massive obstetric haemorrhage; 3rd and 4th degree tears – significantly outside of national parameters. **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:	13th May 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**
• 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 • Rapid Review and Quality Improvement Groups where appropriate for specific service areas challenged	• 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 4. Established Quality and clinical gov internal ICB group – first meeting 30th May 2024		1. The System Effectiveness Group has been revamped and is now led by the Chief Medical Officer (CNO). 2. PSIRF now in place although early days of new approach. 3. This System Patient Safety and Learning Group and weekly Patient Safety Huddles now in place to triangulate hotspot information across the system, including Primary Care and POD. 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. CNO to establish an internal ICB Quality and Clinical Gov group to more formally bring together triangulated data across the system to promote learning and ensure focus support on challenged areas. 5. System Mortality: The national ONS/NHSE data tool, shows SHMI to be 'Higher than Expected'. This figure is different from the figures based on Healthcare evaluation data (HED).	

		There are questions raised about the accuracy of data including coding which is a risk. This is being reviewed by the CMO at the system mortality group working with the acute trust and further discussions will be held to collectively explore the trends and issues and to implement required actions. 6. Rapid Quality Review underway for Massive Obstetric haemorrhage with external lead. 7. Quality Improvement Group (QIG) established for maternity services May 2024. 8. Significant challenges within UEC and GHFT risk rated at 25.
	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**	⟷ ***Unchanged from March report where risk was scored as 4x3=12***
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:**	**14/05/2024**		
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, with a focus on quality and outcome measures. • Impact of operational demand on 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, with further iterations of trials through first half of 2024 dependant on learning (Action adapted to account for PDSA / Trial methodology).		• 1. All workstreams have a trial mobilised or are in further iterations of trials (as at May 2024) Hospital Flow workstream is in roll out phase due for completion by June 2024.	

• 2. Learning from Systemwide Event (Sept 2023) being factored into Transformation Programme (action completed, to be closed). • 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).	• 2. Systemwide Event has been held and actions factored into the programme. Action complete (as at February 2024). • 3. Programme metrics for Working as One are in place. Workstream measures have been developed. Action remains open whilst quality and outcome measures are refined, alongside automated reporting • 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 to create an improvement plan. Plan on Page agreed by system and shared with regional NHSE, SWASFT and ICB colleagues as part of SWASFT contract arrangements. • 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 general practice due to increasing costs and financial risk to delivery and capacity 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. This will be further compounded by potential primary care national industrial action during 2024/25, following BMA Letter (18th April 2024) to all ICBs. LMC advising potential timings will be Q2 onwards. **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)				***unchanged since March report where risk was scored 5x4=20***
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:**	**30 April 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**
• 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) has been developed 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	• Awaiting national DDRB (Independent review body on doctors' and dentists' remuneration Board) pay award decision on GP Contract • Details on when the primary care industrial action will be undertaken and level of industrial action to determine which areas of work/system this will impact	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. The resilience and sustainability of General Practice Sub Group (which includes LMC representation) has been established and is monitoring the situation with regard to Industrial action.	• Volume of shared care and additional 'discretionary' activity, are both unknown with regard to potential industrial action.

• Partners Survey to understand current position on retirements • Primary Care Audit undertaken to understand what is driving increased demand • ARR underspend process completed to enable PCNs to maximise recruitment. • Primary Care Strategy is in place with associated plans • ICB & LMC working with secondary care colleagues (GHFT) to brief them on potential national primary care industrial action and potential impact to their services • Secondary Care/Primary Care Interface Group (senior leads level) has been established and will be briefed and kept updated on potential industrial action as potential impact could heavily focus on the 4 key areas of the interface work			
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 • Primary Care Resilience and Sustainability Subgroup are working with the Primary and Secondary Care Interface Group to ensure a shared understanding of the potential impact of industrial action.		• Working closely with the LMC to understand the potential impact to general practice capacity, due to the sustainability challenges • Regularly surveying practices to understand impact to capacity, particularly urgent on the day care • Resilience and Sustainability sub group - focussed on understanding the impact on general practice and ensuring we are developing action plans to support mitigations • Financial Awareness Training is being developed for all partners and practice managers	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Reporting on Access to Primary Care and 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=16**	**4x1=4**	 ***Increase of this risk from***
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				***3x4=12 since March report***
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:**	**02 May 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 Now being agreed for submission on the 2nd May. Monitoring progress through Planned Care Delivery Board (ICS level meeting with GHFT represented). 2) Additional capacity investments via ERF are being agreed through system prioritisation process. 3) Two new theatres at CGH now operational. 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 9) Patient Engagement Portal phased implementation 10) Renewed OP transformation programme underway at GHFT including roll out of patient portal and Going Further Faster GIRFT initiative		1) Operational planning for 2024/25 being finalised and signed off by all system partners. ERF to continue through 2024/25 with system aiming to achieve significantly higher recovery than the 2023/24 position (which was impacted by industrial action) in addition to 5% productivity increase. 2) All ERF and High Risk investments are being assessed through NHSE triple lock process to assure financial value for money and achievement. Business cases for all key investments have been worked up for system support. 3) Divisions have identified baseline capacity and efficiency expectations and then remaining activity required to deliver waiting time targets. 4) Community Diagnostic centre now open, creating significant additional capacity. 5) ISP contract and activity negotiations underway. 6) 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. 7) Patient Engagement Portal (PEP) go live in April 24 8) Going Further Faster GIRFT initiative to be undertaken in 19 outpatient specialties. Handbooks and self-assessment checklist have been shared and programme being developed.	
	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**	↔ ***Unchanged risk score since March report***
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:**	**19th April 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 has officially finished as of end of Q4 23/24. The process of transferring to BAU is in progress. Service specification has been drafted for key transformational changes. 6 month extension to programme management agreed. ICB PM resources released to support UEC MH programme/Right Care Right Person.	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 ICB PM resource that supported CMHT will now be used to support UEC mental health programme which was previously reported as a gap. 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. • Neurodevelopment Project Team established between GHC/ICB to oversee development of new pathways including working on shared care issues between primary/secondary care.	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.		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.	

	• •Regular reporting to the Children's Mental Health Board and Adult Mental Health Board • •SEND inspection complete and ICB SEND programme board established. • Work is progressing in this area.	Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy. 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 CMHT Access APHC for SMI	

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**	↔ ***Unchanged since March report***
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 9 - The ICB does not meet its breakeven control total in 2024/25 (noted that these risks are to be updated on ICB risk management system) F&BI 10- The ICS does not meet its breakeven financial duty in 2024/25 (noted that these risks are to be updated on ICB risk management system)				
Committee	**Audit Committee / Resources Committee**		**Last Review & Updated:**	**17th April 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 Plan in place and further development in progress • Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme	• Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. • Methodology on realisation of productivity benefits 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 • Monitoring of workforce numbers is incomplete currently across the system		• 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	

		• 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 progressing and plans for new financial year being included, control review is ongoing. Reporting through to the GHFT Finance Committee. • System savings plan for new year and longer term in development, monitoring of progress and delivery by individual organisation and at system level each month to Executives.		• Work underway within GHFT on changes in productivity since 2019/2020 key areas of focus identified and programmes in outpatients and theatres progressing, impact being brought into elective recovery programme • Actions to identify non recurrent measures to help close the financial gap in the plan for 24/25 progressing. • Workforce monitoring for budgeted and worked WTE progressing with monthly reporting and monitoring within organisations and to the system in development.	
	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**	⟷ ***Unchanged since March report***
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 11** - 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:**	**17th April 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 • 24/25 capital programme agreed with focus on mitigating highest risks			• Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed, • ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS, deadline end of July 24 for completion		
	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**	↔ ***Unchanged since last report March 24***
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:**	**13 May 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	• BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium		

	• 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 resources within the EPRR team (the team are currently reviewing capacity and benchmarking against other ICBs)	assurance for design and effectiveness	recommendations (November 2023). • 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. Band 4 admin/ERPP assistant now being recruited to support team System wide EPRR exercise 'Sabulite' has now taken place and learning to be shared to support more robust incident response procedures
	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**	**5x2**	↔ ***Unchanged from March report***
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:**	**13 May 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.			• The ICB Board Cyber development session in December was positively received. • The annual cyber incident response exercise was on 12th March and was well attended. This gave chance to review improvements from last year's exercise and the SWASFT cyber incident.		

- 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 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 29th May 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 is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for May 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 M12 reports) • 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.						
Key Issues to note	Areas of key exceptions have been included at the front of the Integrated Performance Report.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The Integrated Performance Report (IPR) provides an overall summary of the current position of health and social care in Gloucestershire. Issues in delivery will have an impact on our ability to deliver against the priorities for the health and care system that we have committed to. Our performance also feeds into the NHS Oversight Framework and influences segmentation decisions made by NHS England. There is a close link between the risks within the BAF and delivery of our objectives through the Integrated Performance Report.						
Management of Conflicts of Interest	None						

Resource Impact (X)	**Financial**	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** **Jess Yeates**	**Role Title**	Senior Performance Management Lead Director for People, Culture & Engagement Finance Programme Manager Senior Manager, Quality & Commissioning Programme Director – PMO & ICS Development ICS PMO Coordinator	

Sponsoring Director (if not author)	**Performance:** **Mark Walkingshaw** **Workforce:** **Tracey Cox** **Finance:** **Cath Leech** **Quality:** **Marie Crofts**	**Role Title**	Director of Operational Planning & Performance Director for People, Culture & Engagement Chief Finance Officer Chief Nursing 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

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Integrated Performance Report

May 2024

@One_Glos
www.onegloucestershire.net

Integrated Performance Report Contents

Page	Title
Feedback from Committees	
4	System Resources Committee (Performance & Finance)
5	People Committee (Workforce)
6	Quality Committee (Quality)
Summary of Key Achievements & Areas of Focus	
8	Performance
9	Workforce
10	Quality
11	Finance & Use of Resources
Detail of Key Achievements & Areas of Focus	
12 – 28	Performance: Improving Services & Delivering Outcomes *(Including Outcome Measures)*
29 – 32	Workforce: Our People
33 – 39	Quality: Safety, Experience and Effectiveness
40 – 50	Finance and Use of Resources: Gloucestershire Integrated Care System (ICS)
51 – 56	Finance and Use of Resources: Gloucestershire Integrated Care Board (ICB)
Supporting Performance and Workforce Metrics – see document here.	

One Gloucestershire
Transforming Care, Transforming Communities

NHS

One Gloucestershire
Transforming Care, Transforming Communities

NHS

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)

@One_Glos
www.onegloucestershire.net

System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	2 May 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Operational Planning	**LIMITED**	Compliant across most performance trajectories in operational planning. A deficit financial plan submitted 2 May, an executive meeting expected in mid May with NHSE. 32 objectives across 13 areas, no red ratings. Key risks – workforce cap, triple lock on investments.	10 May Executive to Executive meeting 14 May NHSE meeting. Plan closed down, letters issued to systems, in year monitoring of delivery.	Submission to NHSE 2 May
Working as One Benefits	**LIMITED**	Presentation given on £10.4m Working as One savings included in 24/25 plan. Plan shared highlighting performance metrics, and trajectories. Discussion on translating improving performance into cash out savings, can more be done to reach 24 / 25 target. 19 March full model ward trial roll out underway in all medical wards. Committee updated on 4 steps to fully realise target opportunities.	Define tri roll out May 24 model ward roll out to surgery wards Improve data quality entry.	Progress to be monitored and further updates to be provided.
Shared Outcomes Framework	**LIMITED**	Presentation given to committee on Shared Outcomes Framework, accountability and evidence that will need to be collated to progress specific aims for the system. Long term outcomes and service ambitions. Discussion on ICP dashboard and indicators that may be needed, developed to ensure each population group are represented. How can Shared outcomes Framework be incorporated into ICP dashboard.	Future iterations to be shared back to committee.	Progress to be monitored and further updates to be provided.

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

4

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	3 April 24

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Excess Mortality	**LIMITED**	The committee was updated on mortality data which showed concerns about long waits and weekend/weekday mortality and how this was driving SHMI.	A report to be brought back to the August meeting.	August
Martha's Rule	**SIGNIFICANT**	GHFT already have a 'Call for Concern' programme in place, but would be applying to be one of the 100 pilot sites to implement Martha's Rule	Application to NHSE. Updates to be brought back to later committee meeting	Ongoing
Paediatric Audiology Services	**LIMITED**	A national audit of paediatric audiology services had been completed and noted areas of concern for GHFT.	An action plan will be brought to the June committee.	June
Dementia Strategy	**SIGNIFICANT**	The new Dementia Strategy was presented to the committee and was unanimously supported.	Implementation.	-
Maternity & Neonatal	**LIMITED**	The CQC section 29A notice remains in place.	Development work is ongoing.	-

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

Issues referred to another committee

Topic	Committee
None	None

5

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**	BMA balloted junior doctors in March regarding a further 6 months of industrial action, which was voted for.	Await notification of any further dates.	May/June 2024
Band 2/Band 3 Pay issue	**SIGNIFICANT**	**Update**: Agreement reached in GHC and ballot completed - working through implementation with current go live date 1 July. Further discussions with regional trades unions representatives in GHFT and ballot being undertaken.	Agree individual eligibility and implementation of back pay at GHC. Awaiting outcome of GHFT member ballot.	April-June 2024
Failure to secure, retain and develop workforce necessary to deliver the ICS's strategic objectives	**LIMITED**	All organisations continue to focus on a range of recruitment and retention initiatives inc People Promise Managers appointed in both Trusts.	Organisational level workforce plans in place focusing on EDI, staff engagement, recruitment, staff wellbeing and back and agency costs. Continued focus on International recruitment for social care. Continuation of We Want You careers engagement and outreach initiatives.	Early 2024 April 2024 –ongoing May 2024 on going
Decline in GP Partner numbers compared to March 2019 baseline and loss of historical NHSE funding for schemes such as new to Primary Care Fellowship and Mentoring which have supported GP recruitment and retention	**LIMITED**	Discussed at Board development session in April 2024	Business case supported for £170k funding to expand current Partnership programme. This will support taking up to 10 GPs onto the GP Partnership fellowship plus support a minimum of 10-15 existing GP Partners to remain in role.	2024-25

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

Issues referred to another committee

Topic	Committee
None	None

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

@One_Glos
www.onegloucestershire.net

Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- Health checks for people with Learning Disabilities or Serious Mental Illness have been increasing in uptake during the last quarter of 2023/24, with Serious Mental Illness Health Checks in particular achieving their best ever performance with 78.9% of the register receiving a check within the last 12 months. The system expects to meet target commitments in these areas in 2024/25, which will ensure patients in need of follow up intervention are supported to actively manage their health.
- Elective Recovery Performance continues to meet the national target (103% of 19/20 value weighted activity) - at M11 YTD Freeze Gloucestershire ICB commissioned Value Weighted Activity (VWA) is 105.2% of 2019/20 including pathways avoided and we remain on track to meet the M12 end of year target. Without industrial action, performance would have been in the region of 107%.
- With full year performance now available for cancer waiting times, the system has achieved the 28-day Fast Diagnosis Standard on average across 2023/24. Performance against the 31-day wait for treatment has also improved on the 2022/23 position. There are plans in place to support specialties currently not achieving the 62-day treatment target, with the system committing to exceed the recovery expectation for 2024/25 set nationally.

Areas of Focus

- Ambulance response time performance has failed to meet the improvement expectations for 23/24 (30-minute average response time for Cat 2 incidents), with March 2023 Cat 2 response times averaging 44.7 minutes. This has improved to 40.4 minutes in April 2024 (unvalidated), however remains an area of focus for the system and region – SWAST currently has the longest response times of all ambulance trusts nationally, primarily driven by the dispersed population and rural nature of much of the South West region.
- Despite seeing good progress for elective recovery throughout 2023/24, industrial action has reduced the impact of this recovery on reducing the total waiting list. Long waits have increased as a proportion of our waiting list throughout the year, and we are prioritising funding to aid specialties with the longest waits – both in RTT (elective) and diagnostic areas.
- Funding has been agreed locally to support endoscopy (colonoscopy, gastroscopy and flexi sigmoidoscopy) and angiography (including pacemakers, angiograms and angioplasty) to clear the backlog of patients waiting across these areas. Work is ongoing to support the services address the demand and capacity challenges and develop a sustainable offer that meets the system's needs for the future.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Funding Opportunities
- Arts, Health and Wellbeing Centre invited Expressions of Interest for small grants to support research and evaluation projects across the ICS, over 40 grant applications with 16 shortlisted for further review by a panel.
- Submitted bid for UoG/ICS small research & evaluation grant (£30k) for the We Want You team to investigate the primary barriers preventing young people in pursuing careers in the health & social care sectors
- ICB provided £15k to support ICS Leadership Development conference in June and October.

Strategy & Planning
- Final ops planning submission completed 2nd May
- All Steering Group Plans on a page for 24/25 drafted and sent to People Committee for approval

System-wide Development Programmes
- Systems Thinking masterclass cohort 5 commenced in April
- ICS coaching conference 'The Power of Coaching for Change' was held on 25th April – 35 coaches from across the system attended.

Programme Delivery
- Agreed year end and opening 2024/25 position.

Areas of Focus

Strategy & Planning
- Expecting a further ops plan submission – date and detail TBC by NHSE.
- 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
- Exploring (internal) options for further cohort delivery of system thinking masterclasses.
- Promote the ICS Leadership conference series (28th June and 23rd October).

International Recruitment
- Promotion of international recruitment of care workers for eligible providers.
- Continue the pastoral care support arrangements.

People team
- Commencement of two system careers engagement officers – focusing on implementation of a system wide work experience offer.

Quality – Safety, Experience and Effectiveness

Quality

Please note: The Quality report is updated bimonthly.

Key Achievements

- Research Engagement Network members have completed 2 x cultural competency training sessions to support increasing diversity in health and care research. Events were hosted by Inclusion Gloucestershire and The Friendship Café in April 2024 and included discussions about the differences between equality, equity and inclusion, a visit to a mosque and scenario discussions led by an expert by experience. Music Works will host final session of this cohort in May 2024.

- Weekly Patient Safety Huddles have continued into their third month with those participating reporting positive outcomes. The outputs from these huddles has been reported through to the System Quality Group.

- Non-Emergency Patient Transport has recently been reinspected by the CQC and has moved from 'Requires Improvement' to 'Good'.

Areas of Focus

- A new project reviewing mortality data is about to start. The aim is to understand the gap between weekend and weekday mortality and the system factors that affect the SHMI reported by GHFT.

- GHC NHSFT colleagues have come together from across Community Hospitals to celebrate a broad range of QI projects initiated throughout 2023. 12 quality improvement projects were shared at the event which showcased and celebrated the work happening across services and recognised the passion and innovation that has been driven by teams.

Finance and Use of Resources

Finance

- The ICS finance position as at month 12 2023/24 is:

	Year To Date (£k) (Overspend)/Underspend	Forecast Outturn(£k) (Overspend)/Underspend
GICB	0	93
GHFT	0	(535)
GHC	0	984
Total Surplus/(deficit)	**0**	**541**

- The ICS has delivered a year-end surplus position of £541k. In year financial pressures across a number of areas have been offset by underspends within the system.
- The organisational outturn positions include adjustments arising from the System Risk Share agreement.
- Mitigating actions during the year to support the delivery of a surplus position 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 £7.1m underspend against budget for the year. This includes additional National funding allocated in respect of IFRS 16 Leases and the system capital allocation. These funds are being made available from underspends at Regional level. The majority of the capital underspend relates to slippage on Nationally funded projects.
- Agency costs in month 12 remain below the straight line value of the agency cap for the system, for the sixth consecutive month. Actions continue to further reduce the expenditure within both Trusts.

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

@One_Glos
www.onegloucestershire.net

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

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 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 – rate per 1000	102.3	104.8	122.5	110.0	101.5	101.8	106.5
	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	82.6	74.3	81.1	76.5	84.2	80.1	79.8
	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

Please note, Pillar 3 metrics are currently under development and will be included in full in future versions.

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 December 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 December 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*	April 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	March 2024
3.4	*Support Improvements in delivery of Urgent and Emergency Care*	*A&E attendances - Rate per 1000 population*	
3.5	*Support Improvements in delivery of Urgent and Emergency Care*	*Emergency admissions - Rate per 1000 population*	
3.6	*Support Improvements in delivery of Urgent and Emergency Care*	*Long lengths of hospital stay over 21 days*	
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	2020

Improving Services & Delivering Outcomes

ICP Dashboard

- 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.

- An introduction to the Outcome Measures reporting was included in the March 2024 report and can be found here. While the measures on the outcome measures dashboard may be infrequently updated and cover the last 3 years, they have been selected to align to measures already identified as priorities for the system. Change over time will indicate that our programmes are delivering their objectives.

- Gloucester locality stands out as the area with the highest number of metrics showing a statistically significant worse position than the county average – and this reflects where we see our highest volume of deprived communities, and communities with higher ethnic diversity. We know that this is an area with higher health inequalities than much of the rest of the county and so a number of projects and services are focussed on trying to improve the health of this population. For example, roll out of the GRAIL multi-cancer blood test will be focussed initially on areas of higher deprivation – many in Gloucester City.

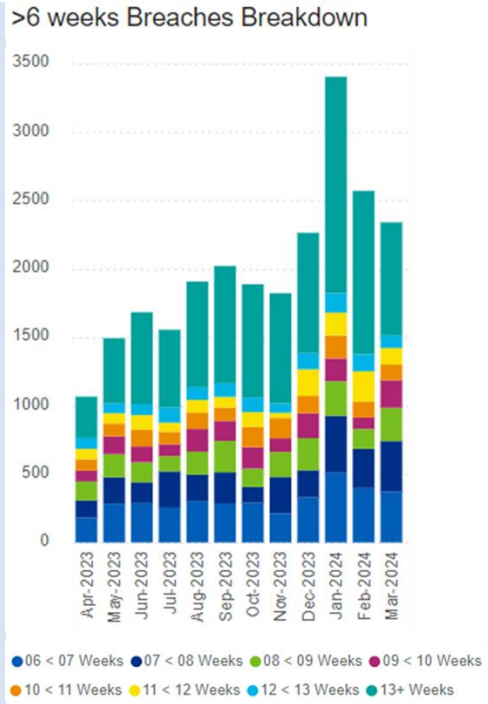
- In terms of indicators that have been updated this month, we see that despite being an area of lower deprivation, the Cotswolds has a statistically significantly lower uptake of physical health checks for people with Serious Mental Illness. This is particularly of note as the Cotswolds has a statistically higher life expectancy in general, while people with Serious Mental Illness are more likely to die prematurely from preventable health conditions.

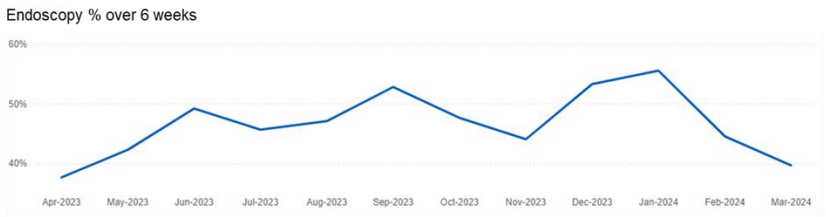
- Data from CVD Prevent (national reporting system for CVD associated measures from primary care) relating to blood pressure and lipid Qrisk treatments shows Gloucestershire, in common with many areas in the South West, has a lower than average (compared the country average) compliance against treatment to target performance metrics. Treated to target measures in CVD prevent do not exclude patients for whom further treatment has been ruled out (where the benefits of reducing blood pressure are outweighed by the side effects or other impact of further treatment). Analysis is underway to determine whether the population structure of Gloucestershire/ the South West has a disproportionate effect on the performance against these measures. Blood pressure is an exemplar theme in our system, and a number of projects are supporting further diagnosis and treatment of high blood pressure, in particular focussed on our areas of higher deprivation where we are more likely to see higher CVD incidence and mortality.

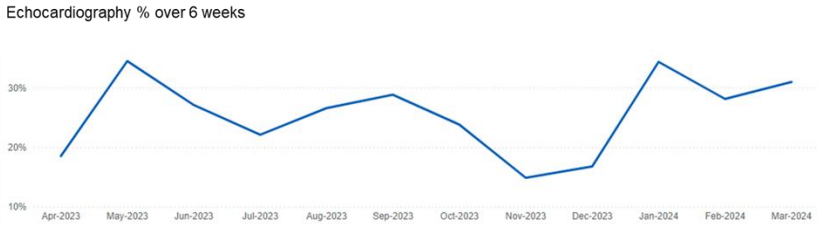
Improving Services & Delivering Outcomes

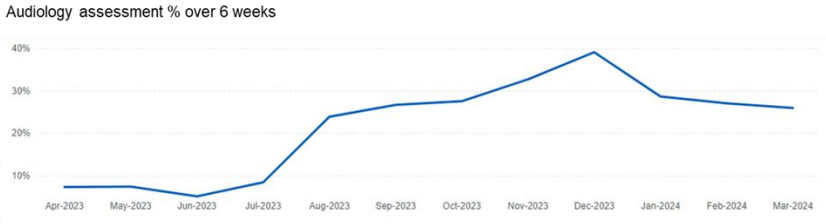
Our Performance: Focus on Diagnostics

- Endoscopy has seen reduction in % patients waiting over 6 weeks in the last 2 months though this remains significantly above the 15% target for March 2024 at 40% (combined).
- Echocardiography waiting list has remained stable over past 3 months, planned recruitment in the service will help increase capacity as activity is not delivering full benefit of additional CDC activity at present.
- Audiology waits have increased in 2023/24 and there is a dedicated plan to address ENT, and in particular patients requiring audiology assessment as part of their pathway.









