Gloucestershire Integrated Care Board Public Meeting

To be held at 1.45pm – 5.15pm on Wednesday 27th November 2024

Committee Room, Ground Floor, Shire Hall, Westgate Street, Gloucester, GL1 2TG
and virtually via MS Teams

Chair: Dame Gill Morgan

Agenda Item	Time	Item	Action	Presenter
1.	1.45 – 1.47pm	**Welcome and Apologies** *Apologies: Mary Hutton, Deborah Evans, (Raghu may dial in)*	Information	**Chair**
2.	1.47 – 1.50pm	**Declarations of Interest** 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.	1.50 – 2.10pm	**Patient Story – Asthma Friendly Schools**	Information	**Douglas Forbes / Gemma Artz**
4.	2.10 – 2.13pm	**Minutes of the meeting held 25th September 2024**	Approval	**Chair**
5.	2.13 – 2.17pm	**Action Log & Matters Arising** • P2 beds/EoL/Dying Matters verbal update (action 20)	Discussion	**Chair**
		Business Items		
6.	2.17 – 2.25pm	**Questions from Members of the Public**	Discussion	**Chair**
7.	2.25 – 2.45pm	**Themed presentation Respiratory whiteboard / risk stratification work**	Discussion	**Leighla Davenport / Emma Crutchlow**
8.	3.05 – 3.15pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	3.15 – 3.25pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.25 – 3.45pm	**Integrated Finance, Performance, Quality and Workforce Report. Dental Access numbers**	Discussion	**Mark Walkingshaw Tracey Cox Marie Crofts Cath Leech**
11.	3.45 – 3.55pm	**Primary Care Access Recovery Plan**		**Jo White & Helen Goodey**
12.	3.55 – 4.10pm	**Review of Intensive and Assertive Community Treatment for People with Severe Mental Health Problems NHS**	Discussion	**Karl Gluck & Sadie Trout**
13.	4.10 – 4.20pm	**Gloucestershire Winter Plan 2024**	Discussion	**Ellen Rule, Kelly Matthews & Eve Olivant**
14.	4.20 4.25pm	**Annual Assurance EPRR**	Discussion	**Marie Crofts**
		Decision items		
15.	4.25– 4.40pm	**S.75 Deed of Variation**	Approval	**Benedict Leigh**
16.	4.40 - 5.00pm	**Upper Gastrointestinal Reconfiguration GHFT**	Approval	**Mark Pietroni & Al Sheward**

Information items				
17.1		**Chair's verbal report on the People Committee** held 17th October 2024 and approved minutes from 18th July 2024	Information	**Karen Clements**
17.2	5.00–5.10pm	**Chair's verbal report on the Primary Care & Direct Commissioning Committee** held Thursday 3rd October 2024 and approved minutes from 8th August 2024		**Ayesha Janjua**
17.3		**Chair's verbal report on the System Quality Committee** held 2nd October 2024 and approved minutes from 7th August 2024		**Prof Jane Cummings**
17.4		**Chair's verbal report on the Resources Committee** held 7th November 2024 and approved minutes from 5th September 2024		**Prof Jo Coast**
	5.10pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 29th January 2025 – 2.00-4.30pm

Boardroom, Shire Hall

NB. This is a long meeting with a break at 3.55pm for refreshments and comfort break

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.