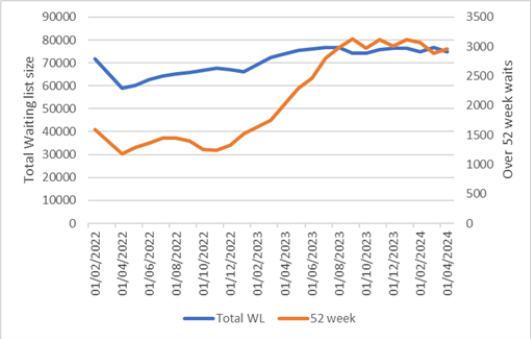
- Overall, 6-week breaches across diagnostics rose to their highest levels in January 2024. There has since been a reduction, with endoscopy particularly reducing over 6-week breaches (February/March 2024 gad increased endoscopy activity via waiting list initiatives which is having an impact). The reduction in 6-week breaches aligns with the overall reduction in the diagnostic waiting list seen during the same period. Additional investment is planned for endoscopy including additional consultants and nurse endoscopists to address the backlog and offer additional substantive capacity across the modalities.

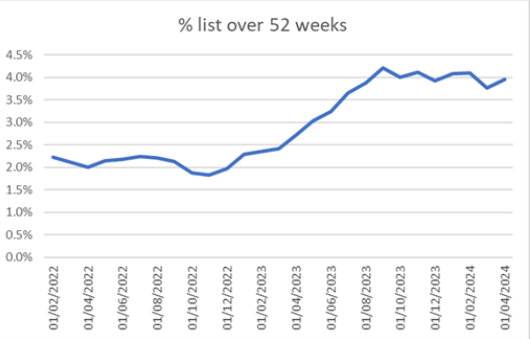
Improving Services & Delivering Outcomes

Our Performance: Focus on Elective Waits

- System position shown (includes GHFT, Out of County and Independent providers). There were 5 over 78 week waits at GHFT in March (and 414 65 week waits). Single specialties with the largest waiting lists include T&O, Cardiology, ENT, Ophthalmology and Oral Surgery.
- Oral Surgery has the largest number of 65 week waits – the majority at GHFT. GHFT are continuing to utilise practice plus at Emersons Green, sending 70 patients/month to aid backlog clearance. An additional locum is planned, alongside transformation in the pathway to improve community capacity for Intermediate Minor Oral Surgery (IMOS) which will help manage long term demand.
- 70% of ENT patients waiting over 52 weeks at GHFT are Otology patients waiting for Audiology. Pathway changes are planned to improve direct to test pathways – however this will need to be supported by primary care in additional to the acute.
- The waiting list has stabilised over the course of 23/24 suggesting the System could have seen a reduction in list size had no industrial action been carried out. The proportion of over 52-week waiters, however, has doubled and now accounts for c.4.5% of the total waiting list.
- As a system we have committed to eliminating 65-week waits by September 2024 and seeing significant reductions in the total number of 52-week waits throughout the year.
- We have reviewed long waits by deprivation and ethnicity and see a higher proportion of the waiting list in our Core20 population waiting under 18 weeks – further work to understand this is required but may be due to later referral in this group.

Treatment Function Name	Total waiting list	> 18 Weeks	> 52 Weeks	> 65 Weeks	> 78 Weeks
Oral Surgery Service	5,399	3,617	998	267	4
Ear Nose and Throat Service	7,939	4,536	856	68	0
Trauma and Orthopaedic Service	9,474	4,108	400	36	2
Cardiology Service	7,782	2,113	168	27	1
Other - Surgical Services	7,619	2,307	201	25	2
Plastic Surgery Service	241	106	25	10	3
General Surgery Service	814	221	23	9	1
Gastroenterology Service	4,428	868	38	6	0
Gynaecology Service	3,527	1,102	36	3	0
Neurology Service	2,556	1,055	48	3	0
Ophthalmology Service	5,411	1,390	19	2	0
Medical - Other	9,158	1,448	50	1	0
Paediatric - Other	1,472	521	32	1	0
Urology Service	4,492	975	77	0	0
Dermatology Service	4,458	1,565	8	0	0
Respiratory Medicine Service	1,354	348	5	0	0
Rheumatology Service	1,097	452	9	0	0
Other	697	60	0	0	0
General Internal Medicine Service	322	51	1	0	0
Elderly Medicine Service	265	44	1	0	0
Neurosurgical Service	171	52	1	0	0
Cardiothoracic Surgery Service	15	0	0	0	0
Other - Mental Health Services	4	1	0	0	0
Total (March 2024)	**78,695**	**26,940**	**2,996**	**458**	**13**





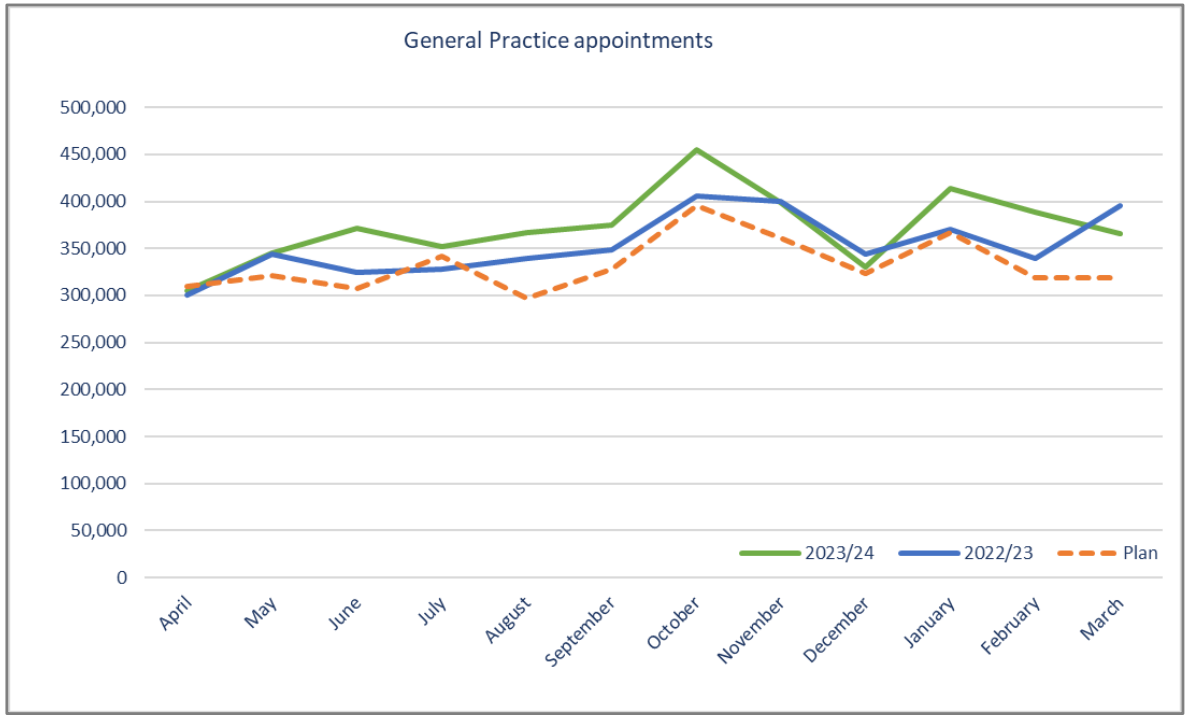
20

Improving Services & Delivering Outcomes

Our Performance – Focus on Primary Care Activity

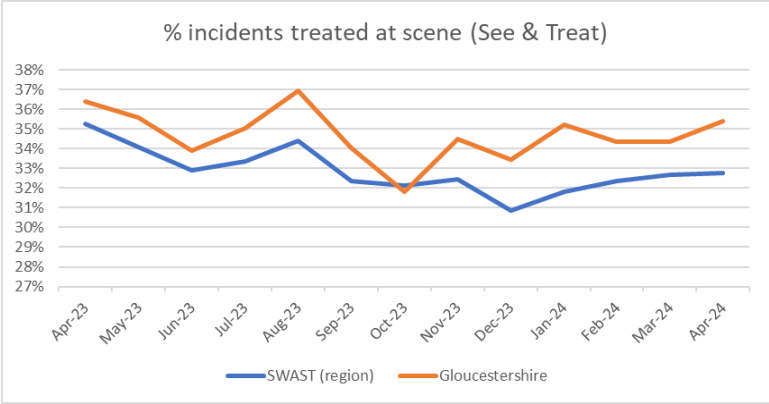
Plan 23/24		22/23 comparison	
Plan 23/24	3,989,551	Actual 22/23	4,240,386
Actual 23/24	4,468,445	Actual 23/24	4,468,445
Variance	**12% increase**	Variance	**5.4% increase**

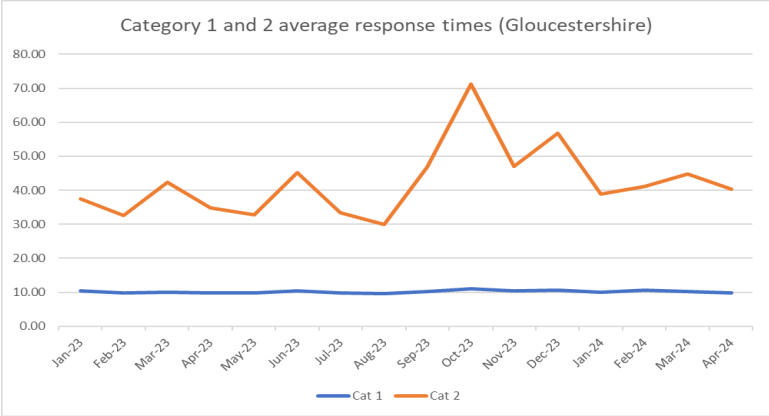
- Demand on primary care in Gloucestershire continues to be high, with full year activity 5.4% higher than in 22/23 and significantly above planned levels. Primary care activity has risen considerably more than population growth since the COVID-19 pandemic.
- Increasingly, primary care is struggling to absorb the demand, at a time when contract value increases have not kept pace with inflation – in particular, primary care staff are outside of the NHS pay awards made nationally last year (e.g. Agenda for Change) and this is adding to pressure felt by primary care when competing for staff with other organisations.



Improving Services & Delivering Outcomes

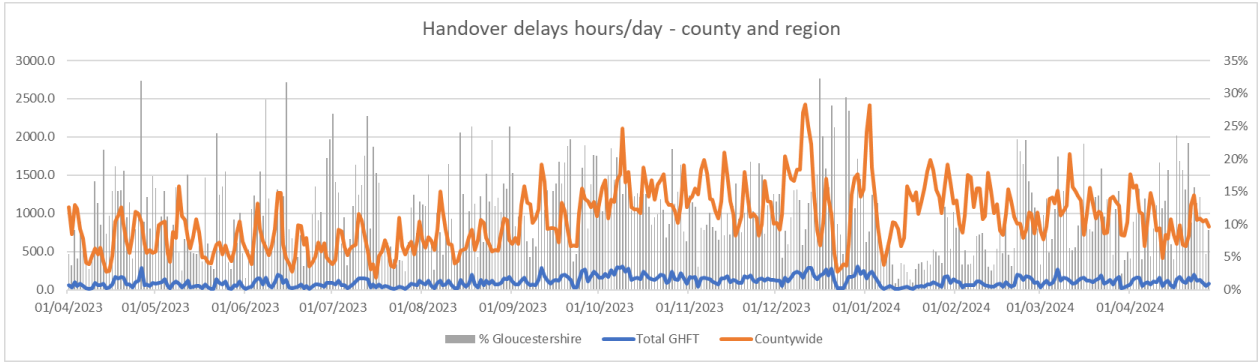
Our Performance – Focus on Ambulance





Average response time (minutes) by district								
Mar-24	Cheltenham	Cotswold	Forest of Dean	Gloucester	Stroud	Tewkesbury	Average	Range
Cat 2	38.0	57.2	52.1	39.7	48.6	38.3	44.7	19.2
Cat 1	8.5	13.0	13.5	7.0	13.5	9.7	10.1	6.4

- Ambulance response times have stabilised but remain higher than the interim recovery target of 30 minutes (county average time). Category 1 response times continue to be higher than the target time of 7 minutes (average response) – performing at around 10 minutes consistently over the last two years. Average response time varies by district – driven by rurality, with lower average response times in our urban centres Cheltenham and Gloucester.
- A key element to aid recovery of response times is the reduction of handover delays which is a priority for the region – these had increased across the whole SWAST region in 2023/24 until January. Gloucestershire accounts for 13% of the total SWAST handover delays (latest month) but has seen overall contribution as low as 6% during January 2024 (when average handover time was 56 minutes). In April 2024, average handover time was 77 minutes.
- In line with our system priorities to maximise community settings for care where possible, SWAST continues to have a higher proportion of incidents treated at the scene (thus avoiding a conveyance) than other areas in the region.



22

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- April overall Type 1 ED 4-hour performance was 58.7% and whole system (GHFT and MIIU sites) was 74.3%. As a system (across Type 1 and Type 3), we are committed to delivering 78% against the 4-hour target by March 2025. Our trajectory recognises our current performance in March 2024, so sets our improvement from 74% in April (which has been achieved), 76% by September and then 78% by March 25 at a system level.
- Current call answering performance of the NHS111 service has improved significantly with 3.9% of calls to the service abandoned in April (against a target of 3%), despite a high volume of calls received. The new Integrated Urgent Care Services (IUCS) is expected to mobilise at the end of November 2024 – with the procurement process currently underway for this. The specification emphasises care co-ordination and efficient navigation of our community offer to make effective use of all alternative offers - including MIIUs where direct booking will be established.
- Work on the mobilisation of the Treasure Seeker pilot in ED to offer support to vulnerable people attending the department is on-going. This includes collaborating with partners from Treasure Seekers and GHFT to undertake process mapping to understand where the Treasure Seekers offer will fit within the ED patient pathway. Development of the necessary policies and procedures, stakeholder mapping, communications strategy, data capture and flow processes, and evaluation plan is underway. Delivery of the pilot is expected to commence in June as a test and learn.
- Handover delays are an area of focus across the South West to support the delivery of Category 2 response times. April average handover time was 77 minutes – the system has committed to reduce this to 40 minutes over 24/25. Category 2 average response times improved in Gloucestershire to 40.44 minutes (from 44.7 minutes in March).
- Virtual wards are now well established in supporting urgent care – with Frailty, Respiratory and Surgery tech enabled pathways in our Virtual Hospital. ARI and SDEC pathways into respiratory are now live with further development planned for 24/25 – expansion of the frailty and surgical pathways, and additional support from pharmacy. Rapid Response has exceeded the 70% target (of 2 hour responses carried out within 2 hours) in March reaching performance of 78.5%. Full 2023/24-year performance was 79.3%. Moving into 2024/25, Rapid Response activity is planned to increase by 10% to further support alternatives to acute hospital care.

Improving Services & Delivering Outcomes

Elective Care

- At M11 YTD Freeze Gloucestershire ICB commissioned Value Weighted Activity (VWA) is 105.2% of 2019/20 including pathways avoided.. The forecast outturn is currently 105%, taking into account industrial action. This year industrial action has accounted for a known 7,344 cancellations equating to c.£3.3m elective activity lost (based on average tariff) – without industrial action the system position is estimated to be 107% at M11.
- RTT performance was 65.8% in March (% of the waiting list under 18 weeks). 52-week waits remain stable to February, with 2,996 patients waiting over a year in March; reduction of 65-week waits is the focus currently for the system with March at 458 (down from 721 in February – a 36% reduction. The system aims to eliminate 65 week waits by September 2024. Theatre utilisation has been improving throughout 2023/24, with specialties carrying out "perfect weeks" to identify areas of focus and sharing learning. Additional investment is planned to support reduction of our longest waits:

Investment	Performance Expectation
Angiography	Angiogram, angioplasty and pacemaker backlog clearance at GHFT. Supports reduction in long waits overall and removes pressure on urgent angiography procedures.
Endoscopy	Additional endoscopy staff to support backlog clearance at GHFT. Supports reduction in long waits for diagnostic tests and long waits on the RTT list. Helps to support delivery of cancer waiting time standards.
ENT	Additional theatre lists and outpatient activity at GHFT – to assist in reduction of long waits for elective care.
Oral Surgery	Additional capacity via locums at GHFT – to assist in reduction of long waits for elective care.
Elective Care Hub	Patient Access Support Team – linking patients to appropriate services such as social prescribing while waiting. They can also escalate their case to an appropriate clinician if their condition has deteriorated or remove patients from the waiting list who no longer wish to proceed with treatment.

- Advice and Guidance requests declined slightly in March – with the 2-day review target performance decreasing from 81.1% achieved in February (the first time >80% this financial year) down to 78.2% . Dermatology had reduced their backlog earlier in the year; however, this is now increasing again. Haematology also have an outstanding backlog, with outsourcing to Consultant Connect agreed to help resolve this. Gastroenterology also saw an increase in the backlog – with contributing factors being explored.

Improving Services & Delivering Outcomes

Primary Care

- As outlined in the focus section, demand on primary care continues to be high. Performance against the Appointments offered within 2 weeks metric has remained stable at 72.8%. This is below the South West and National average, however Gloucestershire has a higher % of planned clinics, medication reviews and procedures than the national average, and a lower proportion of unattended appointments than the national average. We are expecting to continue performing at around 75% of appointments booked within 2 weeks, reflecting current practice and demand.
- Primary care has achieved over the 75% compliance target for both Learning Disability and Serious Mental Illness (SMI) physical health checks in the Q4 2023/24 period. This is a particular improvement in SMI health checks which had been at 60% at the end of Q3.
- The COVID Spring Booster phase for 2024 commenced on the 15th April (Care Homes) followed by all other eligible cohorts on 22nd April. This phase will complete in ten weeks with final vaccinations given by 30th June. Our current work as a Demonstrator site (driving uptake rates for MMR in younger cohorts) has fed directly into the Strategy and much of what has been achieved in the Access and Inequality (A&I) workstream of the COVID programme. The accelerator programme has led to a number of children receiving catch up MMR boosters in the last month.

Dental

- Units of Dental Activity (UDAs) delivered in county have been rising throughout 2023/24 and are planned to increase further in 2024/25 – 36% of Gloucestershire dental contracts will see an uplift in rates paid for this is due to contracts being revised to address locations where rates of pay do not cover dental activity (and therefore discourage NHS dental work being carried out).
- A new patient premium is being introduced for patients who haven't seen a dental practitioner in the last two years. Where a new patient is seen, the practice will get an extra payment in addition to UDA rate. This is a time-limited scheme which launched in March 2024 and will end in March 2025. Patients are able to see which practices in their area are accepting new patients via the NHS website or the NHS app, and the public will be provided guidance via the NHS app and website on eligibility and details of the scheme.
- Gloucestershire is one of 6 areas across the South West that has been identified for Dental Van provision - mobile dental vans will take dentists and surgeries to isolated under-served communities as part of the national plan to recover and reform NHS dentistry. The NHS England central team are leading on this implementation plan. A series of workshops to address issues and actions for this to progress are in progress.

Improving Services & Delivering Outcomes

Cancer

- March performance against the 28-day Faster Diagnosis declined slightly to 73.5% for the system, thus missing the 75% standard, with the overall performance for 2023/24 meeting the target at 75.9%. The March 2023 decline was driven by Out of County providers, as GHFT achieved the 28-day standard at 75%. Urology performance continues to drive 28-day breaches (with knock on impact for 62-day treatment pathways as well). Additional resource into the Urology pathway is due to commence, and further training for the urology nursing workforce is planned to improve productivity particularly around LAPT biopsy. Primary care training has also been delivered to minimise the need for repeat and unnecessary referrals.

- Overall compliance against the 62-day treatment target was 68.1% in March – stable to February's performance. The majority of breaches were in Urology, Lower GI and Gynaecology. GHFT have focussed on reducing the cancer patient treatment list (PTL) backlog throughout March to achieve a year-end total of 185 – a considerable decrease on the position at the start of the year which had been negatively impacted by industrial action.

- Referrals for patients with non-specific symptoms have increased throughout 2023/24 and have now stabilised with 31 made in March 2024. The total for 2023/24 was 398 against a target of 710 (set regionally) – however as a system we do not believe we require such a high volume of referrals into this service due to good direct diagnostic access from primary care and improvement of the referral routes for specific specialties for those with cancer symptoms and this will continue to be our approach through 2024/25.

Improving Services & Delivering Outcomes

Diagnostics

- Diagnostic performance has improved in March despite the waiting list remaining above levels seen at the start of 2023/24, with 16.8% of the waiting list over 6 weeks at the end of the month. Modalities seeing the highest level of 6-week breaches were the endoscopies, echocardiography and audiology assessment as outlined in the Diagnostic focus section.

- Endoscopy remains the main driver of the long waits in the system – with surveillance patients now included on the waiting list. The performance in all sub-specialties has improved form the January position and additional investment is being worked through via the ERF and High-Risk investment process. The community direct access contract with Inhealth (for GPs) has ceased as of 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 provide additional capacity to the system.

- The Community Diagnostic Centre opened the main site building on the 5th February 2024, with additional modalities continuing to come online (sleep studies and lung function tests were rolled out in March 2024). Further service design work is underway, for example the Complex Breathlessness service and Liver Disease “One-Stop” clinic.

Improving Services & Delivering Outcomes

Mental Health

- CYP access continues to be strong across all providers, with latest national data showing access exceeded our target (8040 against a 7340 target). The CAMHS service at GHC just missed the 80% target for referral to assessment within four weeks, achieving 79.5% in March 2024. The average wait for first appointment remains around 20 days and overall numbers on the waiting list have reduced very slightly to 555. The service is currently recruiting to several vacancies, which is affecting performance against this metric.
- Talking Therapies access declined in March 2024 to 818 – the service has failed to reach the operational plan target for access throughout the year. This has been driven by staffing issues and a decline in referrals (experienced nationally). The recovery rate remains excellent, at 52.2% in March 2024. For 24/25 operational priority is on completed treatments and reliable recovery – as a system we have agreed to reduce our target for completed treatments to allow the service to focus on shortening waiting times and quality of service.
- Eating disorders – the proportion of patients assessed within target has improved significantly in 23/24 to date. The March 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 100% of referrals beginning urgent treatment within a week in March (meeting the national target of 95%), and 87.5% of routine referrals beginning treatment within 4 weeks.
- Perinatal mental health access continues to be ahead of trajectory against operational planning targets with 59 women accessing services in March. YTD access throughout 2023/24 was 810 against a full year target of 672. Moving into 2024/25, the 672 target has been rolled forwards (~ 10% of the predicted maternities in the Gloucestershire system).
- Out of Area placement days have reduced throughout 2023/24, with the total for the year at 375 – significantly under the target for the year of 800. Acute Mental Health beds have continued to be under pressure and efforts are focussed on reducing length of stay. Comparative data from model hospital indicates that Gloucestershire is in Quartile 2 (Q1 low / Q4 high) for length of stay and longest stays.
- Dementia Diagnosis has improved significantly in the latest month, increasing to 65.1% of estimated prevalence in March 2024, up from 63.5% in February 2024.

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

@One_Glos
www.onegloucestershire.net

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Recruitment and Retention

- System wide Higher Development Award – GHC agreed to host and focusing on AHPs as a pilot. Scoping of system appetite and local providers underway.
- Social care app, as part of the pastoral support for international recruits, has undergone user testing with initial pilot group. Content continues to be populated and further roll out planned throughout the year.
- Trust People Promise Managers appointed and due to start in May.

Innovation

- The Housing Hub Homeshare scheme, supported by AgeUK is being promoted within Provider Trusts.

Education Training and Development

- Careers engagement and outreach plans for 2024/25 school delivery being finalised.
- Expansion of T-level opportunities continues to grow.
- ICS Apprenticeship Strategy out for final review – going to People Committee in June for ratification.
- Apprenticeship & Careers website – information collation started.
- Care Leavers Covenant - Health & Social Care Careers awareness conference being held at UoG on 17th May with a designated Care Leavers workstream.
- ICS work experience 'one stop shop' being developed.

30

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.
- Sexual Safety Charter – GHC and ICB signed up and e-learning available to staff. GHFT aiming to sign and make e-learning available by end May. ICB Bullying & Harassment survey drafted and will be circulated shortly.
- The first pilot of the System-wide New Starter Conversation is planned to be held May 9th aimed at the independent social care sector. The pilot will be evaluated and based on the results proposals will be developed for wider roll-out across the ICS. The aim of these conversations is to remind staff 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.
- Health, Wellbeing and Neurodiversity in the Workplace event held with independent ASC providers on 23rd April.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

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

- Options for System-wide Leadership programmes being discussed at HRD/OD leads workshops on 30th May.

- A Leadership Conference Series is being planned, with representation from each of the system partners on the Health and Well-being Board. Two event dates for 2024 have been set, June 28th and October 23rd. The aim of these events will be to establish connections and strengthen relationships between leaders across the partnership and each of the events will have a specific theme. The theme of the first conference is 'Health Inequalities'. Communications for the first event went out on 1st May and within the first week, over 130 of the available 150 spaces had been booked.

- The 2024/25 digital priorities have been agreed:
  - Digital Workforce Strategy
  - Digital Literacy
  - Technology Enhanced Learning
  - Learning Management System

32

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

@One_Glos
www.onegloucestershire.net

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The NHSE SW Commissioning Hub Monthly Information pack has been received containing Q3 POD quality information.
- **Dentistry** – The report highlights three cases were received by the complaints team in Q3 relating to a named dental provider. In addition, four were received about the commissioning of services relating to dental access. No serious incidents have been reported and no quality assurance (QA) visits took place in this quarter.
- **Pharmacy** – 3 complaints relating to community pharmacy were received in Q3. No serious incidents have been reported and no QA visits were undertaken in this period. NHSE have informed the ICB of 5 upcoming Community Pharmacy Assurance Framework (CPAF) visits and have invited the ICB to accompany them on these visits.
- **Optometry** – Quality in Optometry (QiO) is a clinical governance toolkit providing assurance regarding the delivery of Community Optometry services. The number of submissions for the 2022-2025 QiO cycle as of 18 January 2024 for Gloucestershire ICB was 100%.

Community and Mental Health

- Following the CQC issuing a section 31 regarding the standards of care at Berkeley House, a period of enhanced surveillance continues. The Quality Improvement Group (QIG) continues to monitor the progress and implementation of the Trust's action plan following the inspection. The Trust is now moving to a phase of embedding and testing actions. Discharge plans for residents of Berkeley House are progressing, one patient has moved into the community this week after 25years in a hospital setting. GHC are considering a written request to lift the Section 31 notice, which has been supported by the QIG.
- 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.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Maternity

- CQC section 29A action plan remains is in place. Maternity remains on NHSE Maternity Safety & Support Programme with Maternity Improvement Advisors for both Midwifery & Obstetrics. A Quality Improvement Group chaired by the CNO will have the 1st meeting on 17th May to decide on the five priority areas that the LMNS/System agree on and will be monitored closely and reported via the monthly group. Massive obstetric Haemorrhage, Safety Culture, Ultrasound scanning capacity, Overdue policies and CQC 'must dos' are being considered as part of the priority areas
- 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.
- A robust recruitment and retention plan has been developed to improve the vacancy rate – currently 12%. A team is in post to support midwifery recruitment & retention
- A review of the staffing options for reopening Cheltenham birth unit and Stroud postnatal beds is underway. A number of new senior midwifery and governance posts have been recruited to strengthen the governance structure within GHT and provide additional capacity to respond to PSI and implement PSIRF

Urgent and Emergency Care – Working as One

- The One Gloucestershire ICB Urgent and Emergency Care improvement programme working in partnership with Newton Europe is now more than halfway through. System improvement metrics for each organisation have been set by flow team & integrated hub.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Serious Incidents

- The system switched over to the Patient Safety Incident response Framework (PSIRF) on 1 March. This has brought the Serious Incident Framework to a close for us.
- Any incidents that were opened under the Serious Incident Framework will continue to follow that process with ICB sign off.

Patient Safety Incident Investigations

- Under PSIRF organisations are prompted to respond proportionally. This might be through new SWARM huddles or After-Action Reviews. For the most complex events, organisations can open a Patient Safety Incident Investigation (PSII).
- Since April 1st eight PSIIs have been opened, shown in the chart to the right.
- Under PSIRF, provider boards are responsible for oversight of investigations, rather than the ICB.

System Investigations

- Partners from across the ICS recently met to start to work out a process for any PSIIs that will need cross system support. This is a requirement of PSIRF and will become more important as the new ways of working are embedded.

Patient Safety Huddles

- Since the switch to PSIRF we have introduced weekly ICB Patient Safety Huddles every Tuesday morning at 9am. These have enabled a cross-section of staff to raise emerging insights and talk about developing trends in the development of patient safety. We hope to extend the invite Social Care colleagues to broaden the reach and enable true system working.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Learn from Patient Safety Events (LFPSE)

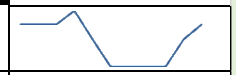
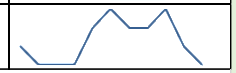
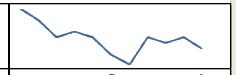
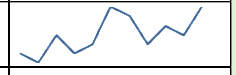
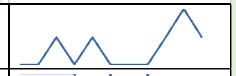
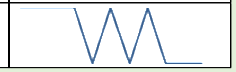
- NHS England have now launched the first version a new tool that will eventually enable the ICB to look at whole system data. While the first version is limited, we have started to see some data come through.
- For April 2024 1217 records were added to LFPSE relating to Gloucestershire. They break down to:
    - 1191 from GHC
    - 1 form ASDA Pharmacy
    - 1 from Morrisons Pharmacy
    - 2 from Tuffley Pharmacy
    - 20 from NewMedica
    - 2 from Nuffield Hospital
- GHC records relate to a wide range of issues from which themes cannot currently be extracted due to national system limitations.
- Pharmacy records all relate to wrong patients on labels and incorrect strength of prescription.
- NewMedica records predominantly relate to cancelled appointments.
- Nuffield records relate to wound care and notes management.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April 2023 – February 2024

		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%	92%	93%		
	% Negative	4%	3%	3%	3%	5%	6%	5%	5%	6%	4%	3%		
GHT A&E	% Positive	83%	81%	78%	79%	78%	75%	73%	78%	77%	78%	76%		
	% Negative	12%	11%	14%	12%	13%	17%	16%	13%	15%	14%	17%		
GHC Mental Health	% Positive	87%	83%	87%	82%	89%	83%	82%	80%	85%	78%	87%		
	% Negative	7%	6%	6%	7%	5%	10%	10%	10%	5%	10%	6%		
GHC Community	% Positive	94%	94%	95%	94%	95%	94%	94%	94%	95%	96%	95%		
	% Negative	3%	3%	3%	3%	2%	3%	2%	3%	2%	2%	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.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

System Clinical Effectiveness Group

- The Chief Medical officer is now the chair of the Clinical Effectiveness Group (SCEG). The Group met in March and will meet bi-monthly. There was a discussion how the CPGs/Clinical Effectiveness could mutually benefit from a specific focus under SCEG. A rolling program of CPG attendees presenting on a standardized list of themes could provide real insight for the group, plus opportunity to assist with any challenges by diversifying oversight.

System Mortality Group (SMG)

- The last SMG was held on 12th March.
- At that meeting the group received a presentation from the Southwest critical thinking unit on mortality data. While inner city Gloucester PCN mortality rates had improved, other PCNs in other areas of Gloucester had worsened. This is a focus for the System Mortality Group.

SHMI

- The Trust's Standardised Hospital Mortality Indicator rate is currently at 114.4 (latest available data from NHSD, covering the period January 2023- December 2023).
- One key factor currently being explored through a special project is how and why weekend mortality and weekday mortality rates differ.
- Mortality has board level focus at GHFT, with the board undertaking a mortality workshop this month to review the data and areas for focus.

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

@One_Glos
www.onegloucestershire.net

One Gloucestershire
Transforming Care, Transforming Communities

NHS

ICS Finance Report

Month 12

@One_Glos
www.onegloucestershire.net

Finance and Use of Resources

Financial Overview & Key Risks

- The year end out-turn is a £541k surplus versus plan.
- The 2023/24 out-turn revenue position includes the impact of the additional funding to cover in-year industrial action, as well as the benefits associated with a number of identified underspends, plus all additional income. The underlying position remains challenging and a number of non recurrent financial savings and income have within the 2023/24 financial position.
- Financial challenges across the system in 2023/24 include pay costs 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 position is net of £6m non-delivery of Financial Sustainability schemes causing an adverse variance to plan and costs relating to urgent care escalation, which will both impact the 2024/25 run rate.
- Full year over delivery of savings plans has been achieved GHC and the ICB. However, GHFT has underperformed by £6m, resulting in a net system over performance of £5m. The GHFT underperformance relates primarily to a shortfall against the UEC target. Savings delivery included a number of non-recurrent savings schemes to help offset slippage in the delivery of recurrent schemes. Whilst the 2023/24 financial position overall has absorbed the under delivery, this slippage in the recurrent efficiencies will result in an increased financial challenge in 2024/25.
- The full year capital expenditure is reported as £7.1m below plan as a result of slippage on Nationally funded capital projects. NHSE has provided an additional IFRS16 allocation to partly cover a significant increase in in-year commitments. The balance of system capital allocation and IFRS 16 overspends will be covered at regional level through capital underspends in other systems in the South West region.

Finance and Use of Resources

Financial Overview & Key Risks

Key Financial Issues

- The GHFT out-turn 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

- The 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, and is also below the 3.7% target in month 12. 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 national target for elective recovery was reduced by 4% to 103% to enable systems to cover the cost of in year industrial action. The ERF out-turn pro-rata is 104.4% including the impact of industrial action that took place in February. The full year 2023/24 ERF forecast has been adjusted following recent reductions in activity performed by two independent sector providers, the adverse impact of further industrial action in January and February and early Easter bank holiday in March. As a result, the overall forecast is for activity performance to show a reduced forecast outturn position, albeit still ahead of the revised National target.

- 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 final 2024/25 system financial plan is scheduled to be submitted to NHSE on 2nd May 2024. The focus within current financial planning is on both reviewing and reducing the recurrent expenditure (underlying run rate) exiting 2023/24 and 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	4,110,777	4,917,975	4,966,780	4,712,981	4,963,563	4,924,622	5,002,586	5,392,767	4,482,467	5,339,500	4,909,754	
		108.2%	112.5%	101.7%	105.4%	114.3%	108.0%	109.9%	107.8%	116.3%	109.5%	102.8%	
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	3,988,601	3,799,381	3,433,762	3,266,695	3,894,244	4,122,050	3,365,312	3,480,126	3,768,274	
		98.5%	90.7%	101.2%	96.5%	77.4%	83.4%	85.6%	88.6%	97.9%	91.3%	91.0%	
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	2,973,335	3,460,707	3,593,148	3,405,331	3,430,792	3,506,104	3,860,335	3,970,985	3,000,512	3,772,572	3,632,016	
		107.1%	112.0%	103.5%	108.7%	112.9%	106.4%	110.0%	110.4%	109.0%	103.6%	108.0%	
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	1,380,833	1,498,329	1,650,900	1,631,341	1,579,059	1,554,454	1,728,821	1,806,093	1,404,317	1,759,613	1,728,244	
		96.0%	98.6%	95.1%	100.8%	102.3%	101.3%	101.7%	102.7%	99.0%	97.9%	101.7%	
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	11,783,737	13,540,890	14,199,429	13,549,034	13,407,175	13,251,876	14,485,984	15,291,895	12,252,608	14,351,810	14,038,287	
		103.0%	103.5%	100.8%	102.4%	99.7%	99.0%	100.6%	101.4%	106.2%	101.1%	99.8%	
	incl.Pathways	106.8%	107.5%	104.9%	106.4%	103.2%	102.5%	103.7%	104.1%	109.2%	104.0%	102.3%	

- The target for Gloucestershire System remains at 103% taking into account year to date Industrial Action.
- At M11 YTD Flex Gloucestershire ICB commissioned VWA is 104.8% of 2019/20 including pathways avoided.
- At M10 YTD Freeze Gloucestershire ICB commissioned VWA is 105.1% of 2019/20 including pathways avoided.
- Year to date (M1-10) industrial action accounts for a known 7,344 cancellations equating to c.£3.3m elective activity lost (based on average tariff).
- The System's likely year to date position, had there been no industrial action is 107%
- All points of delivery (PODs) except elective inpatients and outpatient procedures exceeded plan in month
- Independent Sector providers are continuing to deliver year to date higher activity volumes (131.7%) than GHFT (98.3%) and OOC NHS Providers (91.3%).

Finance and Use of Resources

Finance and Use of Resources: Dashboard

Statement of Net Income & Expenditure Position (£'000)			
Month 12 2023/24 - March	Month 12 Plan Surplus/ (Deficit)	Month 12 Actual Position Surplus / (Deficit)	Year End Variance to Plan Favourable / (Adverse)
Gloucestershire Hospitals NHS Foundation Trust	0	(535)	(535)
Gloucestershire Health and Care NHS Foundation Trust	0	984	984
Gloucestershire Integrated Care Board	0	93	93
System Surplus/(Deficit)	**0**	**541**	**541**

Efficiency Programme (£'000)							
Month 12 2023/24 - March	Month 12 Efficiency Plan	Month 12 Efficiency Achieved	Year End Variance to Plan Favourable / (Adverse)	Full-Year Efficiency Plan	Outturn Efficiency	Outturn Variance to Plan Favourable / (Adverse)	Outturn as % of Target
Gloucestershire Hospitals NHS Foundation Trust	34,721	28,690	(6,031)	34,721	28,690	(6,031)	83%
Gloucestershire Health and Care NHS Foundation Trust	9,883	9,963	80	9,883	9,963	80	101%
Gloucestershire Integrated Care Board	13,128	13,983	855	13,128	13,983	855	107%
Total	**57,732**	**52,635**	**(5,097)**	**57,732**	**52,635**	**(5,097)**	**91%**

Other Metrics				
Month 12 2023/24 - March	GHFT	GHC	GICB	ICS
Better Payment Pratice Code (total paid within 30 days or due date by value)	92%	99%	100%	98%
Capital Forecast Variance to Plan (Under) / Over Delivery - £000	(7,967)	(485)	0	(8,452)
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

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 actual	M12 actual
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	2,343
Gloucestershire Health and Care NHS Foundation Trust	1,786	1,786	631	631	309	534	723	1,550	9	0	453	1,551
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	1,643
System Total	**5,130**	**5,130**	**3,477**	**3,745**	**3,677**	**4,492**	**3,549**	**4,878**	**4,972**	**3,871**	**4,179**	**5,537**

- 2023/24 planned savings totalled £57.7m.
- As at month 12 reporting, the system delivery was £5,097k behind plan. The summary for each organisation's full year delivery performance are:
  - **GHC**: The Trust's cost improvement programme delivered £5.026m of recurring savings against the target of £5.443m by the end of the financial year 23/24. The balance unidentified will be carried forward into 24/25 for identification. Non recurring savings of £4.936m were delivered compared with the plan of £4.44m. Overall GHC delivered efficiencies of £9.963m compared to a plan of £9.883m.
  - **GHFT**: £28.7m of savings have been delivered (£19.3m recurrent, £9.4m non-recurrent). 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). These have been somewhat mitigated by over delivery in other areas. The outturn position was £28,689k delivered versus £34,721k plan.
  - **ICB**: The savings programme amounted to £13.128m for FY 2023/24. The programme has been risk assessed and savings delivery of 13.983m for 2023/24 is reported. This reported position includes £5.028m medicines optimisation savings (£2.04m above plan) alongside under delivery in the UEC programme (£0.918m) and the CHC/placements programme (£0.506m).

Finance and Use of Resources

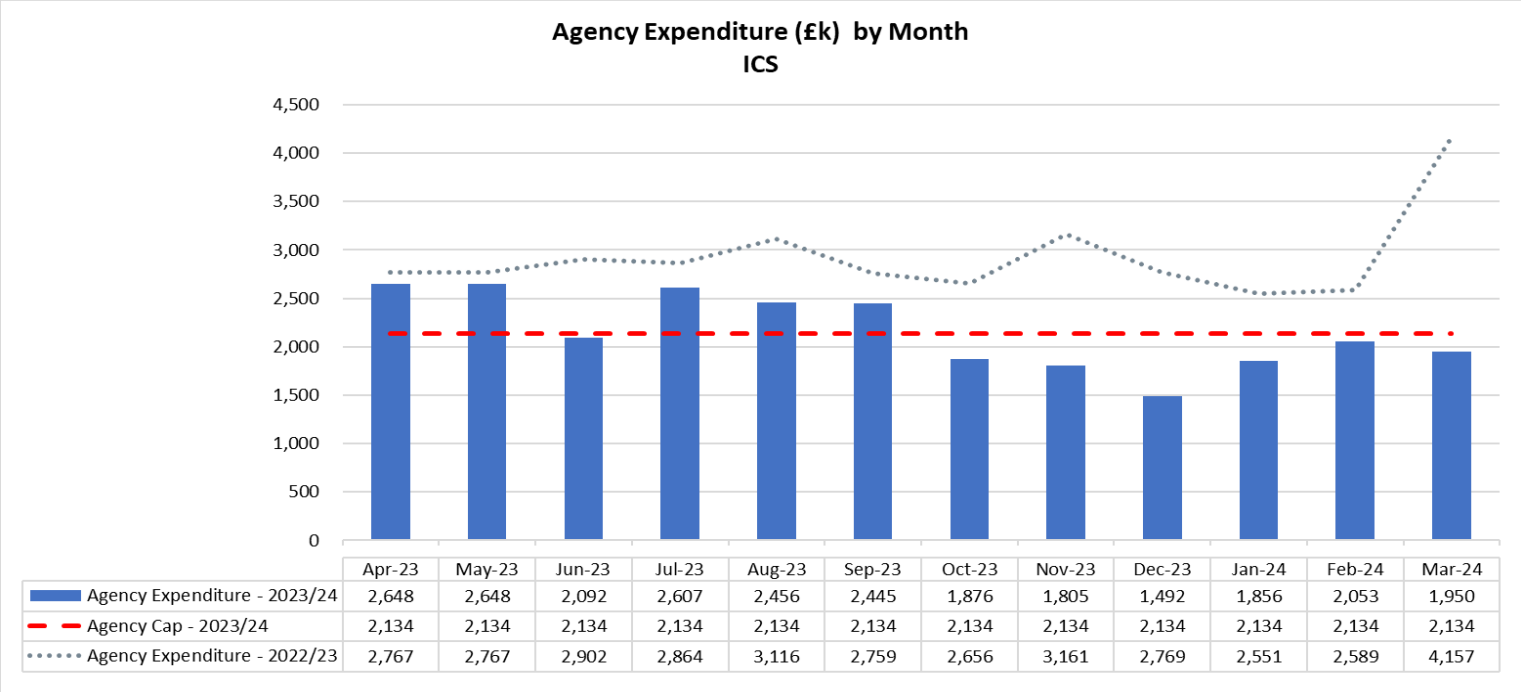
Capital: Organisational Positions, Challenges & Opportunities

Capital Expenditure (£'000)			
Month 12 2023/24 - March	Full Year Plan	Full Year Actual Expenditure	Full Year Variance to Plan (Under) / Over Delivery
System Capital Allocation			
Gloucestershire Hospitals NHS Foundation Trust	26,174	27,133	959
Gloucestershire Health and Care NHS Foundation Trust	11,491	11,137	(354)
Gloucestershire Integrated Care Board	1,188	1,188	0
Total System Capital Allocation	**38,853**	**39,458**	**605**
IFRS16 Lease Capital			
Gloucestershire Hospitals NHS Foundation Trust	1,478	5,880	4,402
Gloucestershire Health and Care NHS Foundation Trust	1,168	865	(303)
Gloucestershire Integrated Care Board	6,228	2,561	(3,667)
Total System Capital Allocation plus IFRS 16	**47,727**	**48,764**	**1,037**
Other Net CDEL sources			
Gloucestershire Hospitals NHS Foundation Trust	20,979	13,012	(7,967)
Gloucestershire Health and Care NHS Foundation Trust	1,841	1,710	(131)
Other (Technical Accounting Adjustment)	335	335	0
Total System Capital	**70,882**	**63,821**	**(7,061)**

- Within the total ICS system capital, capital expenditure on the system allocation and IFRS 16 lease capital is £1,037k overspent at month 12 of 2023/24. NHSE has agreed that this overspend will be offset at Regional level by underspends in other SW system ICS capital allocations.
- The GHFT Total Charge against Capital Allocation (including IFRS 16) reported to NHSI in the M12 Provider Financial Return (PFR) was £33.0m versus a plan allocation of £27.4m, an overspend of £5.6m. An additional funded allocation of £5.7m was agreed late in the year and is held in the ICB IFRS 16 capital allocation..
- The Capital Departmental Expenditure Limit (CDEL) outturn was £46.0m versus a plan allocation of £48.6m, an underspend of £2.6m. Agreed funded adjustments of (£1.0m) to the plan allocation, bring the adjusted CDEL variance position back to an underspend of which had been previously reported and noted by the Region.
- GHC capital spend ended the year just below the anticipated year end forecast at £13.668m. All key schemes were completed and 4 leases were successfully signed before the 31st March.
- The Lexham Lodge asset sale was successfully completed at the end of March.
- *Note: The individual organisation plan figures have been updated to reflect in year changes in allocations, within the overall system total.*

Finance and Use of Resources

Agency Expenditure vs NHSE Cap



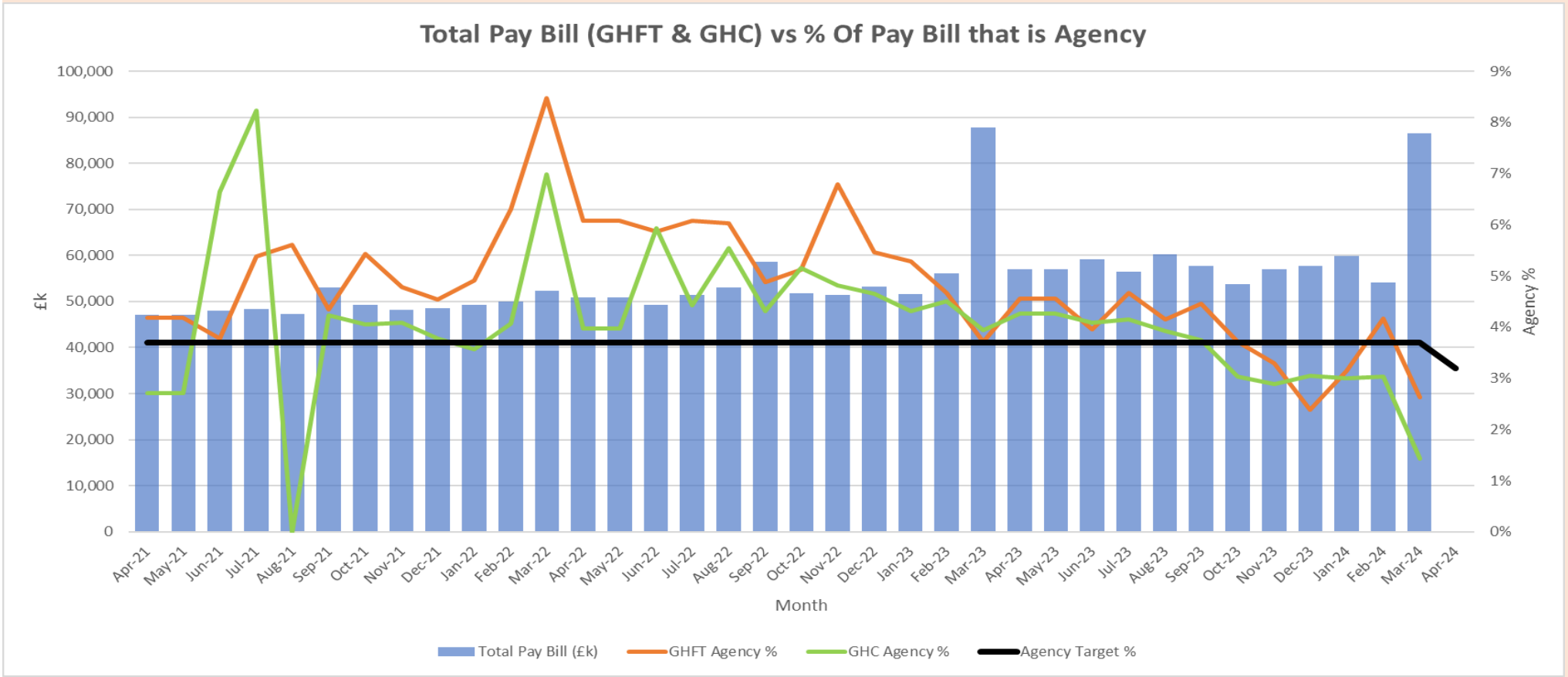
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456	2,445	1,876	1,805	1,492	1,856	2,053	1,950
Agency Cap - 2023/24	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134
Agency Expenditure - 2022/23	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.
- At year end, agency spend has amounted to £25.928m, representing a marginal adverse variance against the full year agency cap.
- The adverse full year variance is attributable to higher agency expenditure in the first half of the year, with monthly expenditure in the second half of the year consistently below the straight line value of the agency cap.
- The agency cap will reduce to 3.2% of gross pay expenditure in 24/25.

Finance and Use of Resources

Agency Spend vs Total Pay Bill



	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	Mar-24
GHFT Agency Spend (k)	£ 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	£ 1,561
GHC Agency Spend (k)	£ 618	£ 618	£ 953	£ 693	£ 903	£ 782	£ 852	£ 799	£ 785	£ 777	£ 808	£ 1,020	£ 777	£ 777	£ 748	£ 726	£ 709	£ 702	£ 526	£ 501	£ 523	£ 533	£ 538	£ 389
Total Agency Spend (k)	£ 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	£ 1,950

One Gloucestershire
Transforming Care, Transforming Communities

NHS

ICB Finance Report

Month 12

@One_Glos
www.onegloucestershire.net

Finance and Use of Resources

Financial Overview and Key Risks

- NHS Gloucestershire ICB month 12 unaudited outturn position is showing a £93k surplus. The ICB received its cumulative historic surplus in month 12 which totalled £20.890m.
- Prescribing has overspent by £5.9m in 2023/24; this position is based on 10 months data with 2 months of accruals. Key drivers in prescribing cost pressures 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 anticipated that No Cheaper Stock Obtainable (NCSO) costs impact for this financial year is £2.3m.
- The Continuing Healthcare month 12 position was a £6.5m overspend. This overspend is driven by activity growth across both residential and domiciliary CHC and funded nursing care and reflects an increasing trend in the number and cost of packages. On-going work is being undertaken in conjunction with GCC colleagues to improve data flows between the organisations.
- The Delegated Pharmacy, Optometry, Dental budgets was £4.3m underspend. The underspend is due to contractual under delivery within primary care dental contracts.
- 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 progressing and the home first service is a key part to enable these changes.
- The children's placement budget has overspent by £1.1m; this is due to ongoing placements including Trevone House.
- The Mental Health Investment Standard (MHIS) achievement was delivered for the financial year. The total expenditure was £106.578m against a target level of £106.525m which was 0.05% over target; this is subject to external review.
- The position is subject to audit.

Finance and Use of Resources

ICB Allocation: MX

Description	Recurrent	Non-Recurrent	Total Allocation
M11 Balance Brought Forward	**1,255,531**	**92,293**	**1,347,824**
Carry forward historic surplus		20,890	20,890
PCT – Community Pharmacy Contractual Framework		394	394
PCT – Pharmacy First Funding		456	456
ICB Weight Management Service		69	69
Afghan ARAP on MoD Sites		63	63
PCT additional IIF Funding – Early Cancer Diagnosis		54	54
PCARP reimbursement 2023/24 digital tools		109	109
PCT Independent Prescribing Pathfinder		2	2
PCT Hypertension incentive fees M8-12		3	3
ARRS Drawdown M12		191	191
DWP Talking Therapies – (1.6)		(2)	(2)
CDC Revenue Costs – Depreciation and PDC costs		404	404
Occy Health transfer		(6)	(6)
Transfer of PCIT		(25)	(25)
Community Pharmacy LFD testing service		23	23
DOAC Rebate Q3 23/24		418	418
Final 23/24 ERF Payment		(1,211)	(1,211)
Diagnostics Pay Uplift M12		9	9
TOTAL IN-YEAR ALLOCATION 23/24 @ M12	**1,255,531**	**114,134**	**1,369,665**

Finance and Use of Resources

ICB Statement of Comprehensive Income In-Year Position

Statement of Comprehensive Income (£'000)			
Month 12 2023/24 - March	M12 Plan	M12 Actual Position	Year End Variance to Plan Favourable / (Adverse)
Acute Services	641,591	641,128	463
Mental Health Services	135,025	134,752	273
Community Health Services	119,854	123,089	(3,235)
Continuing Care Services	67,039	73,549	(6,510)
Primary Care Services	194,948	198,414	(3,466)
Delegated Primary Care Commissioning	122,862	124,266	(1,404)
Other Commissioned Services	38,744	39,066	(322)
Programme Reserve & Contingency	13,471	0	13,471
Other Programme Services	1,440	1,744	(303)
Total Commissioning Services	**1,334,973**	**1,336,008**	**(1,035)**
Running Costs	13,802	12,674	1,128
TOTAL NET EXPENDITURE	**1,348,775**	**1,348,682**	**93**
ALLOCATION	**1,348,775**	**1,348,775**	**0**
Outside of Envelope	**0**	**0**	**0**
Underspend / (Deficit)	**0**	**93**	**93**

Finance and Use of Resources

ICB Savings & Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB) 2023/24 EFFICIENCIES PROGRAMME - AS AT MONTH 12									
PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	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	2,988	5,028	2,040	2,988	5,028	2,040	168.27%	GREEN - Low Risk
	Home Oxygen	150	150	0	150	150	0	100.00%	GREEN - Low Risk
PRIMARY CARE MEDICATION OPTIMISATION - TOTALS		3,138	5,178	2,040	3,138	5,178	2,040	165.01%	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Continuing Healthcare / Joint Placements - All Age	1,547	1,041	(506)	1,547	1,041	(506)	67.29%	RED - High Risk
CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS		1,547	1,041	(506)	1,547	1,041	(506)	67.29%	
URGENT EMERGENCY CARE (UEC)	Discharge to Assess Beds (UEC Efficiencies)	3,100	2,182	(918)	3,100	2,182	(918)	70.39%	RED - High Risk
URGENT EMERGENCY CARE (UEC) - TOTALS		3,100	2,182	(918)	3,100	2,182	(918)	70.39%	
OTHER	ICB Recurrent and Non-Recurrent Efficiencies (E.g. 1.1% Efficieny, Running Costs and Additional Efficiencies)	5,343	5,582	239	5,343	5,582	239	104.47%	GREEN - Low Risk
OTHER - TOTALS		5,343	5,582	239	5,343	5,582	239	104.47%	
2023/24 ICB SAVINGS PROGRAMME - TOTALS		13,128	13,983	855	13,128	13,983	855	106.51%	GREEN - Low Risk

Finance and Use of Resources

ICB Savings & Efficiencies: Overview

Summary

- The ICB has a savings programme totalling £13.128m for the 2023/24 financial year. The programme is showing delivery of £13.983m (106.51%) at month 12 (£13.598m at month 11); this reflects additional medicines optimisation savings offset by under delivery within Continuing Health Care & Placements and Discharge to Assess areas of savings.
- **Medicines Optimisation (£3.138m plan)** - the ICB has received ePact data for ten months of 2023/24 and savings of £5.0m are forecast (£4.7m reported at Month 11). As previously advised, review around medicines rebates savings have been progressed and additional savings are now included at month 12. In-year benefits from schemes addressing practice variation were initially delayed following the primary care offer progressing later than originally anticipated. Savings are now being reported with further related savings expected in 2024/25.
- **Continuing Healthcare (CHC) and Placements (£1.547m plan)** - At month 12, £1.031m savings are reporting (£1.0m forecast savings reported at month 11). The savings are contributed to by Electronic Call Monitoring, Personal Health budgets and vacancies. There are significant challenges in increasing adult continuing care, fast-track and CHC & LD review assessments which are required to be increased each month in order to realize savings from aligning care packages with updated needs assessment. Social care assessment support to deliver increased care package reviews presents a significant risk to the programme.
- **Urgent Emergency Care (£3.1m plan)** - This programme has been focusing on reduction of commissioned discharge assessment beds, 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 12, programme review indicates savings delivery of £2.18m (£2.12m reported at month 11) with the recurrent £3.1m benefits delivered during 2024/25 (i.e. £0.918m under-delivery within 2023/24).
- **ICB Recurrent and Non-Recurrent Efficiencies (£5.343m plan)** - 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 £0.23m are also reported.

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 2024

Report Title	**Primary Care & Direct Commissioning Terms of Reference**		
Purpose (X)	**For Information**	**For Discussion**	**For Decision**
			X
Route to this meeting	Several discussions at the PCDC Committee meetings, conversations with individual committee members and wider system partners and most recently between the Chair of PCDC and the Primary Care team, with governance colleagues.		
	ICB Internal	**Date**	
	PCDC meeting	4th April 2024	
	Chair of PCDC & PC meeting	18th April 2024	
Executive Summary	There have been some discussions at the PCDC Committee and meetings with the Chair of the PCDC Committee on the scope and remit of this committee, informed by the recent changes brought about by the delegation of dental, pharmacy and optometry from NHS England to the ICB and a review of the committee now nearly two years on from the inception of the ICB in July 2022.		
Key Issues to note	There are a number of proposed changes to how the committee operates which are summarised below: • That the committee focuses on two distinct roles namely: assurance of the operational matters and decisions within the jurisdiction of the delegated functions related to primary care, pharmacy, optometry and dental; and a strategic focus concentrating on the primary care strategy, dental strategy and developing optometry and pharmacy strategies. • That the committee receives reports from the Primary Care Operational Group (PCOG) on operational matters such as contracting, performance, quality of services and changes to local services. The PCDC Committee will receive a wide range of assurance reports based on these areas and will approve the proposed operational recommendations of PCOG. • That the committee has sufficient space and capacity to focus on the long term strategic plans for primary care and POD including workforce and will receive and input into those developing strategies and plans. • That the PCDC Committee will seek to operate as all other sub-committees of the ICB Board by reporting its minutes to the Board held in public, and the Chair of the committee providing a verbal update rather than the PCDC committee meetings being held in public. *The ToR will also be updated with any minor changes related to links / sections and paragraphs related to regulations and any minor changes with regard to terminology.*		

Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The changes proposed in this paper seek to enhance the efficiency and effectiveness of the PCDC Committee. Without the committee the ICB would lack assurance of primary care performance, operational issues and reporting to the ICB Board. Clearly defined ToR facilitate appropriate and robust decision making essential to good governance. The risk is low as the ToR have been appropriately updated and reflect the required role and remit of this committee. Add a risk rating, even if low: (4x2) 8 (4x1) 4 (residual meaning accepted risk)			
Management of Conflicts of Interest	There are no conflicts of interests related to this paper, the proposed changes have been discussed with PCDC members and supported by the Chair of the committee.			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	There is no financial impact associated with the changes to the ToR.			
Regulatory and Legal Issues (including NHS Constitution)	PCDC Terms of Reference are included in the Governance Handbook which is aligned to the ICB Constitution			
Impact on Health Inequalities	There is no impact on health inequalities related to the proposed changes to the ToR			
Impact on Equality and Diversity	There is no impact on Equality and Diversity related to the changes to the ToR			
Impact on Sustainable Development	There is no impact on sustainable development related to the changes to the ToR			
Patient and Public Involvement				
Recommendation	The Board is asked to • Approve the changes to the PCDC Committee ToR and changes to the way that the PCDC Committee operates.			
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**	
Sponsoring Director (if not author)	**Ayesha Janjua, Non-Executive Director; Chair of PCDC Committee** **Helen Goodey, Director of Primary Care and Place**			

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

Primary Care & Direct Commissioning Committee

29th May 2024

Background

The ICB is now nearly 2 years old since its establishment on 1st July 2022, and its structure and processes have been subject to regular review and change. The Terms of Reference for each of the ICB Board sub-committees is reviewed on an annual basis. With a change of Chair for the Primary Care & Direct Commissioning (PCDC) Committee this year and the acquisition of commissioning responsibilities for pharmacy, optometry and dental, the committee has been debating its direction, remit and scope. Following on from its meeting in April 2024, a further meeting was held with the Chair of PCDC and the primary care team to discuss the role of the committee and its future direction. Members of the committee as well as system partners who attend the committee such as Local Authority partners, have been engaged on the key changes described below to ensure agreement on these changes. This is in addition to the discussions with the ICB Chair and Chief Executive on the proposed changes in this paper.

The following changes are proposed to ensure that the committee remains effective and efficient and works within the scope of its delegated authority for primary care and POD services.

1. Operational focus of the Committee

Rationale for change

Currently, a large amount of time at PCDC meetings is taken to discuss operational matters; often these discussions repeat conversations that have already happened in other forums such as Primary Care Operational Group (PCOG).

Proposed changes:

PCDC will review and provide assurance on the following key reports and substantive items that have been initially reviewed and scrutinised by to the Primary Care Operational Group a sub-group of the PCDC committee as follows:

- Performance reports
- Quality reports covering primary care services and POD; the reports will also include the latest updates on patient and public engagement undertaken in primary care and POD
- Contracting and finance reports
- Risk reporting for primary care and POD
- Operational matters including mergers, change of boundaries etc.

The reports will be reviewed by the PCDC Committee and where further information or explanation is required the committee will ensure that this is provided before approving / noting the reports.

2. Developing the strategic focus of the PCDC

Rationale for change

Due to the over-focus on operational issues, there is less time in PCDC to consider strategic issues facing primary care and POD.

The move to a clearer assurance and strategic role means that the committee has the opportunity to concentrate on planning for the long-term; on discussing the development of innovative schemes that improve access and the quality of primary care and POD services available to people. The two-part committee agenda will allow committee members to best use their time to concentrate on the key issues facing Gloucestershire and that operational matters can be dealt with by PCOG a sub-group reporting into the PCDC Committee. Importantly the committee will retain an oversight and assurance role ensuring that operational matters are scrutinised and evaluated before being approved / supported.

Proposed changes:

The PCDC Committee will have two broad functions that of assurance and strategy. Two thirds of the meeting will be devoted to assurance with the remaining one third of the meeting focusing on strategic matters including the primary care strategy, the primary care infrastructure plan, development of primary care networks, Integrated Locality Partnerships as well as the dental strategy and plan and developing strategies for optometry and pharmacy.

In line with other ICB Committees we will also develop the PCDC meetings work plan to include 'deep dive' sessions to drive more in-depth assurance in key areas and focus on longer term-strategic issues.

The ToR for PCDC have been updated to include this more nuanced approach that balances the need to focus on assurance as well as strategy. The changes to the attached ToR are in Red. These changes will also be reflected in the PCDC agendas.

3. Alignment with ICB and regional governance processes for public involvement

Rationale for change

There are seven ICBs within the Southwest region and none of the ICBs with the exception of Gloucestershire hold their meetings in public but do report those meetings to the Board via committee minutes. Gloucestershire ICB is seeking to fall in line with all other southwest ICBs. The ToR for PCDC Committee were updated in May 2023 to take account of the delegation of POD services to the ICB from NHS England. There is no reference in the ToRs updated in May 2023 that meetings will be held in public as there is no statutory requirement to do so and the ToRs were drafted in line with other ICBs and with other ICB committees.

Over the past two years since the establishment of the ICB only 5 members of the public have attended the PCDC Committee meetings, which have been held every other month since July 2022.

Proposed changes:

PCDC will discontinue meetings held in public and will ensure that minutes of the meetings are made available to the public. Meetings will continue to take place every other month and the minutes will be reported to the Board held in public in line with all other sub-committees of the ICB Board.

Engaging the public in the development and provision of local services is a key priority of the ICB and there are a range of mechanisms that we will use to ensure the public transparency and engagement on primary care and POD services is maintained. Our ongoing mechanisms include Practice Participation Groups (PPG) with general practices having a PPG, a bi-monthly countywide PPG Network hosted by the ICB Engagement Team, a Primary Care Strategy PPG Reference Group with PPG representatives from across the county who have been informing the development of the new Primary Care Strategy) the Get Involved in Gloucestershire (GIG): https://getinvolved.glos.nhs.uk/ our online participation platform where people can share their views, experiences and ideas about local health and care services and find out about ways to get involved; the new One Gloucestershire People's Panel, with over 1000 members, regularly surveyed about health and wellbeing topics. In addition, we have the ICS Information Bus, which tours different areas and communities engaging people in health and care issues such as dementia, heart failure, cancer, carers hub and obtaining people's views on local services - it has also acted as a base for Nurse on Tour, visiting GP practices across the county providing experience to student nurses.

Committee members and participants have also been discussing developing additional ways to ensure public engagement and transparency on primary care. These include the following suggestions which will be tested and explored further:

- Use of the newly established One Gloucestershire People's Panel to gather views about primary care and POD services.
- Use of website updates for any key decisions made by the Committee that have public interest such as practice boundary changes.

As the PCDC ToR do not require that the committee holds its meetings in public there is no proposed change to the PCDC ToR, in this respect.

4. Removal of Associate NED in ToR

We propose the removal of the Associate NED from the membership of PCDC set out in the ToR as that is no longer a requirement.

Recommendation

The PCDC Committee requests that the Board approves the changes to the PCDC Committee Terms of Reference and the changes proposed to the PCDC ways of working.

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD

PRIMARY CARE & DIRECT COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Version	Author	Approved by	Review	Type of changes
V01	Helen Edwards			Creation of ToR
V02	Christina Gradowski			Content
V03	Jo White			Content
V04	Dan Corfield			Consistency changes in line with other committee ToRs. Formatting.
V0.5	Dan Corfield			Final reconciliation of membership
V0.6	Dan Corfield			Incorporating feedback from Committee Chair Designate
V1.0	Dan Corfield	Board of ICB 01/07/2022	Annually	Final version for ICB start date
V1.1	Christina Gradowski	Board of the ICB 31/08/22	Annually	Amendments to the ToR i.e., membership and PCOG ToR
V 2.0	Marion Andrews Evans and Christina Gradowski	Board of the ICB 31/05/2023	Annually	Amendment to the ToR i.e., clarification of quality assurance; inclusion of the POD requirements
V.3.0	Christina Gradowski	Board of the ICB 29/05/2024	Annually	Amendments to include clarification that the committee is responsible for strategy as well as assurance

Contents

1. Introduction 4
2. Purpose 5
3. Delegated Authority 5
4. Membership 5
5. Quoracy 7
6. Voting and Decision-Making 7
7. Frequency and Notice of Meetings 7
8. Committee Secretariat 7
9. Remit and Responsibilities of the Committee 8
10. Relationship with the ICB and other Groups/Committees/Boards 11
11. Policy and Best Practice 11
12. Monitoring and Reporting 12
13. Conduct of the Committee 12
14. Review of the ToR 12

1. Introduction

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

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

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

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

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

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

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

2. Purpose

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

2.2 The Committee has two distinct roles: assurance of the delegated functions related to primary care, pharmacy, optometry and dental services; and a strategic role scrutinising the long term strategies and plans related to these services including the infrastructure plan.

3. Delegated Authority

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

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

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

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

4. Membership

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

4.2 The Board will appoint the seven committee members:

- Committee Chair: shall be a Non-Executive Director of the ICB who is not the Chair of the Audit Committee;
- Committee Vice-Chair: Independent Non-Executive Director of the ICB with a remit for Quality.
- Chief Executive Officer or Deputy CEO of the ICB
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Chief Financial Officer

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

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

4.5 **Attendees and other Participants**

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

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

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

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

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

4.6 **Attendance**

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

5. Quoracy

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

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

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

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

6. Voting and Decision-Making

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

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

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

7. Frequency and Notice of Meetings

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

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

8. Committee Secretariat

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

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

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

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

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

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

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

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

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

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

9. Remit and Responsibilities of the Committee

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

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

9.3 The Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. It will retain oversight of progress

against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness.

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

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

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

9.6 The Committee shall also have oversight of the strategies and plans pertaining to primary care and POD services, these will also include workforce plans and the primary care infrastructure plan.

9.7 **Primary Care Networks (PCNs)**

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

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

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

- Maintain or establish identified Network Areas to support the local population.
- Review any waived PCN list size requirements wherever possible and appropriate to best support the local population;.
- Ensure that each PCN has at all times an accountable Clinical Director.

- Align each PCN with an ICB that would best support delivery of services to the local population.
- Collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN

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

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

9.8 **Financial Accountability**

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

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

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

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

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

9.8.5 The Committee shall receive information regarding the allocation of operational and transformation funding provided to individual practices and PCNs, both capital and revenue, and similarly shall receive information on the use of those funds relative to the achievement of agreed objectives. The Committee shall hold practices and

PCNs to account for value for money and other pertinent metrics regarding any such funding. Such monitoring and accountability notably includes, but may not be limited to, all items listed under sections 9.3 and 9.4 of these Terms of Reference

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

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

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

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

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

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

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

11. Policy and Best Practice

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

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

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

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

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

12. Monitoring and Reporting

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

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

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

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

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

13. Conduct of the Committee

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

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

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

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

14. Review of the ToR

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

APPENDIX 1

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

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

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

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

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

1.1.4 management of the Delegated Funds in the Area;

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

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

2. General Obligations

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

2.2 The role of the ICB includes:

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

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

2.3 In respect of integrated working, the ICB must:

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

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

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

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

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

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

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

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

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

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

2.4.6.1 name of the Primary Medical Services Provider;

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

2.4.6.3 location of provision of services; and

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

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

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

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

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

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

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

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

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause **Error! Reference source not found.** (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be

able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in **Error! Reference source not found.** (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

APPENDIX 2

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2B: Primary Dental Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

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

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

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

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

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

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

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

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

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

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

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

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

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

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

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

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

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

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

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

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

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

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

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause **Error! Reference source not found.** *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 10 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, **Error! Reference source not found.** (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the

Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

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

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 12 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph 10.1**Error! Reference source not found.** above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

APPENDIX 3

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

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

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

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

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

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

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

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary

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

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

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

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

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph *);

2.5.6.3 location of provision of services; and

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

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

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

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

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

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

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause **Error! Reference source not found.** (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in **Error! Reference source not found.** (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

APPENDIX 4

THIS APPENDIX HAS BEEN TAKEN FROM THE DELEGATION AGREEMENT

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph* of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph * **Error! Reference source not found.** of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph x of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;

LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph*. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[1], specifically:

2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.3 lists of persons participating in the Electronic Prescription Service[2]

[1] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations

[2] Regulation 10 of the Pharmaceutical Regulations

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs* to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph*.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[3];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[4];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[5];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[6];

2.1.16 making LPS Schemes[7], subject to the requirements of paragraph 5;

[3] Schedule 2 of the Pharmaceutical Regulations
[4] Part 10 of the Pharmaceutical Regulations
[5] Regulation 11(3) of the Pharmaceutical Regulations
[6] Part 11 of the Pharmaceutical Regulations
[7] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[8] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[9];

2.1.21 determining Dispensing Doctor Decisions[10];

2.1.22 preparing and maintaining Dispensing Doctor Lists[11];

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[12];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[13];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

[8] Part 13 of the Pharmaceutical Regulations
[9] Part 7 of the Pharmaceutical Regulations
[10] Part 8 of the Pharmaceutical Regulations
[11] Regulation 46 of the Pharmaceutical Regulations
[12] Schedule 3 of the Pharmaceutical Regulations
[13] Regulation 94 of the Pharmaceutical Regulations

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[14]; and

2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph **Error! Reference source not found.** of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph* of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

[14] Regulation 114 of the Pharmaceutical Regulations

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

   9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

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

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

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

   12.1 collection and disposal of clinical waste; and

   12.2 provision of translation and interpretation services; and

   12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 29th May 2024

Report Title	**System Resource Committee – updated Terms of Reference**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	System Resources Committee – 2nd May 2024				
Executive Summary and Key Issues	System Resource Committee TOR have been updated as per a review from the Committee. There have been further clarifications around the aims and the remit of the committee, along with further clarification of the role of the Committee regarding the NHS Oversight Framework. As agreed with Committee members, the Committee will run in 2 sections. These sections include a partnership section and ICB section. Members are welcome to stay for both parts of the agenda, and this approach will also ensure that meetings are designed to make optimal use of partner time. Where possible, partners will be notified in advance of agenda items that would benefit from their involvement and engagement				
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without ToR ICB Board sub-committees would be unclear under what terms the committee operates, its jurisdiction and powers would not be defined and could lead to committees assuming powers they do not have and making inappropriate decisions. Add a risk rating, even if low: (4x1) 4 (4x1) 1 (residual meaning accepted risk)				
Management of Conflicts of Interest	The changes have been considered by members of the committee and supported. It is the Board's decision whether to approve the changes to the ToR. No conflicts of interests have been declared or identified.				
Resource Impact (X)	**Financial**		**Information Management & Technology**		
	Human Resource		**Buildings**		
Financial Impact	The Committee will provide oversight and assurance to the Board in relation to efficiency, outcomes and value for money in the use of resources and oversee and recommend proposals to allocate resources where appropriate across ICS partners to address finance and performance related issues that may arise				

Regulatory and Legal Issues (including NHS Constitution)	The System Resource Committee will obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice as authorised by the ICB Board.		
Impact on Health Inequalities	As detailed in the ToR		
Impact on Equality and Diversity	Not referenced in the ToR		
Impact on Sustainable Development	Not referenced in the ToR		
Patient and Public Involvement	N/A		
Recommendation	The Board is requested to: • Approve the updated System Resource TOR		
Author	**Ryan Brunsdon**	**Role Title**	**Governance Manager**
Sponsoring Director (if not author)	**Tracey Cox , Director of People Culture & Engagement**		

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

NHS GLOUCESTERSHIRE
INTEGRATED CARE BOARD

SYSTEM RESOURCES COMMITTEE

Version	Author	Approved by	Review	Type of changes
V1.0		Integrated Care Board	Annually	Approved Terms of Reference
V1.1	Ryan Brunsdon / Mark Golledge		Reviewed by System Resources Committee on 07.3.2024	Clarified the aims of the System Resources Committee Clarified the role of the Committee regarding the NHS Oversight Framework Highlighted that the Committee business would take place in two parts to make effective use of time of partners Clarified definitions including definition of value-based decision making Ensured that digital is within the remit of this Committee
V2.0	System Resources Committee		Final Terms of Reference reviewed by System Resources Committee on 02.5.2024	

Contents

1. Introduction 4
2. Purpose 4
3. Delegated Authority 6
4. Membership 7
5. Quoracy 9
6. Voting and decision-making 9
7. Frequency and notice of meetings 9
8. Committee secretariat 10
9. Relationship with the ICB and other groups / committees / boards 11
10. Policy and best practice 11
11. Monitoring and Reporting 12
12. Conduct of the Committee 12
13. Review of ToR 13
APPENDIX: Detailed remit and responsibilities of the Committee 14

1. Introduction

1.1. The System Resource Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution. These Terms of Reference (ToR), set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2. The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

2.1. NHS England outlined the role of the ICS in the delivery of integrated care in the paper 'Integrating care: Next steps to building strong and effective integrated care systems across England'. The ICS's role is to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money;
- helping the NHS to support broader social and economic development.

2.2. Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility.

- Each Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions.
- Each Committee will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members.

2.3. The overall purpose of System Resources Committee is to support the ICB to ensure that the system delivers value in health and care. This means '*achieving our priority outcomes through the most effective use of the resources available to us'*.

2.4. Achieving our priority outcomes means:

- Achieving health and wellbeing outcomes for our population
- Achieving outcomes for people that use our services, and
- Ensuring we improve health equity across specific population groups (in service access and experience as well as health and wellbeing outcomes).

2.5. In order to fulfil this function, the Committee will provide oversight and assurance for matters relating to system resources allocation, performance against strategic plans and financial performance including:

- Delivery of population health and wellbeing outcomes and service performance
- Impact of outcomes and performance on specific groups of the population.
- Efficiency, productivity and value for money in how the outcomes and performance are being delivered across the system.
- Financial performance both of the ICB and of NHS organisations within the ICB footprint including understanding how and where we spend our money.

2.6. Specific areas the Committee may consider that enable delivery of these objectives includes:

2.6.1. Improving population health and healthcare: by ensuring that resources are prioritised to support:

- improvement in health outcomes;
- increased efficiency and value for money of the delivery of healthcare across the ICS.

2.6.2. Tackling unequal outcomes and access: by ensuring that resources are prioritised to support:

- reducing health inequalities;
- increasing social justice and health equity.

2.6.3. Enhancing productivity and value for money: by ensuring that resources are prioritised to support:

- the system to take an approach that assesses value in decision making across organisations and programmes of care;
- delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches.

2.6.4. Helping the NHS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership.

2.7. In support of these functions, the specific areas for the Committee to consider are outlined within the Appendix to these Terms of Reference.

2.8. The Committee will have for oversight for Gloucestershire's performance within the NHS System Oversight Framework which is the NHS England framework for oversight of Integrated Care Boards and Partner Trusts.

2.9. The current Oversight Framework places ICBs and Partner Trusts into one of four segments based on overall performance. The Committee will pay particular attention to performance within the oversight themes relating to performance/outcomes and finance and use of resources.

2.10. Should NHS Gloucestershire ICB be placed into "Segment 1" (highest performing) or "Segment 4" (Recovery Support Programme) the Committee will be responsible for overseeing the response. For Segment 1 this will include identifying exploring opportunities from 'earned autonomy'. For Segment 4 this will include oversight of contributory work within the NHS England Recovery Support Programme.

2.11. The Committee will approve policies and standard operating procedures (SOPs) as relevant to the committee's business.

3. Delegated Authority

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

3.2. The System Resource Committee is authorised by the Board to:

3.2.1. Investigate any activity within its terms of reference;

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

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

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

3.2.5. Establish mechanisms to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the

membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3.3. For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

4. Membership

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

4.2. The Committee will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

4.3. The Board will appoint no fewer than five members of the Committee including:

- Independent Non-Executive Director of the ICB who leads on Resources (Chair);
- A Non-Executive Director who ideally holds a finance qualification – this could be a co-opted member from one of the ICS Partner Boards (Vice Chair);
- Chief Executive Officer of the ICB;
- Chief Financial Officer of the ICB;
- Director of Strategy and Transformation of the ICB;
- Director of Operational Planning and Performance of the ICB.

4.4. Members will possess between them knowledge, skills and experience in accounting; risk management; strategic and financial planning; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.5. Chair and vice chair

4.5.1. In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Director of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.5.2. The Chair of the Committee shall be independent and therefore may not chair any other committees.

4.5.3. Committee members may appoint a Vice Chair who will be a Non-Executive Director who ideally would hold a finance qualification – this could be a committee member co-opted from one of the ICS Partner Boards.

4.5.4. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.6. Attendees and other Participants

4.6.1. Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by other invited and appropriately nominated individuals who are not members of the Committee.

4.6.2. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the health and wellbeing board(s), secondary, mental health and community providers, notably:

- Directors of Finance of each main health system Provider partner (Community & Mental Health; Acute);
- Directors of Strategy of each main health system Provider partner (Community & Mental Health; Acute);
- Director of Finance and Director of Strategy of the Local Authority; notably as required for specific agenda items.
- One Independent Non-Executive Director of each main system partner (Community & Mental Health; Acute; Local Authority), who chairs their equivalent committee responsible for the allocation and utilisation of financial and other material resources.
- Primary Care

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

4.6.4. The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

4.7. Attendance

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

4.8. Structure

4.8.1. The business of the Committee shall consist of two sections:

Partnership Section – this will focus on areas of shared interest across system partners including matters relating to resource allocation (including financial – revenue and capital) and performance.

ICB Section – this will focus on areas of relevance for the ICB and will also include standing performance and financial updates.

4.8.2. This approach will also ensure that meetings are designed to make optimal use of partner time. Where possible, partners will be notified in advance of agenda items that would benefit from their involvement and engagement.

5. Quoracy

5.1. Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy.

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

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

6. Voting and decision-making

6.1. Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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

6.3. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

7. Frequency and notice of meetings

7.1. The System Resource Committee will meet at least 6 times a year. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2. The Board, Chair or Chief Executive may ask the System Resource Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

8. Committee secretariat

8.1. The Committee shall be supported with a secretariat function which will include ensuring that:

8.1.1. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

8.1.2. Attendance of those invited to each meeting is monitored and those that do not meet the minimum attendance requirements are highlighting to the Chair.

8.1.3. Except in the event of urgent meetings, meetings (including date and time) will be scheduled a year in advance. Meetings will usually be held as a hybrid meeting (both virtual and in-person).

8.1.4. The agenda and supporting papers will be issued 5 working days before the meeting. There may be occasions where there is a need for papers to be issued later (e.g. during operational planning) but this will be the exception rather than the norm.

8.1.5. All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. This will be in addition to the formal declaration of interest log.

8.1.6. Good quality minutes are taken in accordance with the standing orders and agreed with the chair so that a record is kept of matters arising, action points and issues carried forward;

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

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

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

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

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

9.2. The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the System Resources Committee.

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

9.4. The Committee will work closely with the other committees in the ICB where appropriate and relevant e.g. implementation of the Internal Audit recommendations and receive assurances to the Audit Committee.

9.5. The Committee will work closely with the other finance/resource committees in the ICS where appropriate and relevant to ensure consistency in best practice and appropriate transparency in the oversight, monitoring and probity of the use of public resources.

9.6. The Committee will investigate identified areas of concern with regard to the ICB's internal controls referred by another committee or the Board of the ICB.

10. Policy and best practice

10.1. When considering matters, the Committee should take into account the following points:

10.1.1. All statutory requirements applicable to ICBs (including Accounting, Health and Safety, Information Security, etc.);

10.1.2. NHS England requirements and standards;

10.1.3. Best professional practice and standards;

10.1.4. NHS Best practice and guidance;

10.1.5. Emerging risks and issues.

10.2. The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its terms of reference and within a limit determined by the Chief Finance Officer.

11. Monitoring and Reporting

11.1. When considering matters, the Committee should take into account the following points:

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

11.1.2. The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders;

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

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

12. Conduct of the Committee

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

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

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

12.2.2. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

12.3. Equality and diversity

12.3.1. Members must demonstrably consider the equality and diversity implications of decisions they make.

13. Review of ToR

13.1. The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

13.2. The System Resource Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

APPENDIX: Detailed remit and responsibilities of the Committee

1.1. The Committee will provide oversight and assurance to the Board in relation to:

Efficiency, Outcomes and Value for Money in the use of resources:

1.2. System Resources Allocation:

- Improve population health and healthcare delivery by ensuring that resources are prioritised to support improvement in health outcomes and increased efficiency and value for money of the delivery of healthcare across the ICS;
- Assure the approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICB strategy;
- Support the ICS objective of tackling unequal outcomes and access by ensuring that resources are prioritised to support programmes that reduce health inequalities and / or increase social justice and health equity;
- Support the ICS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership;

1.3. Enhance Productivity and Value for Money:

- Provide leadership across the system to adopt a values-based decision making approach across organisations and programmes of care;
- Assure the delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches to ensure financial resources are used in an efficient way to deliver the objectives of the ICB;
- to monitor the identification and delivery of system efficiencies across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged;
- to receive exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

1.4. System financial management framework

- to agree the strategic financial framework of the ICB;
- to have oversight of the ICB financial information systems and processes to be used for financial planning in line with the strategy and national guidance;

- to oversee and recommend proposals to allocate resources where appropriate across ICS partners to address finance and performance related issues that may arise;
- to consider all major and material investment/disinvestment service changes or efficiency schemes prior to submission to the Board for approval where appropriate.

1.5. Financial monitoring information

- to receive assurance on the effective monitoring of the ICB in-year financial performance against plan, with consideration of underlying activity and relevant performance data as appropriate, identifying key issues and risks requiring discussion or decision by the Board;
- to oversee and challenge the financial position and financial impacts (both short and long-term) to support decision-making;
- to be assured that all plans and reports are supported by robust activity and financial information;
- to be assured that there is robust financial and activity modelling to support the ICB priority areas;
- Provide oversight of the Financial Strategy including the medium-term financial plan (MTFP)
- to be assured there is a robust understanding of where costs sit across the system, the drivers of system cost, and the impacts of service change on costs;
- to oversee the development of an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood;
- to be assured that appropriate information is reported to manage financial issues, risks and opportunities across the ICB;
- to consider and comment on strategic risks on the corporate risk register.
- to have oversight of the financial position of ICS partners, and how this relates to the system control total to ensure that we achieve the best financial outcome for the system;
- to receive in year financial performance reports from ICS partners which are based on common approaches, estimates and judgements.

1.6. Performance

- Assure the ICB's performance against the Constitution and other Local Performance Measures.
- Assure that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

1.7. Capital

- Have oversight of the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers;
- Receive assurance that the estates plan is built into system financial plans;
- Have oversight of the digital strategy and plans that are delivered across the system;
- Assure the System capital programme and annual capital budgets against the capital envelope and consider actions that need to be taken to ensure that it is appropriately and completely used and recommend to the ICB;
- Consider proposals for investment in line with an agreed prioritisation process for the ICB and NHS partner organisations;
- Review recommendations from the capital prioritisation process and assure recommendation to the Board for approval.

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Public Session

Thursday 1st February 2024, 15.30-17.00pm
Board Room & Virtually at Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Ayesha Janjua (Chair)	AJ	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
Ellen Rule	ER	Deputy CEO & Director of Strategy & Transformation, NHS Gloucestershire ICB
Prof Jane Cummings	JC	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MC	Chief Nursing Officer, NHS Gloucestershire ICB
Participants Present:		
Andrew Hughes	AH	Associate Director, Major Projects, NHS Gloucestershire ICB
Becky Parish	BP	Associate Director of Patient & Public Engagement, NHS Gloucestershire ICB
Carol Alloway Martin	CAM	Councillor, Gloucestershire County Council
Christina Gradowski	CGI	Associate Director Corporate Governance, NHS Gloucestershire ICB
Jeanette Giles	JG	Head of Primary Care Contracting, NHS Gloucestershire ICB
Julie Symonds	JS	Deputy Chief Nursing Officer, NHS Gloucestershire
Jo White	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
Nigel Burton	NB	Healthwatch Representative, Healthwatch Gloucestershire
In attendance:		
Ryan Brunsdon	RB	Governance Officer, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB

1. Introduction & Welcome

1.1 The Chair welcomed RA and MC to the public session of Primary Care & Direct Commissioning (PC&DC) Committee. The meeting was also declared to be quorate.

1.2 There were no members of the public present in the meeting.

2. Apologies for Absence

2.1 Apologies were received from Helen Goodey (HG), Helen Edwards (HE) and Olesya Atkinson (OA).

3. Declarations of Interest

3.1 The Register of Integrated Care Board (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)

3.2 CAM declared an interest in agenda item seven as a patient of one of the practices. CAM had sought advice from Gloucestershire County Council (GCC) who had advised that it was fine for CAM to attend that part of the meeting.

4. Minutes of the Previous Meeting held 7th December 2023

4.1 The minutes of the meeting held on 7th December 2023 were approved as a true and accurate recording of the meeting.

5. Matters Arising and Action Log

5.1 **Action 4 –Tewkesbury, Newent & Staunton (TWNS) Primary Care Network (PCN) Evaluation. Action to be Closed.**
JW to bring back a suite of Quality Improvement projects to a future meeting. **Action to remain Open.**

Action 12 – PCN Support Sessions update. A verbal update was to be given during this meeting. **Action to be Closed.**

Action 13 – Monthly Dashboard Workforce numbers. Included in the Workforce Report. **Action to be Closed.**

Action 14 – Radiology Reporting Backlogs. Business Case had gone forward for additional radiologists and issue discussed at recent Board. **Action to be Closed.**

6. Questions from Members of the Public

6.1 There were no questions received from members of the public.

7. Application to merge Coleford Family Doctors and Brunston & Lydbrook Practices

7.1 An application had been received to merge Coleford Family Doctors and Brunston and Lydbrook practices from 1st April 2024. The practice list size on merger would be 13,400. The partners of the practices had originally agreed to merge in 2019 and patients were informed of a possible merger in 2020. This application had brought forward the merger and the practices were engaging with staff and their Patient Participation Groups (PPGs).

7.2 A merger before relocation would be a good thing from an organisational perspective, allowing them to build the team and enhance resilience. The merger was proposed for 1st April 2024, and they would become Coleford Medical Practice. The merger application was taken to the Primary Care Operational Group (PCOG) on 9th January 2024 and the areas discussed had been noted in the paper, particularly the importance of the merger in relation to the resilience and sustainability of the practices. The Primary Care team had informed all parties that they would be supported throughout the merger process.

7.3 There were no questions from members of the Committee.

***Resolution:* The Committee noted the report and approved the application to merge Coleford Family Doctors and Brunston and Lydbrook practices to become Coleford Medical Practice as from 1st April 2024.**

8. Application to merge Regent Street Surgery and High Street Medical Centre

8.1 The application was one of a proposal to merge Regent Street Surgery and High Street Medical Centre as from 1st April 2024 to become The Berryfield Surgery. The merged

practice list size would 11,774 patients. There had been a natural evolution between the two practices. The three partners were the same on each contract.

8.2 The merger would enable the practices to meet the challenges of primary care and it was hoped by merging they would become more attractive to new partners and clinicians. Patients had been constantly involved in the practices' journey to align the services ahead of the merger and any impact on patients would be minimal.

8.3 Engagement with staff had been ongoing since February 2023 and staff were keen to progress with the merger. PCOG had discussed the merger application at its meeting on 9th January 2024. Both practices would continue to be supported by the Primary Care team throughout the merger process.

8.4 It was to be noted that legal advice had been received in terms of the retention of dispensing rights.

8.5 BP noted that the practice had discussed the merger with their patients and the Engagement team would be very happy to work with staff to implement a PPG going forward.

***Resolution:* The Committee noted the report and approved the application to merge Regent Street Surgery and High Street Medical Centre to become The Berryfield Surgery as from 1st April 2024.**

9. Application from Brockworth Surgery to change Practice Area

9.1 An application had been received from Brockworth Surgery to change their practice boundary. The surgery were proposing to increase their practice boundary into areas that they already have registered patients residing in; and at the request of the ICB to include some rural sections of land ensuring practice coverage.

9.2 This had been discussed at PCOG on 9.1.24 who acknowledged there would be no significant impact on neighbouring practices and the proposed expansion will cover areas that currently do not have GP coverage and whilst these areas are rural and currently have limited scope for development, it would provide coverage if this changes in the future. AJ queried whether the change of boundary would destabilise the four other practices in the area. JG said that any impact would be very minimal.

***Resolution*: The Committee noted the report and approved the application from Brockworth Surgery to change their practice area by increasing their practice boundary.**

10. Highlight Reports

10.1 General Practice and Primary Care Networks (PCNs)

10.1.1 JW reminded members that this report was sent to the Board and summarised key workstreams for all the elements of the Primary Care and Place Directorate.

JW explained here had been some assurance work around some of the funding streams for Primary Care Networks (PCNs) for which work is still ongoing.

Considerable work was being conducted to ensure that practices and PCNs were deriving benefit from some of the courses being run as part of the Improvement Programme for NHS England (NHSE). JW said there were varying challenges which

would involve collaboration with NHSE and PCN Directors. More updates would follow (See Action 4 above).

JW updated members on the Learning Disability and Serious Mental Illness (LD&SMI) activity which was marginally below the same point last year but in line with the action plans recorded in December 2023 at 91%. As of 2nd January 2024, 39.7% of SMI Health Checks had been completed (the national target was 60%), a substantial improvement on the same time point for the previous year (26.8%).

Uplift information was being awaited on a number of enhanced services which usually required extra staff to be employed to deliver those services.

Following closure of two contingency hotels and one closing in April 2024, this would leave just two hotels open. This section of the meeting had been fully discussed in Part 2 earlier and detailed in the report.

Digital was part of the access recovery programme, a big part of which was around telephony work. Timescales and pace had been challenging along with practices needing to use a framework which did not necessarily include their current providers. Further updates would follow.

Action: RB to place Digital on the April 2024 PCDC Public agenda in relation to Primary Care Access Recovery Plan (PCARP). **RB**

10.2 Pharmacy, Optometry & Dentistry

10.2.1 The ICB were working with other South West regions to agree how to finalise the transition element of delegation for POD and reports were awaited.

The ICB were working with the Hub so that where dentists were not meeting their targets, remedial plans would be formulated with them to mitigate contract breaches.

All community pharmacies had now signed up to Pharmacy working together to build neighbourhood relationships between pharmacies and member practices. The digital element behind this will lessen the workload for practices receiving information back from pharmacies.

Workforce - The Fellowship Scheme for General Practice Nurses (GPNs) would cease at the end of 2023/2024 and Fellows onboarded before this time would receive 2 years' funding. Information around funding was awaited for 2024/2025.

Expressions of Interest were being actively collected from practices around the Family Care Flexible Staffing Pool.

There was continuing focus on apprenticeship numbers for staff retention and recruitment from entry level to senior roles. This was mainly for non-clinical roles but included pharmacy technicians and nursing associates. The Integrated Care System (ICS) Carers team were promoting family care roles to school age children in Gloucestershire and the We Want You team were providing information on working in the NHS.

Key work was continuing around the Primary Care Nursing Workforce Development with some study days coming up in February and some potential further money from the Fundamentals Programme. A total of 13 nursing students were being supported by Practice Education Facilitators.

10.3 Primary Care Strategy 2024-2029

10.3.1 The Primary Care Strategy was a massive piece of work and the Primary Care Strategy Group was chaired by Dr Olesya Atkinson (ICB Board member and PCN Clinical Director). The group were very active, with good representation and had elicited some really good discussions around the challenges.

10.3.2 CAM asked whether the triple vaccine, measles, mumps and rubella (MMR) would be used for measles. JS said that details were contained in the Quality Report and that the triple vaccine would be used. A piece of work was being done around public education on this.

10.3.3 AJ said the report mentioned a change in commissioning around Covid vaccinations and asked whether this relation to Section 7a delegation. JW said that a vaccination lead was in place which was really helping particularly due to the ICB were having to respond quickly to measles.

10.3.4 AJ commended Pharmacy First and said this was a fantastic opportunity in terms of linking with the public and being able to support them. NHSE were pulling back on many areas of funding and consideration would have be given as to how some of this would be picked up around retention in Primary Care, given that this funding would not be coming back this year or thereafter.

10.3.5 AJ also wanted to know how far off plan Primary Care were around the recruitment of some of the Additional Roles Reimbursement Scheme (ARRS) roles and asked JW figures could be provided on recruitment vs. planned figures and how far off plan Primary Care were in the recruitment of some of those roles. JW thought that this was on track but there was a challenge around using all the funding. **Action: JW to provide up to date information on the ARRS roles from PCNs at the next meeting in April.** **JW**

Resolution: ***The Committee noted the content of the PCN, POD and General Practice Highlight Report.***

11. Performance Report

11.1 JW explained that the South West region had produced a draft dashboard to examine some of the Access Recovery Plan indicators which included appointments. JW was keen for some feedback on data on the dashboard was presented, being especially careful with Red Amber Green (RAG) rating. A drop in face to face appointments for example of 2.1% was not significant compared to 12.5% nationally and given the constraints in practices, if this were clinically appropriate, this would be a sensible use of resources. The dashboard was still in development but it was hoped to bring this quickly on enabling people to see movement that need to be discussed, together with any performance concerns.

11.2 MC asked whether there had been any duplication between Gloucestershire Health and Care NHS Foundation Trust (GHC) and surgeries calling patents in for their Annual Health Checks these and wondered where resources were being put and whether there had been any problems in accessing information.

11.3 JS confirmed that there was a lot of training which was done alongside the Learning Disability Mortality Review (LeDeR) workstreams and the Learning Disability (LD) workstreams in which Trudi Pigott was involved. It was mainly driven by Primary Care

and more information could be given to MC on this in the joint meetings. JS explained that GHC would only support some of the shared accommodation or any of the inpatient mental health settings. JW said the challenge was around these Annual Health Checks taking place in the last quarter which was when a lot of the activity came through. The target was achieved last year and was expected to this year, but it had been very close.

11.4 JS said the timescales in terms of planning was always at 12-monthly intervals, but if this were to be moved forward, the number count would not be as good. MC said that those with learning disabilities generally died 15-25 years before the general public so this was a massive health inequality, therefore anything else that could be done would be welcome. JS said the local LD Group and LeDeR forums were very proactive. The Learning Disabilities update would be going through the Quality Committee and would be due soon.

11.5 AJ referred face to face appointment data and said that Gloucestershire was still showing below the national average. After discussion, it was agreed that a narrative should be included along with the numbers to accurately reflect the data being presented.

Action: JS and JW to include narrative in regarding face to face GP appointments. **JS/JW**

Action: BP to bring qualitative appointment data from Healthwatch to the April meeting together with results from the People Panel Survey re online services for the public vs face to face services. **BP**

11.6 JS said that clinicians had a different view on what data should and should not be seen and the Quality team could examine how that looked from a patient perspective around what types of things they felt was better seen face to face.

Key points from Communications Discussion:

- Checklists for patients
- Use Pharmacy First service to enhance public education in some areas
- Use the new website to build in information
- Consider the variations in communities and exercise caution
- Patient advice on how best to use their GP practices, giving examples of good practice in various formats
- Link up with digital hubs to give patients information on accessing services

Other comments:
JC said people often forgot or would panic when faced with an illness or some trauma and would decide what was best for them, which was to see a doctor. Communications needed to be repeated many times, be available for people when they needed it, and be offered in different languages. NB said If NHS 111 were better, it would help with the issue of patients deciding what was urgent.

11.1 Primary Care Networks

11.1.1 JW spoke about the various PCN indicators and their performance on the Investment and Impact Fund (IIF) dashboard. There were certain indicators which were more difficult than others. The Primary Care team did offer support to PCNs/practices so that they could make the best use of any available monies.

11.1.2 JW informed on the PCN ARRS roles recruited in December :

- North Cotswolds PCN recruited an additional 5 Digital & Transformation Leads (1 WTE)

- Rosebank PCN recruited an additional 2 Care Coordinators (total 1.76 WTE)
- TWNS PCN recruited an additional GP Assistant and a Physician Associate (2 WTE)

11.1.3 AJ asked how significant the impact would be of improving the accuracy of appointment data in terms of performance. JW said that Gloucestershire had issues that had been escalated regionally and nationally that would affect the indicator ACC-08 (Appointment Booking to Seen Time). It was unsure whether everyone would be affected nationally but there were some system errors around things being lost if they were being coded a certain way. This was a serious issue, especially as it was linked to funding. Some information was awaited on this and it was noted that there was still a lot of work to be done in sorting these system issues out.

11.2 Primary Care Access Recovery Plan (PCARP)

11.2.1 AJ recognised the good progress having been made on the Plan which was helpful.

11.3 Pharmacy, Optometry & Dentistry (POD)

11.3.1 There had been a slight fall in September against August 2023 of Units of Dental Activity (UDAs) and Units of Oral Activity (UOAs) which was representative of the region as a whole. It was a direction of travel that was not an area of concern and was expected. There was a well-documented piece of work that was addressing this. CAM expressed that it was felt as though POD was developing well and the position felt more comfortable than that of last year. There was some information on pharmacy items dispensed in the report.

11.3.2 AJ said that Optometry did not seem to be discussed as much, which ER thought was due to optometry being in a different place in Gloucestershire. The ICB (and previously CCG) had worked with optometry for over a decade, having developed strong relationships in Gloucestershire. The NHS had been recognised regionally in the 2023 NHS Parliamentary Awards for its outstanding digital optometry project. Due to the hard work on sustainability the public had good coverage on optometry with feedback being very good particularly around additional enhanced services. ER suggested clinicians be invited along to a future meeting to share some of the learning in optometry. BP mentioned audiology services being offered at optometrists.

JW suggested that liaison with Kerry O'Hara could incorporate Ophthalmology work into the Highlight Report. **Action: A presentation and report to be brought back to the PC&DC within the next 12 months on audiology and optometry.** **KOH/RT**

ER said it would be useful to understand any future contract risks. NB said he often used optometry services and was happy to help offer a patient viewpoint on this as part of the analysis.

Resolution: The Committee members noted the content of the Performance Report.

12. Primary Care Quality Report

12.1 JS updated on the Primary Care Quality Report, noting that all pharmacies had signed up for the service which had gone well. Now that this was up and running, work would revisited on repeat prescriptions and Out of Hours services.

12.2 The Primary Care Nursing Strategy had now been completed and was signed off yesterday. This would be available soon and would link into the wider Primary Care Strategy work as an Annex. This would address workforce and received the involvement of all the practice nurses.

12.3 JS said that regarding the contingency hotels, the updates discussed in the previous meeting had been sent to relevant practices and up to date information would be available regarding the contingency hotels. It was noted that some of the other ICBs had commented on the risks of homelessness where some of these asylum contingency hotels had closed. An assumption of there being somewhere for these people to go was not always the case.

12.4 A Reception, Staging and Onward Movement (RSOM) location was now in place at Beachley Barracks in Monmouthshire, which could accommodate approximately 200 new arrivals. There was a proposal to work alongside GDoc Ltd., to manage longer term medical provision for people bearing in mind that the site would remain open until the end of December 2024. There were approximately 13,000 Entitled Persons (EPs) across the UK, and it was worth noting that there were a further 16,000 EPs in Pakistan that would need to be transferred to the UK. The St Athans MOD base in West Wales had taken 500 EPs recently.

12.5 The biggest challenge locally was to ensure that these people were health screened and had access to GP provision whilst balancing this against what was an already very overstretched Primary Care service; in particular how Lydney would be supported to take this on. JS explained that the service model was based around on site provision and was confident that it would work over the next 12 months. Liaison with secondary care services would ensure any provision of specialist care needs. It was anticipated that this would operate as one big site as local authority housing was not available. Throughput was extremely slow and was not what the RSOM site had been set up to achieve.

12.6 AJ queried whether this should be added to the Risk Register or was it something that was a watching brief to be added to future agendas for updates. JS responded that with the model suggested and the funding provided alongside that from NHSE, then it was not a risk. If the model did not work, then it would become a risk. The funding from NHSE would be available this week and the skills of the medical staff would need to be well utilised. AR said there would be a lot of mental health needs alongside the physical health. JS mental health was a big concern for the children in the contingency hotels. Women's health was more of a concern with the adults. JS said this had been a huge ask at short notice with a lot of work involved.

12.7 BP said that an update on the System Experience Group would be brought to the next meeting. **Action: BP to bring an update on the System Experience Group to the next meeting in April 2024.** **BP**

12.8 AJ mentioned Experts By Experience presentation at the ICB Board yesterday and asked if this would be something that would be co-produced in the future, enabling best possible representation, to which BP responded that this would be the case.

Resolution: The Committee members noted the content of the Primary Care Quality Report.

13. Financial Report – December 2023

13.1 At the end of the November 2023 the ICB's Delegated Primary Care co-commissioning budgets were showing a £0.449m overspend position on the £80.9m budget Year To Date (YTD). The budgets had been reviewed and realigned based on planned expenditure. The YTD Pharmacy, Optometry and Dental (POD) position was £2.844m underspend with a £5m forecast underspend which was non-recurrent.

13.2 The Month 8 forecast for Primary Medical Services was an overspend of c£750k. The Investment and Impact Fund (IIF) for 2023/24 was higher than budgeted, creating an overspend in year. Mitigations against this had not proved possible. The overall overspend had been brought into the ICB position and was therefore covered.

Resolution: the Committee members noted the content of the Financial Report.

14. ICS Transformation Programme & ILPs Highlight Report

14.1 HG in her absence wanted JW to draw the attention of the Committee members that following the Locality and Neighbourhood showcase event on 15th November 2023, CAM requested attendees to submit abstracts for consideration at the 24th International Conference of Integrated Care to be held in Belfast. The overarching theme would be "Taking the Leap: making Integrated Care a reality for people in communities."

14.2 JW was delighted to say that further to this, six abstracts had been submitted and accepted from Gloucestershire, which were explained by JW. JW thanked CAM for her support and encouragement around this exciting opportunity to demonstrate the work of colleagues at this event.

Resolution: The Committee members noted the contents of the ICS Transformation Programme and ILPs Highlight Report.

15. Any Other Business

15.1 There was no other business to discuss.

The meeting formally closed at 17.05pm.

Date and Time of next meeting: Thursday 4th April 2024, 15.30-17.00, at 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)

Minutes Approved by: PC&DC Committee

Signed (Chair):Ayesha Janjua Date:4th April 2024

NHS Gloucestershire System Quality Committee Session

Thursday 15th February 2024, 2.00–5.00pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Ananthakrishnan Raghurum	AR	Chief Medical Officer, GICB
Hannah Williams	HW	Acting Director of Nursing, Therapy and Quality, GHNHSFT
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marie Crofts	MC	Executive Nurse & Director for Quality, GICB
Suzie Cro (deputising for Matt Holdaway)	SC	Deputy Director of Quality Programme Director Nursing and Midwifery Excellence, GHFT
Participants Present:		
Alison Moon	AM	Non-Executive Director and Chair of Quality Committee, GHNHSFT
Christina Gradowski	CG	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 Miles	JMi	Area Manager East Gloucestershire, Children's Services, GCC
Julie Symonds	JS	Deputy Chief Nurse, GICB
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Katie Hopgood	KH	Public Health Consultant, GCC
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Shabana Warne	SW	Assistant Director, Children's Social Care, GCC
In Attendance:		
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Maniza Rahman-Harris	MRH	Associate Non-Executive Director, GICB
Olesya Atkinson	OA	GP Partner and Clinical Director for Cheltenham PCN
Ryan Brunsdon	RB	Board Secretary, GICB.
Richard Thorn	RT	Senior Commissioning Programme Manager, GICB
Dan Corfield (Agenda Item 8)	DCo	Associate Director, ICS Development, GICB

1. Introduction and Welcome

1.1 JCu welcomed some new members to the System Quality Committee meeting. It was noted that this would be the last System Quality meeting for Alison Moon.

2. Apologies for Absence

2.1 Apologies were received from Matt Holdaway (MHo), Sarah Morton (SM), Becky Parish (BP), Melanie Munday (MM), Jo Bridgeman (JB), Siobhan Farmer (SF) and Vanessa Catterall. 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)

There were no Declarations of Interest.

4. Minutes of the last meeting held 13th December 2023

The minutes from the last meeting held on 13th December 2023 contained some small amendments in section 6.4 to include the word "not" and re-write the paragraph around risk discussion being good practice. The minutes were then agreed as an accurate reflection of the meeting and the minutes were approved.

5. Matters Arising & Action Log

5.1 Verbal update on Paediatric Audiology

5.1.1 SC informed the Board that the issues reported were in relation to governance and that no harm had come to any patients. Clear Standard Operating Procedures (SOPs) were being set up and would be signed off by the Surgical Board next week. The covering paper and Action Plan would be coming to the Quality Delivery Group at GHFT in March 2024 and any subsequent concerns could be brought back to this Committee.

5.2 Verbal update on Committee Effectiveness Survey

5.2.1 CG reported that this had gone to the Patient Engagement Team and a request had been made to see whether the Governance Team could be trained and have its own licences which would help with sending out more survey work. An electronic link allowing greater access to the software had not yet been enabled.

5.3 Verbal update on End of Life Care

5.3.1 JCu reported that a Chair's visit to Charlton Lane and Gloucester Royal Hospital had taken place two months ago around End of Life care. Palliative Care staff had expressed concerns around fast-track funding and delays. The subject was then raised again at the ICB Public Board meeting on 31st January 2024 by Deborah Evans and a request was made for a short piece of work to be done to examine the End of Life policy, the implementation of the guidance around fast-track funding, and whether the ICB were implementing correct decisions.

Benedict Leigh had mentioned that Gloucestershire ICB were spending significantly more on fast-track funding than other areas of the Country. This meant that people were having the choice of being able to die in their own homes, which was not necessarily an unwise decision. Gill Morgan had requested further work be undertaken and findings be brought back to the System Quality Committee.

MC informed members that this piece of work was still in progress and End of Life team were still examining information and considering the views of those staff working on the ground.

AR said he thought further education was needed around when to use the fast-track system in the county and to see what other support was available. Further work, in which AR was interested, was required in order to support patient choice and to manage symptoms during the last few months of life.

HW said that this was a subject which was very important to her and enquired as to whether this would involve sense checking with patients, families, and practitioners. MC said she was not able to quantify this, as queries had been raised at the time of the Chair's visit, where MC had not been present. MC said the feeling on the ground was that it was *not* felt as though more money was being spent on fast-track funding as previously

mentioned. It was important that the policy was being implemented as well as capturing what this felt like in district nursing etc., and also people being clear on, and knowing what fast-tracking actually was. HW offered help to MC and her team if this was needed at any point.

JCu recalled that staff that day had been really open about what they were doing well, alongside some of the challenges being faced on getting fast-tracking to Primary Care or independent prescribers to obtain prescriptions in advance.

The Palliative Care team had explained that they had applied for fast-track funding for someone that they felt was nearing the end of their life and wanted to be discharged home to be able to pass away there. The staff had informed JCu and Deborah Evans that the only way funding for the Hospice at Home service could be provided, would be go through the Continuing Health Care (CHC) service which would cause unnecessary delays and prevent people from getting home. Further scrutiny of evidence and data would be required as the staff currently only had small numbers to work with.

AM said that this work was supported by the GHFT Quality Committee who had discussed choices at end of life. Clarity would be needed around what was in scope and what was outside of scope in order to ensure that this was a focused piece of work. AM said the Trust would be happy to provide further advice if required.

A future update would be included as part of the agenda at the April Committee meeting.

5.4 Verbal update on Migrant Health

5.4.1 This would be covered in Item 7.3 of the meeting in the ICB Quality Report below.

5.5 Action Log

Action 4: OPEN

Action 14: OPEN

Action 16: It has been suggested that this action be closed alongside action 18 and superseded into a new action as this is an ongoing piece of work regarding quality metrics with the new CNO, new CMO and JC. **Action Closed.**

Action 18: It has been suggested that this action be closed alongside action 18 and superseded into a new action as this is an ongoing piece of work regarding quality metrics with the new CNO, new CMO and JC. **Action Closed.**

Action 24: To be discussed as part of the agenda. **Action Closed.**

Action 38: A revised risk report has been included within the papers and as part oof the agenda. **Action Closed.**

Action 40: To be included as part of the agenda. **Action Closed.**

Action 43: Learning from Deaths Report included as part of the agenda. **Action Closed.**

Action 44: Draft minutes from December included within the paper pack, and a verbal update from February to be given during the SQC. **Action Closed.**

Action 45: Verbal update provided under Matters Arising above with regards to Paediatric Audiology. **Action Closed.**

Action 46: This has been raised with the DHSC. **Action Closed.**

Action 47: Childrens Social Care update was provided during the meeting. **Action Closed.**

Action 48: Verbal update to be given at the Committee. An update was also requested at the January ICB Board to be brought back to a future Board/Development session. Regular updating will be presented to SQC. **Action Closed.**

Action 49: Annual Committee Survey to be discussed as part of the agenda. **Action Closed.**

6. Risk Report & Board Assurance Framework (BAF) Update

6.1 CG said that she and RB had done a first cut of the BAF data and had met with most of the Risk Leads in the ICB Directorates, having gone through the BAF with them to explain the advice and guidance around the writing of risks from Audit Committee feedback. CG explained the risks and ratings and how staff would be updating these. A further iteration would be available before being presented to the Audit Committee and it would then go to the Board.

6.2 JCu spoke about BAF Risk 8 being on the Risk Register and this felt to her as though this belonged to the Resource Committee. JM mentioned Pillar 2, Improving Health & Care Services and Improving Access to Care and did not want to lose sight of the fact that there were other people in the county apart from those waiting for acute care.

Discussion:

- BAF 8 on System Resources Committee BAF is to be moved to the System Resources Committee BAF as the levers to improve and mitigate this risk were the Resources and Performance, to sit under System Resources.
- The Director's Updates should be very short, pithy and current to enable the Audit Committee to have the necessary assurance that various Committees were examining the finer details of the strategic risks on their allocated BAFs
- MC mentioned the failure of getting timely access to services resulting in clinical harm, End of Life and residual risk scoring.
- CG had produced a Glossary of Terms to help staff determine which was a control assurance and which was an action.
- KH mentioned the Emergency Preparedness, Resilience, and Response (EPRR) risk and asked whether the Operational Group could have visibility of the Risk Report as she had not seen this yet.
- AM thought that BAF 8 should be looking at the backlogs and how to minimise health inequalities in the county, and how leadership for that would come through the System Quality Committee.
- CG said there were two strategic risks around inequalities and these had been amalgamated into one but this went to System Resources rather than to System Quality.
- JCu said that Quality and Performance often went together in other ICBs as a Committee. It was felt that the performance aspect should sit within the System Resources Committee and JCu felt this Committee should focus on system-wide

aspects, one of which was Health Inequalities and felt that should come to this Committee

- JSo said that Douglas Blair had noted that two of the BAF risks had been very similar to each other and the wording had not been sufficiently differentiated on the description and. The wording should be re-examined so that both these risks could be covered.

6.3 RB described how the reporting on risks had been revised and this was the first time that risks were being reported through a high level dashboard showing titles which would hopefully prompt some of the conversation. The Corporate Risk Register had been demonstrated to Risk Leads to show them how the Risk Register needed to be completed on a monthly basis due and to provide the correct assurance and scrutiny that risks were being reviewed by leads and reported to the appropriate Committees. Currently there were three risks rated at 20 for the System Quality Committee but one of those would be requested to be closed at the Audit Committee on 7th March 2024.

6.5 JCu recognised the amount of work having been done and said that the Risk Register contained some very specific things. Any high level comments could be made today but any other comments could be fed back and a review could be conducted before the next meeting on 3rd April 2024.

6.6 JSo said it would make sense to have the Register denoting those risks at 12 or above due to the strategic nature of this Committee, understanding that Operational Executives would be managing those lower rated risks. JCu and other members agreed with this suggestion. This Committee should be used as a way of flagging risks that required a more systematic and system approach to management, support and improvement. JCu also agreed that harms caused by any delays in the system was an important part of the System Quality Committee agenda.

Action: CG to review the BAF risks, move BAF 8 risk to System Resources BAF, remove risks rated 12 or below and bring a revised BAF to the April meeting. **CG**

Resolution: The committee noted the updates on the Risk Report and Board Assurance Framework.

7. System Partner Highlight Assurance Reports

7.1 GHFT including Maternity/LMNS

7.1.1 JCu spoke about the methods of reporting individual system assurance, the flagging of potential risks brought to the System Quality Committee and how these would feed into the Committee to be taken forward or discussed further. SC said that GHFT would always provide the Quality & Performance Report, the Key Issues and Assurance Report (KIAR) which included links to papers, whilst other papers would be seen by the GHFT Board and could be read for interest.

SC updated with highlights:

- A progress meeting on the Section 29A received from Maternity was expected with the Care Quality Commission (CQC) at the end of March 2024 with two actions from the Notice expected to be completed.
- Surgery did not receive another Section 29A and had demonstrated significant improvement. An action plan was in place for must do and should do actions.
- Reports were still awaited from inspections in Children and Young People, Urgent and Emergency Care (UEC). A draft report had come in for Stroud Maternity but needed to be checked by the Trust for factual accuracy processes.

- A link had been included for the Trust's communications around the BBC Panorama programme. The feedback from staff had been one of sadness but before that programme had been aired, many improvements had been made within Maternity services.
- Maternity services did however remain challenged and pressurised and were still on the Maternity Safety Support Programme.
- The CQC Maternity Services Report was published on 9th February 2024. This would be taken through to the Quality and Performance Committee and stated that Gloucestershire was on a par with other organisations and there were no declines in the scores.

JCu said that she had found the Maternity Report an interesting read and it had contained a large amount of detail and demonstrated the considerable work undertaken in order to document everything.

KH referred to the drop in figures for September 2023 to 20.7% when it was normally in the 80% plus region for the Two Week Wait breast cancer symptomatic referrals. SC said she believed this had been addressed in the Trust's recent Quality and Performance Committee with additional reports having already been taken to the Committee. AM thought this data could be out of date and this could change.

Action: SC to provide an update on Breast Services and bring to a future meeting. **SC**

AM stated that here were a huge amount of papers for this meeting and she asked where the System Quality Group fitted in, in terms of detail around organisations. This is a challenge for staff in the Trust who spent a great deal of time in feeding the regulators which created a huge amount of paperwork.

MC thought this Committee could concentrate perhaps on top five highlights and five concerns to keep things simple. The Committee needed to know where to look for gaps and where to drive improvement. JS felt it would be good to highlight specific things and to note what it felt like for those staff involved on the ground. If documents were too big, they could lose their meaning and people might not be able to digest them thoroughly.

AR stated that the lack of consistency around data was a worry. This was an issue that needed further investigation, especially around mortality. JCu thought this might have been picked up in the Trust but would be discussed later on in the meeting.

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 JM and HW updated the Committee:

- There was a focus on the quality priorities that had been identified. More detail on this was contained in the Appendix.
- The new Complaints process meant that longer delays might be experienced around the more complex complaints, but a lot more of these would be resolved earlier on, which would be of benefit to patients.
- Housing still remained a big system issue for patients being discharged.
- GHC continued to make good progress on data reporting and demonstrating Least Restrictive Practice.

- The GHC Quality Committee were reassured that any pressure ulcers (managed by GHC but that had not developed whilst under the care of GHC), were managed appropriately. HW was proud of the level of expertise exhibited by staff and had no concerns. System-wide group reporting was beginning to identify the areas for which increased education (outside GHC) were needed.
- A suite of reporting metrics had been developed to show the signals of Closed Culture rather than the noise. These were focused on areas where Closed Culture was more likely but not exclusively. They would be rolled out to all areas, including Community Teams.
- All actions following the Trust's core inspection nearly two years ago, were completed and services not inspected had completed their self-assessments. Additional Peer Reviews would be undertaken.

JS said she would like any learning on pressure ulcers to be shared and maximised in Primary Care so that this could be replicated. MC said the data relevant to PU's (developed in service or not in service) and related pathways would be areas of examination to understand PU's per overall contacts, for instance so that evidence was available. This could be broken down per team enabling visibility of the level of pressure related to harm. HW said she would be happy to support work in this area.

JSo expressed concern around the Referral To Treatment (RTT) deadlines in the Report referring to services significantly missing targets and some having been changed from 8 weeks to 18 weeks. HW said some of the locally mandated services were being examined to make them more reflective of what was happening on the ground. HW explained the long waits were due to Covid catch ups, with staff having been redeployed during the pandemic. Individual recovery plans were in place for each service. HW gave assurance that waiting lists were constantly reviewed from a risk perspective, ensuring that people's needs were assessed during those waits. **Action: ICB Contract Manager to provide JSo with information on locally and nationally mandated services.**

ICB Contract Team

JCu said the focus needed to be on what the System Quality Committee could do to drive improvement forward, examining resources and opportunities to relieve pressure in Primary Care to lessen the health impacts on the population. HW said that GHC would be, and were already, heavily engaged with any quality improvement activity, although aspirations needed to be realistic due to national workforce shortages, an ageing workforce across all therapies, as well as the lowest numbers ever for nursing degree programme applications.

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 JS updated on the Report which had already been presented at the Primary Care and Direct Commissioning (PC&DC) Committee on 1st February 2023.

Highlights were:

- The Pharmacy First initiative where all 107 pharmacies had signed up for the scheme with the scope being impressive and good feedback having received.
- Beachley Barracks in Monmouth was a site for relocating Afghan EPs (Entitled Persons) who had the right to reside in the UK. GDoc would now be providing a service model for health screening to support medical and nursing services on the

camp. JS updated further as per the Report, saying this would be a regular agenda item for this Committee.

JCu said she would be interested in OA's view around Primary Care quality. It would be good to see some data and something that demonstrated the differences having been made in the parts that the ICB was really responsible for. MC said that this had been discussed with JS earlier in the week and the quality team were looking to review repots and content. JCu said it would be useful to know if any incidents were ever reported in Primary Care as they were seeing large numbers of people all the time.

OA said that there would often be an overlap between PC&DC and this Committee as far as papers were concerned and would have expected to have seen something around appointment data, as well as other things around quality improvement. G-Care now enabled GPs to report in more frequently around general practice. **Action: JCu said further insight and suggestions from OA about what to include in future reports from Primary Care would be much appreciated.** **JS & OA**

It was agreed that regular updates would be provided on Migrant health at future committee meetings.

Resolution: The Committee members noted the verbal update on the Integrated Care Board (ICB) Quality Report.

7.4 Children's Social Care

7.4.1 JMi said Gloucestershire Children's Social Care had refreshed its improvement plan and was now working to a multi-agency Ambitions plan, focused on achieving a 'good' outcome at the next full inspection, anticipated in 2025. The Ambitions plan reflected the recommendations of the recent National Review of Children's Social Care.
Action: JMi to share the Ambitions Plan with Committee members. **JMi**

Demand for services remained high with a high number of children subject to Child Protection Plans and a high number of children in care. The Ambitions plan would ensure that the right children were being protected and looked after and that the system worked alongside and with families to create change.

JMi explained that there was a robust audit process in place with where approximately 40 children's records were thoroughly audited and moderated every month. Advanced Practitioners, undertake 'Practice Weeks' when senior leaders went back to practice with social workers and gathered feedback from children, young people and families. JMi offered to circulate the Ambitions Plan to the Committee if they so wished.

JM said she had attended the Children and Young People's Day at Churchdown recently which had revealed that Education, Health and Care Plans (EHCPs) were not very well integrated. There were also a number of children who were not able to be educated in Gloucestershire with a desire for more preventative work in a joined up way. JM asked where feedback on education would be obtained in terms of the numbers of children being excluded or not receiving any education at all. **Action: JMi to collate data on numbers of children excluded from school or not receiving schooling to inform a report to be brought back to the next System Quality Committee meeting.** **JMi**

It was suggested that Business Intelligence might be able to provide data in the future around those children with neuro-developmental issues who may not be in education, training or employment.

JM said that huge investment could be made by initiating preventative work to prevent children being taken into care or being excluded and to reduce inequalities and prevent people from being harmed. JCu said early intervention tied in with some of the Integrated Locality Partnership (ILP) and Primary Care Network (PCN) quality improvement project work which was really important and all focused on health inequalities. JMi said again, it was important to target the right children for preventative services.

Resolution: *The Committee members noted the verbal update on Children's Social Care.*

7.5 System Quality Group Report

7.5.1 JCu said that she would like to see draft minutes of the System Quality Group as soon as possible after they were available. JCu noticed that the Inner City Gloucester PCN mortality rate was 25% higher than any other PCN in the South West but this was not noted on any of the Quality Reports or papers. This was a high number and was likely to be related to health inequalities and access to services. This was to be included within the Agenda for the April Committee.

RM said that this work had come about from the South West Critical Thinking Unit at NHSE and had been discussed widely at the System Mortality Group (of which AR was the new Chair) and this was on the agenda for the next System Quality Committee. The South West Critical Thinking Unit would be presenting to the System Mortality Group and RM would ensure that this was reported back to the Committee. This linked to the work on heatmaps which would show where the biggest health inequalities were and where the collective focus was required.

KH said she would be happy to bring work to the System Mortality Group and said that Public Health were in the process of developing a Power BI dashboard around health inequalities. This could help with some of the Core20PLUS5 activity. **Action: KH to bring back some further information on the Power BI dashboard to demonstrate health inequalities activity, to a future meeting.** **KH**

Resolution: *The Committee members noted the verbal update from the System Quality Group Report and the content of the draft December minutes.*

Resolution: The Committee members noted the verbal update on the System Quality Group Report.

8. CQC Inspection Preparation

8.1 MC stated that Trudie P in the quality team alongside DCo was leading on this work which is in its infancy given the lack of confirmation of the metrics from CQC as yet. MC is attending a further meeting with the CQC around the inspection metrics so will have further information following that. DCo explained that 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. Pilots for ICS assessments in Dorset ICS and Birmingham and Solihull ICS began in August 2023 with a conversation to be held shortly with Dorset ICB to see how they had managed with their pilot.

Operational planning timelines were very late and therefore the dates around ministerial approval, the publication of methodology and guidance and the go-live dates were currently very uncertain and likely to slip by at least a month.

DCo described the Assessment Framework overview whereby the focus of the ICS assessments would be examining the following three themes:

- Leadership
- Integration
- Quality and Safety

Whilst this was preparatory information-gathering work, the CQC assessment would include interviews with patients, families, carers and the wider public as well as staff and leaders, non-ICS partners including regional, other regulators, other accreditation bodies and multi-agency bodies.

DCo explained the governance arrangements saying that a short term CQC Preparatory Task and Finish group would be set up, which would be held to account by the Quality Committee via the System Quality Group with appropriate reporting. It was proposed to provide a regular 1-page RAG report to Strategic Executive via Operational Executive.

An Evidence Tracker had been created which had broken down all the subject matter to be achieved which would involve experts across the system. ICB leads would be using this to populate as much evidence as possible which would give the ICB a self-assessment from which a Gap Analysis and Action Plan could be created. Despite the Action Plan not being finalised, DCo said he would be happy, if need be, to present this to the CQC to demonstrate the work already having been completed so far. Work was already underway on collating further evidence.

8.2 JSo asked whether other Committees would be involved, as well as the System Quality Committee and the ICB Board, as it would involve a good deal of scrutiny around the Board Assurance Framework (BAF) risks. MC said that this was new to everybody and would involve essentially involve all Committees. However, further intelligence would be gathered from Dorset ICB, with still more work for the CQC to decide how this would play out. DCo said there would be a couple of lead names initially to ensure that the right degree of information was being provided, without unnecessarily involving others at this stage.

8.3 SC said that the approach looked robust and it would be good to test this when some of the Trust's reports were published to be able to look and track some of the quality issues.

EW said information was being shared from GCC with DCo and the team with regards to this new approach from the CQC and in terms of Local Authority Assessments, the CQC were announcing around six per month and as soon as South West Council were notified, then this would be shared with colleagues. MC said that patients and other stakeholders such as the voluntary sector, would be very much involved with all the work.

DCo would be reporting back to the System Quality Group on risks and progress as the evidence base continued to be built.

Resolution*: *The Committee members noted:

- ***The information available to date regarding the anticipated changes and approach to CQC system assessments.***
- ***The preparation work to date, as supported by Operational Executive (23rd January) and Strategic Executive (15th February).***
- ***The Committee members approved the proposed governance and reporting arrangements and requirements for the CQC preparatory work.***

9. Patient Safety Incident Response Framework (PSIRF) and Plans for Ratification of GHFT & GHC Plans

9.1 RM said that Version 1 of the system policies would be evolving throughout the year with GHFT and GHC having approved their policies, the ICB policy approved by the Executive Team on 23rd January 2024, which would be going live on 1st March 2024. The policy was being brought to this Committee for final ratification and approval. This would link into some of the areas within the assessment framework under CQC.

9.2 There were changes on how insights would be gathered and how outcomes would be shared, and most importantly, sharing the learning. Implementation of some weekly safety huddles would be designed to bring intelligence together and triangulate information. The System Safety Group would start with AR as Chair and this would feed into this Committee. A monthly PSIRF Implementation Review Group would also run for a year.

9.3 A review of the policy would take place after six months to examine what changes were needed and how things were working, with a formal review at 12 months, which would come back to this Committee.

9.4 MC thanked colleagues for all the work achieved before her arrival saying this was a massive change around incident reporting and learning. MC stressed the importance of people needing to be fully trained around any investigative work, which would take longer whilst using the new PSIRF. MC thought the outcomes would be far more significant in terms of the learning. JCu agreed that the new system responsibilities would be changing and thought the new approach would be beneficial.

9.5 AM asked what the picture for Gloucestershire as a system would be around this around detailed education, training and support to aid staff with a different way of working. AM asked if a short description could be written from a staff and/or clinical point of view about the new system changes in the ways of working in Gloucestershire. **Action: RM to ask Patient Safety specialists to draft a short paper on the new PSIRF in Gloucestershire for staff and clinicians.** **RM**

9.6 AH suggested that it might be useful to build a stakeholder map and this was an opportunity to challenge behaviours in a way not previously done before and to look at meaningful actions rather than just to review and close down actions. AH pointed out that the ICB policy had not been circulated with the papers. **Action: RB to circulate the ICB PSIRF policy document to members of the Committee.** **RB**

9.7 AR suggested that the Committee members authorise the Chair to sign off the ICB policy for PSIRF. JSo and JCu said that they would be happy to look at the policy by 20th February 2024 and give formal confirmation that approval was granted at that point. The policy would be circulated to Committee members and unless there were any major concerns, this would be positively approved. RM and the Quality team were thanked for the work that had gone into bringing the PSIRF policy to fruition. **JCu/JSo**

***Resolution*: The Committee members were happy to approve the ICB PSIFR policy subject to confirmation from the Chair and Co-Chair. The GHFT and GHC policies for the Patient Safety Incident Response Framework (PSIRF) had been approved by their Boards and were ratified by the System Quality Committee.**

Post Meeting Note: The Chair approved the ICB PSIRF policy following the meeting which was then circulated to members.

10. GHFT Learning from Deaths Assurance Report – Q4 January to March 2023

10.1 SC informed the Committee members that the Hospital Mortality Group was chaired by Mark Pietroni and the Learning from Deaths Report was produced from that meeting and went to the Trust's Quality and Performance Committee and also to the Board. Key issues to note were contained in the report and questions and comments were invited from Committee members.

10.2 AM and the Committee had found the verbatim comments in Appendix 2 of the report very interesting and important. There was reliance on the Mortality Group to raise any outliers and one for this report was around weekend discharge, for which Mark Pietroni had instigated a piece of work.

10.3 JCu said weekend mortality was mentioned but there were no further details. It had now been flagged and work done around this would come back to the Quality Committee at a future date. JCu said it was reassuring to see a good level of oversight. It was noted that the Summary Hospital-level Mortality Indicator (SHMI) was back in range but only just and JCu expressed a view around perhaps people thinking it was acceptable to be somewhere in the middle, rather than aspiring to be amongst the best, and to take steps to bring the Trust to that position. Upper gastro intestinal (UGI) mortality had been flagged by members of the public.

10.4 AR stated that he did not think that the SHMI was where it ought to be, which could possibly be due to coding issues. AR said the trends around mortality in certain areas which should be noted and it was hoped that the system could work collaboratively to share the information already available, particularly in Primary Care, to try to rectify any data issues.

10.5 AM would like to use the UGI issue that had gone to AR see whether it should have been flagged in internal systems and processes within the Trust before it was brought to AR's attention by a member of the public. AM wondered whether she and SC could use this as a live example and back track into the systems in order to be able to describe the story and examine the issues surrounding it. AR said this had been discussed and reviewed last year but there was a bigger piece of work here. AR said he would like to use this as an example to look at processes from which the system could learn how to flag potential problems. **Action: AR/SC to examine data mortality reporting and processes bring findings back to a future Committee meeting.** **AR/SC**

Resolution*: The Committee noted the content of the GHFT Learning from Deaths Assurance Report.*

11. Local Government Peer Review Report

11.1 EW informed the Committee that the Peer Review Report had been published in October 2023 and other system partners and organisations would have the opportunity to see this. This contained things that were relevant to the ICS system work and would be of interest to those involved in system planning. Slides had been circulated prior to the meeting. The Improvement Plan was still in draft form and had not been signed off internally by GCC, but it was felt useful for the Committee to have sight of it.

11.1.2 There were no surprises revealed by the Peer Review, but certain things had been prioritised and needed to be addressed at pace in terms of the emphasis that it was felt the CQC inspection might place on some of those things.

11.3.2 Positives:

- It was recognised that staff were dedicated, skilled and committed to delivering good outcomes to people.
- New senior staff appointments were seen as positive by staff and partners giving opportunities for transformation of the service by the new team.

Areas of Improvement:

- Embedding the voices of local people in planning and design, through co-production. This had not been as well recognised in Gloucestershire as it had in other local authorities and steps were being taken to really drive this forward.
- It was imperative for staff at all levels to use data intelligently to drive transformation and manage business as usual, and to invest in the capacity and capability and use of data analysis tools. Work was being undertaken around health checks for internal data.
- Greater clarity was needed around key priorities and narrative, aligned to the Transformation Programme to ensure this was fully communicated and understood.
- The partners in the health and care system were well aligned, but there was potential to further develop strategic intent and system-wide solutions.
- There is insufficient, visible and data driven assurance that the expectations of the section 75 agreement with GHC to deliver Care Act duties in relation to Mental Health Social Work and Occupational Therapy were being met. This had moved up to the top of the list of priorities and leadership and focus would be directed to some of those areas of work.
- The service, the Council, and its partners needed to further develop a collective understanding of the CQC framework and its potential implications and work together to achieve the best possible outcome. It was hoped to work closely with DCo and team around the implications for the system as well as for the GCC.

Regular updates would be provided to the Quality Committee on the Improvement Plan.

Resolution*: The Committee noted the verbal update on the Local Government Peer Review Report.*

12. GHC Trustwide Inpatient Safe Staffing Review 2023

12.1 HW updated on the paper, which was for information only and had been circulated prior to the meeting. Due to the NHS Triple Lock, it had been advised that it would be much easier for this proposal for investment to be successful if it were to be shared with the Committee from a quality perspective.

12.2 HW explained how the Trust were required to produce an annual Safe Staffing Report to Board, in addition to the six-monthly census. It was expected that the Trust would use the evidence-based tools for the most appropriate environment.

12.3 **Proposed cost of revised model:**
The proposed total cost to fully implement the revised staffing model was £4,064,521 for Community Hospitals and Mental Health Inpatient units in GHC (excluding Montpellier Unit and Berkeley House).

Total Additional WTE
This equated to 34.1 WTE Registered Nurses (RN's) 's and 48.7 WTE Health Care Support Workers (HCSW's)
• Mental Health 39.7 Total - 19.7 RN's WTE 19.8 HCSW

• Community Hospitals 43.3 Total – 14.4 RN's 28.9 HCSW

12.4 **National benchmarking**
As a Trust, GHC appeared to benchmark notably low for the number of care hours per patient per day (close to the middle of the range as whole workforce at 116/190). The paper clearly articulated that the Trust needed this investment and would offset the current agency spend at the same time.

12.5 MC was pleased about this good piece of work which contained a lot of detail and the evidence based methodology used and was really good in examining the Safe Staffing requirements. MC had a few clarifying questions about data and community hospitals which she would take up with HW outside of the meeting. It was hoped in future to develop a system Safe Staffing model as this was the sort of paper and standard that should be aspired to. MC stated that there were plans to review community hospital patient populations and this may have an impact on staffing required however this was not addressed in the paper and the paper did not include the new Forest of Dean Hospital because the staffing for that was already established.

Resolution*: The Committee members noted the content of the GHC Inpatient Safe Staffing Trustwide Review 2023.*

13. Policies for Approval

13.1 Removal of Benign Skin Lesions

13.1.2 The proposed changes to the ICB policies relating to removal of benign skin lesions, management of non-specific low back pain, and use of Bevacizumab for non-ischaemic central retinal vein occlusion and branch retinal vein occlusion, had been reviewed and recommended for approval by both the ICB Effective Clinical Commissioning Policies Group and the System Clinical Effectiveness Group.

13.1.3 JS queried how facial disfigurement would be classified, represented, and wondered if this had been explored elsewhere. **Action: JS to follow aspects of facial disfigurement up with RT following the meeting.** **JS**

13.2 Management of Lower Back Pain and Sciatica

13.2.1 The policy had been changed to increase various methods of pain relief (epidural injections and facet joint injections etc.) which could increase workloads but reduce potential surgeries. MC said she would like to understand the clinical process and JCu said that clinicians had sight of all policies before they came to the Committee. KH queried the reduction of effectiveness over time of repeat injections. RT explained that injections would be allowed only where long term benefit had been demonstrated. The impact would be checked every time to ensure that this was the right thing for the patient. The new policy would replace the old one as it was no longer used.

Resolution: ***The Committee approved the Skin Lesion and Back Pain policies following review and update.***

14. Meeting Review, Items for Escalation to the Risk Register and Any Other Business

14.1 Any comments on the meeting or the Risk Register should be directed to the Chair. Thanks were extended to Alison Moon for all her assistance with the meetings and she

was wished well for her future roles. There were no items of Any Other Business to discuss.

The meeting formally closed at 17.05pm.

Time and date of the next meeting:

Wednesday 3rd April 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 8th February 2024, 14.00 – 16.00pm

Virtually and in the Board Room at Shire Hall, Westgate Street, Gloucester, GL1 2TG

Members Present:		
Karen Clements (Chair)	KC	Non-Executive Director, Committee Chair
Emily White	EW	Director of Quality, Performance and Strategy, GCC (Deputising for Sarah Scott)
Marie Crofts	MC	Chief Nursing Officer, ICB
Prof Jane Cummings	JC	Non-Executive Director, Committee Vice-Chair
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
Coral Boston	CB	Lead for Equality, Diversity & Inclusion, GHFT
Neil Savage	NS	Director of HR & OD, GHC
Ruth Thomas	RT	Associate Director OD, Learning and Development, GHC
Sophie Atkins	SA	People Programme Manager, ICS
Zack Pandor	ZP	Strategic Workforce Transformation Programme Manager, ICS
Anis Ghanti	AG	Head of Organisational Development & Leadership GHC
In attendance:		
Nikita Davis	ND	HR and Governance Project Officer, ICB
Ryan Brunsdon	RB	Board Secretary, ICB

1 Introduction & Welcome

1.1 KC welcomed everyone to the meeting adding that she was pleased to be chairing her first Committee meeting.

2 Apologies for Absence

2.1 Apologies were received from Dr Ananthakrishnan Raghuram (AR), Deborah Evans (DE) and Sarah Scott (SS).

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 26th October 2023 were approved as an accurate record of the meeting.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **26.10.2023, Item 6.7** – ICS People Function Summary Report. This action was requesting closure. Link to ASC workforce infographic sent to Committee on 13.11.2023. **Action closed.**

6 Integrated Care System (ICS) People Function Summary Report

6.1 TC gave an overview of the People function summary report, highlighting the information around consultant and junior doctors' intentions relating to future strike action which is likely to be forthcoming.

6.2 TC noted a positive change that had been made to legislation relating to volunteers, explaining that employers are no longer required to complete a full employment history for all volunteer applicants, therefore helping to streamline the recruitment process.

6.3 TC relayed that the ICB is in the process of bidding for two grants. The first is called Volunteering for Health and is a grant of up to £500,000 for systems to develop their capacity and infrastructure around supporting volunteers across health and social care; an expression of interest (EOI) has been submitted at this stage and is being led by the Gloucestershire Hospitals NHS Foundation Trust (GHFT) Charity Director. The deadline for submitting the initial bid is 23rd February 2024.

6.4 The second EOI has been submitted for Work Well funding which is a national initiative and provides an opportunity for up to 15 sites to progress work to help people with barriers to employment; this is due to the significant numbers of people who are currently out of work and citing ill health as a reason. The funding would be used to provide a light-touch assessment and support service, and if successful Gloucestershire would work on a locality basis across the six districts in order to tap into local support offers and services.

6.5 TC gave an overview of the We Want You project being run by the Careers and Engagement team who are targeting years seven to nine in 19 secondary schools across Gloucestershire and aiming to raise the profile of health and care careers through various workshops and drama-based sessions. TC reported that the project had begun to garner interest across the Southwest and nationally and had recently featured as part of an NHS Employers case study.

6.6 NS highlighted that both GHFT and GHC had been successful in securing funding from the regional team for two fixed-term People Promise managers to support delivery of the *People Promise* commitments. GHC have advertised for the role, which is for 12-months.

6.7 CR reported that GHFT will be advertising the role shortly and confirmed funding was available for 18-months. CR added that GHFT are in a slightly different position as they already have a staff experience improvement programme, which has been running for 18-months. As much of the job description for the people promise manager was similar to the staff experience manager's role already in place, they have found a way to integrate the role as a temporary workstream within the wider programme.

6.8 TC explained that the People Team had been engaged as part of the wider operational planning process and will be involved with refreshing the Joint Forward Plan and

producing operational narrative for the overall submission. Full operational planning guidance for the coming year is yet to be received so the expectations around the people function aren't specifically clear, but there is clarity around expectations regarding workforce numbers, productivity, and agency and temporary staffing expenditure. For example, agency spend being no more than 3.2% of the total pay bill, keeping workforce numbers at 2023/24 levels and being able to evidence productivity improvements. TC added that the three sub-groups of the People Board are looking at the work plans for next year and refreshing the "plans on a page" (POAP) which will draw on the ambitions set within the People strategy. TC reported that there may be a need for some out of committee engagement to ensure the narrative and actions being highlighted for 2024/25 are supported by the Committee and in line with priorities to address current workforce challenges.

6.9 SEA advised on the operational planning submission deadlines:

- 1st submission is due 29th February however, this may be pushed back if the final guidance isn't circulated this week.
- 2nd submission is due 21st March.
- Final submission is due in May and should incorporate feedback from NHS England (NHSE).

SEA confirmed that the steering group POAP's would need to be circulated virtually for approval to meet the various deadlines.

6.10 CR queried whether the reference to keeping staffing to 2023/24 levels referred to worked or established levels. TC confirmed it meant worked. SEA informed the Committee that the workforce leads were in discussion with finance leads and have contacted NHSE with numerous queries to aid with the response.

6.11 KC remarked that the Committee are charged with overseeing actions to mitigate what is the joint top risk for the system and acknowledged the challenges and constrained timescales, but posed the question of how all the organisations will work together to ensure that the people plans in each part of system and across it are comprehensive, coherent, and robust enough to deliver meaningful improvements to our people outcomes. KC added that this would be a conversation for a smaller group outside of the committee to ensure that at the end of the planning process every organisation has a plan they are satisfied with and can stand behind.

6.12 TC advised that NS, CR and TC are part of the POAP discussions, but added that it was a helpful challenge, and this that question could be used to frame the conversations around developing the POAPs, with further scrutiny and challenge then provided by the committee.

RESOLUTION: The People Committee noted the content of the ICS People Function – Summary Report.

7 <u>Workforce Intelligence & Programme Highlight Report</u>

7.1 ZP reported that the business case to fund the system-wide health and wellbeing service, (The Wellbeing Line), for another year until March 2025 had been approved from s256 workforce funds. However, there is a need to look longer-term at health and wellbeing services, so there have been discussions in the health and wellbeing sub-group around developing a strategy and understanding the needs and provision in both individual organisations and across the system, in order to see if the service could be delivered in a sustainable way. ZP agreed to share an evaluation of the Wellbeing Line with Committee. **ZP**

7.2 ZP highlighted a project that recently launched within the independent care sector to recruit international staff and advised that they are now engaging with local care providers who have expressed an interest in recruiting staff, with over 24 care homes now signed up. The project will run for approximately a year to 18-months with the aim of recruiting up to 100 staff. ZP commented that greater uptake had been expected and attributed this to recent announcements involving changes to immigration policy. To provide reassurance to both potential candidates and providers information was being prepared advising them that they would not be adversely impacted by the changes.

7.3 ZP advised that cohort five of the Systems Thinking Masterclass had been planned over the next few months and that the previous four cohorts had been very successful. ZP outlined that the course provides teams who are working on system-wide pieces of work with a practical set of tools to progress their work, but again there is a need to look at the longer-term sustainability as the programme is currently funded through the region with one further cohort left to run. ZP agreed to share an overview of teams and organisational uptake of the training to date and evaluations with KC and any other committee members who would like to see it. **ZP**

7.4 SEA added that prior to 2023 10 cohorts of a system-wide leadership and development programme had taken place, financed by Health Education England (HEE) workforce development funding, and is being looked at as part of a wider leadership development review to see if it still meets the needs of the system. SEA further added that a specific role had been created to collate information about what is currently available for first time line managers and leadership and development offers from all system providers in order to do a gap analysis and look at what could be done at system level.

7.5 ZP confirmed that work was ongoing to establish a business case to provide housing hub support for both international and local staff. This would aid in retaining staff as accommodation support has been flagged as one of the reasons staff may not be attracted to, or choose to stay, within the health and care sector.

7.6 SEA gave a brief overview of the workforce metrics with current vacancy rates as follows:

- 13.6% across the ICS
- 8.1% across the Trusts
- 9.1% across social care

Leavers rates were as follows:

- 13.7% for NHS providers
- 11.7% for social care

There have been further reductions in agency usage relating to full-time equivalent (FTE) staff.

7.7 SEA noted that the leavers rate within 12 months of starting across this year was significantly higher than last year, so they were collating additional information from the Trusts and social care in order to do a deep dive by staff group and reasons for leaving to look at why it is so much higher. SEA commented that at first glance there were a lot of fixed-term contracts that had ended, so this could be one of the reasons behind the data, but they would share the information when it was available. KC agreed that it would be very helpful to see what comes out of the deep dive.

7.8 JC shared that nationally the Kings Fund had completed a review of the early experiences (first year to 18-months) of nurses and midwives and following this produced some messaging specific to those fields that may be worth pursuing. MC concurred with the discussion and added that whilst attrition is not a new issue, the reasons for it may have changed so it would be very helpful to see the deep dive breakdown as it would help to identify where to focus resources and specific areas to target.

7.9 KC identified that approximately six months will have passed since the last retention report so agreed with attendees that this would be a longer agenda item and focus area for next committee meeting.

7.10 NS reported that a number of members of the committee are participating in a new Exeter University region-wide recruitment and retention study, and that surveys and questionnaires had already been sent out with results expected in approximately six months. NS added that whilst the results were unlikely to show anything significantly different, there is already data from the staff survey that show real health and wellbeing related issues that need to be considered alongside national and regional data.

7.11 SEA agreed and drew a link between staff health and wellbeing and potential future caps on workforce numbers and productivity, agreeing that this may need to be a focus next year and looked at as a potential risk.

7.12 TC queried whether there was any additional information the committee would like to be regularly reported and confirmed that there was an open invitation for the committee to request other meaningful data. SEA advised that they would shortly be reviewing the metrics that are used to measure particularly outcomes relating to the POAP, which they would be happy to share with KC and anyone else interested when agreed.

7.13 KC observed that relating to attrition the system is not looking at the associated costs of recruitment and temporary cover, or what the level of attrition is doing to the competency levels in GHFT and GHC and whether there is a risk of inexperience in any parts of the system. JC agreed that it would be beneficial to look at the skill mix as well as the numbers of staff. KC requested a conversation with TC, NS and CR outside of the committee to discuss this. **TC**

7.14 EW commented that from a data perspective if the committee wanted to also look at the independent sector, then the Skills4Care data could be useful. SEA confirmed that this data is used for this specific report, but the level of detail needed for the deep dive isn't available from that dataset.

RESOLUTION: The People Committee noted the content of the Workforce Intelligence & Programme Highlight Report.

8 <u>Headline Staff Survey Results</u>

8.1 TC outlined that NHS organisations had received staff survey results. Whilst results are currently embargoed pending publication of further benchmarking data and agreement on national release, HRDs agreed it was useful to share their headline results. TC added that this year Primary Care had been invited to share their results, from which they had a 46% response rate, but the data was not yet available, so would be reported on at a later meeting.

8.2 CG gave a brief overview for the ICB:

- Improved response rate from 74% in 2022 to 76.8% in 2023 with 88.2% of those stating that they are satisfied with the opportunities for flexible working patterns.
- 85.3% of staff feel their immediate line manager values their work.
- Increase from 48.6% in 2022 to 51.9% of staff who are satisfied with levels of pay, but still falling short of the national average of 55.9%.
- The ICB overall positive score, (out of 29 ICBs who participate in the Picker survey), shows Gloucestershire has the second highest overall positive score, compared to being fifth in 2022.
- The following areas have all shown a steady but consistent decline in scores from 2021 – 2023, although remaining well above the Picker average:
    - Would recommend the ICB as a place to work was 83% in 2021, 80% in 2022 and 75% in 2023. (Picker average 52%).
    - If friend/ relative needed treatment would be happy with standard of care provided by organisation was 71% in 2021, 58% in 2022 and 57% in 2023. (Picker average 48%).
    - Care of patients/ service users is organisation's top priority was 84% in 2021, 81% in 2022 and 77% in 2023. (Picker average 66.7%)
- The ICBs most improved scores from 2022 – 2023 included an increase in staff reporting harassment/ bullying or abuse (42% up to 52%). There had been a small increase in the number of staff who said they had been bullied. There had also been an improvement in staff reporting they never/ rarely feeling burnt out because of work (39% up to 44%).
- The ICBs most declined scores from 2022 – 2023 include the number of staff who answered that they were not planning on leaving the organisation (from 73% down to 63%), whether the ICB made reasonable adjustments to enable staff to carry out their work (from 93% down to 83%) and whether teams have enough freedom to do their work (from 79% down to 71%).

8.3 CG summarised that some scores had been surprising given the introduction of the Reasonable Adjustments policy, Health Passport, and Zero-Tolerance against Abuse policy, however these were not widely known about at the time of the staff survey. The ICB recognises the teams/ areas most likely to require support of this type so will do some more targeted work in those areas. The ICB will also focus on appraisals and why staff do not feel they help them improve in their jobs and are conducting focus groups to look at this in more detail. Finally, there has been a further decline in the number of staff who feel the ICB acts fairly in terms of career progression and promotion. The ICB will be looking at competency frameworks to support careers and promotion conversations with staff, and at succession planning for the future.

8.4 CR gave a brief overview for GHFT:

- Improved response rate from 50% in 2022 to 63% in 2023, but once adjusted to take out staff who don't work on site the response rate will increase to 68%.
- 47% of staff would recommend the organisation as a place to work, which was an increase from 43% in 2022.
- 46% of staff would be happy with standard of care provided by the organisation if a friend/ relative needed treatment, compared to 44% in 2022.
- Response rate to care of patients/ service users is organisation's top priority remains at 63%, same as in 2022 and will be looked into.
- In 2021 and 2022 GHFT had one of the lowest positive score changes (64th out of 65 Trusts), but in 2023 are now 12th out of 62 for overall positive score change, which is a huge improvement and achievement.

- Against the People Promise elements, CR highlighted that whilst improvements have been made, most scores are still well below the Picker national average (who covered 143 Trusts in 2023) so there is still work to be done.

8.5 CR informed the Committee that after the 2022 staff survey, GHFT set up a staff improvement programme which has had a lot of investment and has clear areas of focus: teamwork and leadership, anti-discrimination and building a safe speaking up culture, all of which link to the People Promise elements and triangulate with what the Care Quality Commission (CQC) Well Led inspection identified as areas to focus on. CR added that there are clear principles behind each workstream, with a strong focus on building relationships.

8.6 CR reported that following 2022 staff survey all staff received a letter inviting them to identify one change that would enable them to recommend the organisation as a place to work or to receive care. A temporary task force was put in place to look at the findings, not only to demonstrate a response to staff opinions but also to look at things that could be delivered on quickly. An example of this was about staff having access to nutritious food, which was one of the task force workstreams, and it has been a positive experience being able to draw a tangible line between the increase in score and the work that had been undertaken. CR concluded that they are now working to ensure that each Division's strategic objectives reflect the staff experience improvement programme objectives.

8.7 Committee members recognised and congratulated GHFT on the significant improvement in results and emphasised their combined appreciation of the hard work that has gone into supporting this.

8.8 MC commented that whilst prevalent in the patient safety agenda, the confidence and belief from staff about speaking up is also key here, and that whilst the Freedom to Speak Up (FTSU) initiative encourages this, it will be how staff are treated when things don't go to plan or do speak up that will impact their confidence to do so and how they feel about the organisation. CR agreed and identified that there is an underpinning restorative and just culture piece of work to begin building the foundations to support this.

8.9 TC reflected on the upcoming financial challenges for the system and queried whether, regarding the investments to support some of the specific initiatives put in place to respond to the staff survey, there were any risks that the Committee should be aware of for 2024/25. CR advised that from 2023, GHFT Board prioritised staff wellbeing, retention, and morale over other strategic objectives, so it is high on the agenda, and through reshuffling of budgets they have been able to invest in the programme. Some of the workstreams will have an operational impact so has been identified as an intolerable risk.

8.10 NS posed the question of whether there could be a system-wide cost saving if all organisations were to use the same staff survey provider as last year the ICB and GHFT used Picker and GHC used QVIA. TC, NR, and CR to explore opportunity for sharing staff survey provider. **TC/NR/CR**

8.11 NS gave a brief overview for GHC:

- Improved response rate from 55% in 2022 to 58% in 2023.
- All seven People Promise scores had improved scores, with staff engagement and morale scoring significantly higher than other benchmarked providers.

- 60% of questions had improved results, 39% had worsened and 1% remained unchanged.
- There was a decrease in the number of staff who reported wanting to leave the organisation.
- There was an increase in the number of staff who would recommend GHC as a place to work from 69% in 2022 to 73.4% in 2023.
- There was an increase in the number of staff who would recommend GHC as a place to receive care from 73% in 2022 to 77% in 2023.

Relating to bank staff, NS reported:

- A slight reduction in response rate from 23.4% in 2022 to 22% in 2023.
- Six of the seven People Promise themes had improved scores, highlighting that bank staff had score three of them higher than substantive staff had. This could be down to not being in the working environment day-in-day-out.
- There was an increase in numbers of staff who feel valued by their line manager which NS identified was largely due to the work of one of their clinical managers on increasing management supervision for bank staff.
- There was a slight increase in number of bank staff who would recommend GHC as a place to work and also as a place to receive care.

8.12 NS summarised that, pending national comparator data, the three key areas of focus for GHC are health and wellbeing, internationally educated nurses and harassment and violence at work from patients.

8.13 ES gave a brief overview for Gloucestershire County Council:

- Response rate for 2023 was 69.13% which equates to approximately 2700 staff.
- 88% of staff would recommend GCC as a place to work.
- 93% of staff reported that they understand their responsibilities with regards to Equality, Diversity & Inclusion (ED&I) within their role.
- 90% of staff stated they have a good working relationship with their manager and colleagues.
- Areas for improvement are change management which scored 40% and communication which scored 51%, so GCC will be looking at how to maximise on the good relationships staff say they have with their managers to improve on these scores.
- GCCs next steps will be to look at Corporate, Directorate and Team level action plans.

8.14 KC commented that it was useful to have sight of the results for both health and social care, and queried whether there were any consistent themes that could be explored as a system-wide approach, for example the quality of performance management conversations. TC suggested that bullying and harassment, line management relationships, team dynamics, leadership development and staff wellbeing were all common themes and proposed using the People Board as a forum to share good practice and learning against organisational action plans.

8.15 CG relayed that she had attended a recent event run by Picker who reported that the areas that had seen the most improvement in scores were pay, staffing levels, organisational commitment to work/life balance and essential staff who work additional hours. The scores which had fallen the most were the way that staff are treated by patients, carers, and families, increased harassment from colleagues, feeling trusted to do their job, raising concerns around clinical practice and whether organisations offer challenging work, summarising that there was lots of commonality between

Gloucestershire organisations which would enable them to share good practice. There was also discussion around health and wellbeing and upskilling line managers with soft skills and how to have difficult conversations.

RESOLUTION: The People Committee noted the content of the Headline Staff Survey Report.

9 **Equality, Diversity, and Inclusion Update and Workforce Race Equality Standards (WRES) Action Planning**

Coral Boston and Anis Ghanti joined the meeting.

9.1 TC noted that it was currently race equality week and outlined that the Gloucestershire Chairs had put out a shared, system-wide press release highlighting the ICS's commitment to securing equality and detailed some of the work being done to support this.

9.2 TC outlined that the National ED&I Improvement Plan had been published in June 2023 setting out six high impact actions for systems to follow. Its purpose was to raise awareness, understanding and collective accountability through a single improvement plan. TC commented that the timescale for delivery against the whole action plan was still unclear, but there were a number of key actions that should be delivered by March 2024. TC acknowledged that all organisations still have a way to go, for example the ICB is still in the progress of ensuring that every Board member has an EDI objective and is developing improvement trajectories.

9.3 TC moved on to discuss the Workforce Race Equality Standard (WRES), advising that the organisational data presented in the papers consists of a mix of 2022 and 2023 data. The Committee observed that the data presented as it was by NHSE Race Equality team was not easy to read or interpret, and TC reflected that it would perhaps be more useful to see year on year trend data instead.TC invited providers to discuss their position and future action planning.

9.4 CB stated that GHFT have aligned their actions to the EDS improvement plan so are similar to previous years in terms of looking at fair recruitment and supporting colleagues through coaching and mentoring. CB reflected that despite ongoing work in these areas, the data shows that there is little progression from 8a upwards so there will be a keen focus on individual mentoring, support, and developmental opportunities to try and improve this because whist the data does change slightly, it then becomes stagnant. CB discussed internationally recruited staff who are experienced and senior when coming from abroad but whose career progression is slow. CB is liaising with other organisations who are also looking at how international recruits advance in their careers.

9.5 CR commented that the landscape across ED&I is quite cluttered with WRES, Workforce Disability Equality Standards (WDES), EDS22 etc., and advised that GHFT had undertaken an exercise to streamline the various objectives and have produced an ED&I action plan that has been mapped entirely against the six high impact actions. CR added that each high impact action has three specific points underneath them and they have all been mapped against a timescale and action plan, so are confident GHFT will be in a different position in the future.

9.6 KC relayed that she had attended a session with Roger Kline to understand whether the evidence of actions that impact on moving diversity and inclusion forward were the same across the public and private sectors and confirmed that it is. KC invited TC to share some perspective on effective planning in this area following their conversation with Sim

Scavazza who is currently the acting Chair for Buckinghamshire, Oxfordshire, and Berkshire West (BOB) ICB.

9.7 TC noted whilst organisations attempt to implement things in good faith, such as introducing training and policies, evidence suggests they are not the most effective or impactful, and that raising visibility and embedding accountability would be key to making a difference to the ED&I agenda. TC described an approach that has been put in place in the Imperial College Healthcare Trust in London for interviews at band seven and above, whereby the recruiting manager is expected to write to the Chief Executive to explain and justify why the panel did not offer the position to any candidates who were of Black, Asian, and minority ethnic (BAME) background. This adds another check and balance to enable staff to think more proactively about how they are approaching the recruitment process.

9.8 TC added that there was also a requirement as part of the high impact actions for organisations to set an improvement trajectory and commented that whilst this could be tricky to do it would provide something tangible to be held to account against. TC concluded that it would be crucial to look for one or two meaningful actions that can be taken that could create some momentum in this area.

9.9 NS remarked that there needs to be a significant difference in the way things are done and that until organisations start owning and being explicit about institutional racism, things will not move forwards. NS citied it had been 20 years since Nigel Crisp had released a 10-point equality plan for NHS chairs and chief executives in an attempt to shift the importance of the outcomes from an EDI perspective across the NHS, and in that that time little had changed.

9.10 KC queried whether it would be logical for a smaller group to get together outside of the committee to come up with a more radical, evidence-based proposal for supporting the actions that will be taken forwards. TC advised there was an ED&I session being held on Friday 16th February where there would be an opportunity to consider this and invited KC to attend.

9.11 JC stated that in 2015 she was the Executive Director who implemented the WRES nationally, and that it is very disheartening that little change is seen year-on-year. JC agreed that it would be key to get this into the forefront of people's minds and drawing on the advice of experts in the field should accompany this.

9.12 KC agreed stating there is good evidence to support actions that can and have made a meaningful difference, but that these solutions require true organisational buy in to be successful as they involve de-biasing organisational processes which could be seen as intrusive and taking away manager discretion. KC summarised that she would be happy to join the EDI session and advised that both Sim and Roger have offered their input if needed. MC also expressed interest in being involved with taking this agenda forwards and agreed that this would need authentic Director and Senior Lead buy in and engagement with staff to show that it really matters and to make the necessary changes.

9.13 CB commented that minority groups within each organisation have been consulted on many occasions about how they are feeling so need to be careful about asking the same questions again and that it is up to organisations to convince staff that this time it is real, and something will be done differently otherwise the engagement may not be there. KC agreed that this was a valid point.

9.14 CR stated that whist she mostly agreed with CB, the "you said, we did" notion can give staff the impression that once they have relayed feedback, they can wash their hands of it and that it's over to the organisation to sort, which in turn generates a lack of empowerment and understanding that individuals are also responsible for being part of the solution. CR added that GHFT are looking at how to ensure the authority and responsibility for this agenda can be shared and embedded wider than the central corporate team to ensure staff feel empowered, responsible, and accountable so the same patterns aren't repeated.

9.15 KC commented that co-creation could be a useful tool to secure engagement, by involving colleagues in the solution design process without having to ask the same questions again.

9.16 TC to forward invitation to ED&I session next week to appropriate committee members who are available to attend. TC suggested it would be beneficial for anyone attending to do some prep around researching the evidence base about what works and to provide some clarity around the data or feedback already given by staff to help structure the session. **TC**

CB left the meeting.

RESOLUTION: The People Committee noted the content of the Equality, Diversity, and Inclusion Update and Workforce Race Equality Standards (WRES) Action Planning report.

10 Agency and Temporary Staffing Expenditure

10.1 SEA provided some background and outlined that temporary staffing had been a high priority for the last couple of years with the Southwest being an outlier with some of worst performance across the country. Nationally the focus has been on agency spend, however due to total bank and agency spend taking some Trusts over their WTE, bank spend is now being looked at as well, although not yet in Gloucestershire.

10.2 SEA advised that over the last couple of months GHC have met their target for agency spend, and that whilst GHT have started to meet their target this wouldn't offset the overspend from the beginning of the year, so we are forecasting the ICS to be over its target spend. SEA highlighted that GHFT had set a challenging target last year as part of the operational plan, which was a 3.4% reduction in use of agency staff compared to GHC who set theirs at 0.7%.

10.3 SEA explained that a task and finish group had been set up to share best practice. The decline in agency usage from October at GHFT was attributed to making agency booked shifts available to bank staff, a practice that GHC previously had in place. SEA added that GHC had also seen a positive change in usage following the pilot launch of a centralised rostering team on two inpatient wards who were responsible for providing robust rostering management including making sure staff were taking annual leave and time owed appropriately across the year.

10.4 SEA relayed that the NHSE cap is 3.2% of the total pay bill with 0% framework agency usage from July 24 and emphasised that this would be challenging, particularly in relation to mental health services as they have temporary staff supporting patients in GHFT and not permanent staff. SEA advised Anna Gleghorn will be looking at this over the next year.

10.5 Continuation of centralised rostering for inpatients will continue at GHC and GHT are piloting team rostering on another ward that is part of the retention action plan and are hopeful that this will also have an impact on temporary staffing levels. Full details regarding next steps can be found in the papers circulated prior to the meeting.

10.6 KC queried whether the run rate levels would be sustainable in the new financial year. SEA stated that whilst they had been challenging last year, and would likely continue to be this year, there is potential for the improvements that have started to make an impact and for continued progress, but further discussions were needed with finance. SEA added that there were other areas being looked at, such as longer lead in times for rostering, but advised that there is still work ongoing to make sure that the processes in place are robust and settled before changing it.

10.7 CR reported that in relation to temporary staffing the medical division is the most challenging for GHFT, but they are holding regular meetings to look at this. Additionally, GHFT have mapped out where all interim staff sit and the exit plans for the roles, as well as looking into more creative approaches to recruitment, particularly in relation to roles the organisation were unsuccessful hiring to previously and are now using high-cost locums to cover. CR summarised that whilst the industrial action of the last year had hindered the ability to really see the improvements they are definitely there and can be seen on a monthly basis particularly in relation to agency spend which is currently lower than it has been.

10.8 NS informed the committee that both GHFT and GHC are involved in some regional level temporary staffing work which is looking at implementing a shared regional rate card for nursing and medical agency staff, as well as the additional approach of no off-framework agency staff being used. NS continued that this would be challenging to execute and there could be some exemptions to this when looked at against patient safety, staffing levels etc.

10.9 KC proposed that the committee share some of the work that has been done in this area with the Board at one of their development sessions so that the level of effort, detail, shared working, and creativity is seen and understood.

RESOLUTION: The People Committee noted the content of the Agency and Temporary Staffing Expenditure.

11 People Committee Risk Register Update and Board Assurance Framework (BAF)

11.1 TC outlined that the workforce risk on the BAF had been refreshed. The full BAF would be re-presented to the Audit Committee and Board in March. TC advised we are seeking to articulate a sub-risk relating to the ED&I agenda given current challenges in this area.

11.2 TC outlined the six areas of identified risks that are rated 15 and above:

- Loss of a number of non-recurrent funding streams in 2024/25 (risk score 16 – no change)
- Inadequate Workforce Supply (risk score 16 – no change)
- On-going industrial action (risk score 16 – no change)
- Band 2/3 Healthcare Assistant (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)

- ICS Workforce Infrastructure (risk score 16 – increased from 12 since last reporting period)

11.3 TC advised that funding issues around some of the ICS workforce had been resolved for 2024/25 but emphasised that in the future there would likely be further challenges to providing a sustainable ICS People support function. We need to see what national decisions are made around long-term workforce planning and infrastructure funding.

RESOLUTION: The People Committee noted the content of the People Committee Risk Register.

12 Policy Updates

12.1 CG explained that as part of the terms of reference each committee are responsible for a group of ICB policies, and that the committee were being asked to ratify three policies:

- Physical Activity at Work policy – reviewed by Susan Doran, Wellbeing Consultant, and updated to reflect current ICB working and newer resources.
- Freedom to Speak up policy which is a new ICB policy and details the process for speaking up, examples of what to speak up about and emphasises that staff will not endure victimisation or retribution as a result of doing so. (The full policy was included in meeting pack shared with committee members prior to the meeting). CG advised that a FTSU report will be presented to the Board on an annual basis.
- Secondment policy – reviewed by Jacqui Pearce, People Manager in the Commissioning Support Unit (CSU). CG highlighted that the criteria for secondments was strengthened and generally updated in line with the ICB policy review schedule.

12.2 SEA queried whether the policies are shared internally in the ICB before being presented to the Committee to approve. CG clarified that the approval process involves policies being presented to an appropriate sub-group/ forum, such as the Staff Partnership Forum (SPF) for consultation and agreement, then to Operational Executives for senior approval, before going to a suitable committee for final sign-off. It was noted this process allows for system partners to ratify the ICB's policies.

12.3 JC commented that the process makes sense as it ensures that the ICB is not releasing policies that are significantly different to, or don't fit with other partner organisations. JC added that the process for approving policies had been done differently at another committee she recently attended and suggested a standardised approach across all committees.

RESOLUTION: The People Committee approved the Physical Activity at Work policy, FTSU policy and Secondment policy.

13 Any Other Business

13.1 There was no other business to discuss. KC thanked the committee for a lively and engaging meeting.

Date and Time of next meeting: Thursday 18th April 2024 at 2pm in Shire Hall.

Minutes Approved by: NHS Gloucestershire ICB People Committee

Signed (Chair):Karen Clements
Date: Thursday 16th May 2024

NHS Gloucestershire ICB System Resources Committee

Held at 2.00pm on Thursday 7th March 2024
as
Hybrid Meeting via MS Teams and in ICB Canton Room, Shire Hall Gloucester

Members Present		
Prof. Jo Coast	JC	Non-Executive Director, Chair
Cath Leech	CL	Chief Finance Officer, ICB
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Karen Clements	KC	Non-Executive Director, Member
Participants Present:		
Chris Buttery	CB	Finance Programme Manager, ICB
Jaki Meekings-Davis	JMD	Non-Executive Director, GHFT
Sandra Betney	SB	Deputy Chief Executive
Mark Golledge *(Agenda Item 6 &7)*	MG	Programme Director – PMO & ICS Development, ICB
Karen Johnson	KJ	Director of Finance, GHFT
Tom Hewish *(Agenda Item 8)*	TH	System Operational Planning Lead, ICB
Shofiqur Rahman	SR	Deputy Chief Finance Officer, ICB
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon *(Agenda Item 7)*	RB	Board Secretary, ICB
Louise Holder *(Agenda Item 8)*	LH	Senior ICS Programme Manager, ICB
Julie Soutter	JS	Non-Executive Director, ICB Audit Committee Chair
Haydn Jones *(Agenda Item 8)*	HJ	Associate Director Business Intelligence, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the System Resources Committee.

2. Apologies for Absence

2.1 Apologies were received from Steve Brittan, Angela Porter, Ellen Rule, Mary Hutton and Ian Quinnell.

2.2 The Chair confirmed that the System Resources Committee meeting was quorate.

3. Declarations of Interest

3.1 There were no Declarations of Interest (DOI) received other than those presented by way of the Register.

4. Minutes of the System Resources Committee Meeting Held 16th January 2024

4.1 The minutes of the meeting held on 16th January 2024 were approved as an accurate record of the proceedings.

5. Action Log & Matters Arising

5.1 Action Log

5.1.1 **Action 26. 16/01/2024, Item 4.2.2,** Committee Terms of Reference (TOR). It was decided to divide future agendas into two parts. The agenda has been split into a Partnership and ICB section. **Item closed.**

5.1.2 **Action 27.16/01/2024, Item 4.2.2,** Committee Terms of Reference (TOR). Members committed to reviewing the Committee's Terms of Reference. A report on TOR was submitted before members on 7th March 2024. **Item closed.**

5.1.3 **Action 28. 16/01/2024, Item 5.3.3,** Shared Outcome Framework It was agreed that a further update on the development of the Shared Outcomes Framework would be brought back to the Committee. **Item remains open.**

5.1.4 **Action 29. 16/01/2024, Item 6.1,** Operational Planning Guidance. Members requested further update on operational planning guidance. An update was presented. **Item closed.**

5.1.5 **Action 30. 16/01/2024, Item 8.2,** Investments & Benefits Review. It was agreed that criteria be crafted to identify key schemes that are to be monitored by the evaluation task and finish group. **Item remains open.**

5.1.6 **Action 31. 16/01/2024, Item 9.1,** UEC Benefits Plan. It was decided that a deep dive review was required but that this should be undertaken with wider system partners. **Item remains open.**

5.1.7 **Action 32. 16/01/2024, Item 11.2,** Risk Management. Members asked RB and CGi to arrange and run training programmes with service areas. This was implemented. **Item closed.**

6. Terms of Reference (TOR) Review

6.1 MG presented the draft TOR before the Committee and members reviewed the draft. JMD suggested that the TOR should encourage a system wide approach to resource planning. JMD added that TOR should help communicate and guide resource allocation and planning across all organisations in the One Gloucestershire Integrated Care System (ICS).

6.2 MW concurred and added that the ICB's activities inherently gravitated toward joined-up plans. CL gave examples of how the ICB was already playing this role. She gave an example of how the ICB worked with Gloucestershire County Council (GCC) and Gloucestershire police to drive system working and create joint posts. MW emphasised that networking should clearly be reflected within the TOR. Members identified sections of the draft which would benefit from revision.

6.3 **RESOLUTION: The System Resource Committee noted the draft Terms of Reference and referred the draft back for amendment prior to submission to the Board for approval.**

7. **System Resources Committee Risk Register Review**

7.1 MG presented BAF risks aligned with the Three Pillars and ICS strategic objectives for 2023-24 as agreed by ICS partners. The risks were as follows:

- BAF1: The failure to promote and embed initiatives on health inequalities and prevention;
- BAF9: Insufficient resources to meet strategic priorities;
- BAF10: Insufficient resources to provide sustainable estate and replacement programmes for equipment and digital infrastructure.

7.2 RB presented before members the Corporate Risk Register (CCR) and corporate risks associated with the System Resources Committee. RB explained that the Governance team consulted with Risk Leads across the ICB to ensure risks were subject to appropriate review. RB also explained that the heads of directorates also received monthly reports on risk. The risks which were presented impacted the following areas:

- ICS Digital Strategy;
- Operational and workforce capacity for transformation
- Project delivery and benefits realisation;
- UEC performance metrics.

7.3 In terms of assigning risks, members observed that some of the risks spanned across committees assigning such risks was problematic.

Members asked that arrangements be made to have a spotlight on a specific risk at each meeting and that this be setup. **Action: MG, RB and GN to facilitate appearance of stakeholders before members.** **MG & RB**

7.4 **RESOLUTION: The System Resource Committee noted the Risk Review report.**

8. **Planning**

8.1 Joint Forward Plan 2024-29

8.1.1 LH presented the plan and described it as a systemwide strategic plan, broken down and reported on annual basis. LH explained that the Joint Forward Plan defined the strategy, provided the objectives, and evaluated progress made the previous financial year. LH emphasised that the plan was based on shared vision and goals, and success of the plan depended on effective partnership and public engagement.

8.1.2 Members discussed the report and offered suggestions. JMD emphasised the importance of scrutinising barriers to achieving outcomes and she gave an example of how the prevailing car park problems in Cheltenham impacted delivery of workforce and services that reversed inequalities.

8.2 2024-25 Financial Plan

8.2.1 CL presented the Capital plan and cautioned that the plan was fluid therefore figures and metrics presented before members could change.

CL stated that the ICB believed that it would operate within its planned capital resource limit. CL clarified that the system's long-term 5-year plan was subject to annual updates and the year 2024-25 update was in progress and it followed a process of scrutiny and Assurance by partners.

CL stated that system partners were committed to exploring ways of containing their capital expenditures to remain within resource limit. CL stated that the system would welcome extra capital allocation if made available and partners would maximise benefit from any capital injection.

8.2.2 CL cautioned that prevailing forecasts pointed toward a mismatch between cost increase and productivity, with costs expected to accelerate faster. CL highlighted that the 2024-25 Revenue plan currently showed a significant financial deficit position.

CL added that a further challenge lay in that cost pressures were exacerbated by an increasing workforce in the county. There was a need to mitigate pressures without compromising quality and safety. CL stated that the ICB and partner organisations were responding through exploring several ways of reducing the deficit. Finance Directors, together with Task and Finish Groups and Chief Executives were working very closely to realise planned outcomes.

8.2.3 HJ explained that the partner organisations, as part of Savings planning, had identified areas that would deliver savings. Relevant Groups, including Task & Finish Groups, were set up to support efforts to identify Savings, at both organisational and system level. CL concurred and reiterated that partner organisations were tasked with identifying both transactional and transformational Savings at local and system level.

CL cited potential areas of Savings for the ICB and partner organisations. CL also cited levels of exposure to risk faced by each target area of Savings. KJ stated that GHFT had, at the time of reporting, identified 72% of its target Savings.

8.3 2024-25 Operational Planning

8.3.1 MW, TH and HJ presented the report and MW highlighted the strong engagement from partners despite challenges resulting from the delay in the issuing of relevant guidance by NHS England. TH presented the operational planning timeline. TH stated that the system partners made a high-level submission on 29th February 2024, and he added that the submissions were at that stage high-level.

TH explained that the ICB and its partners were working toward full submission to be made on 21st March 2024. TH highlighted that the ICB was working on a very tight timeframe, and he emphasised that this was a situation not unique to the ICB.

TH stated that the operational plan would go through partnership Assurance process before submission.

8.4 RESOLUTION: The System Resources Committee noted the Joint Forward Plan and work that had been completed on Operational Planning.

9. Items of Escalation from System Partners

9.1 There were no items from system partners.

10. Performance Report

10.1 MW presented and stated that current national focus was upon the 4-hour standard in the Emergency department. MW added that the 65-week cancer standard was another area of national focus.

MW highlighted that January 2024 saw considerable progress in reducing ambulance response times and handover delays as compared to December 2023. MW stated that demand for Primary and Dental HealthCare continued to rise in the county and pressure on diagnostics remained of concern.

10.2 MW stated that we were focusing on year 2024-25 Operational plan designed to reduce health inequalities and other target health outcomes.

MW highlighted a new national requirement which stipulated that with effect from 1st March 2024 every hospital with and Emergency department was required to maintain a minimum of 76% performance against the 4-hour standard. MW caution that local performance was just marginally acceptable.

10.3 MW stated that elective performance which had been adversely affected by industrial action was recovering, and waiting list was beginning to go down. MW also stated

that pressure persisted in 62-day cancer performance and the system remained focused on reversing this trajectory.

Members discussed the performance report.

10.4 **RESOLUTION: The System Resources Committee noted the Performance report.**

11. Month 10 Finance Report

11.1 CL delivered a verbal update and cautioned that some adjustments were still being made to some capital items within the system.

CL explained that in terms of revenue the ICB and its partners were projecting a breakeven year-end position.

CL highlighted that the local system had contained direct costs comparatively better than other systems. CL stated that the local system had received funding to cover for industrial action in the months of December 2023, and January and February 2024.

11.2 **RESOLUTION: The System Resources Committee noted the Month 10 Finance update.**

12. Any Other Business

12.1 Members discussed the proposed System Resource workshop focusing on *"What do we spend our money on".* Members brainstormed around the approach to the session. Members reflected on the value of a workshop in supporting improvement of understanding expenditure and resource management. Members agreed to proceed with the proposed workshop and agreed in principle to hold the workshop in September 2024 and also invite the Chair of NHS Gloucestershire ICB. **Action: MG, RB and GN to follow up and facilitate the workshop.** **MG**

The meeting ended at 4:00pm.

Date and Time of Next Meeting: 2nd May 2024 at 2:00pm (Hybrid).

Minutes Approved by: Signed (Chair):Prof Jo Coast Date: Thursday 2nd May 2024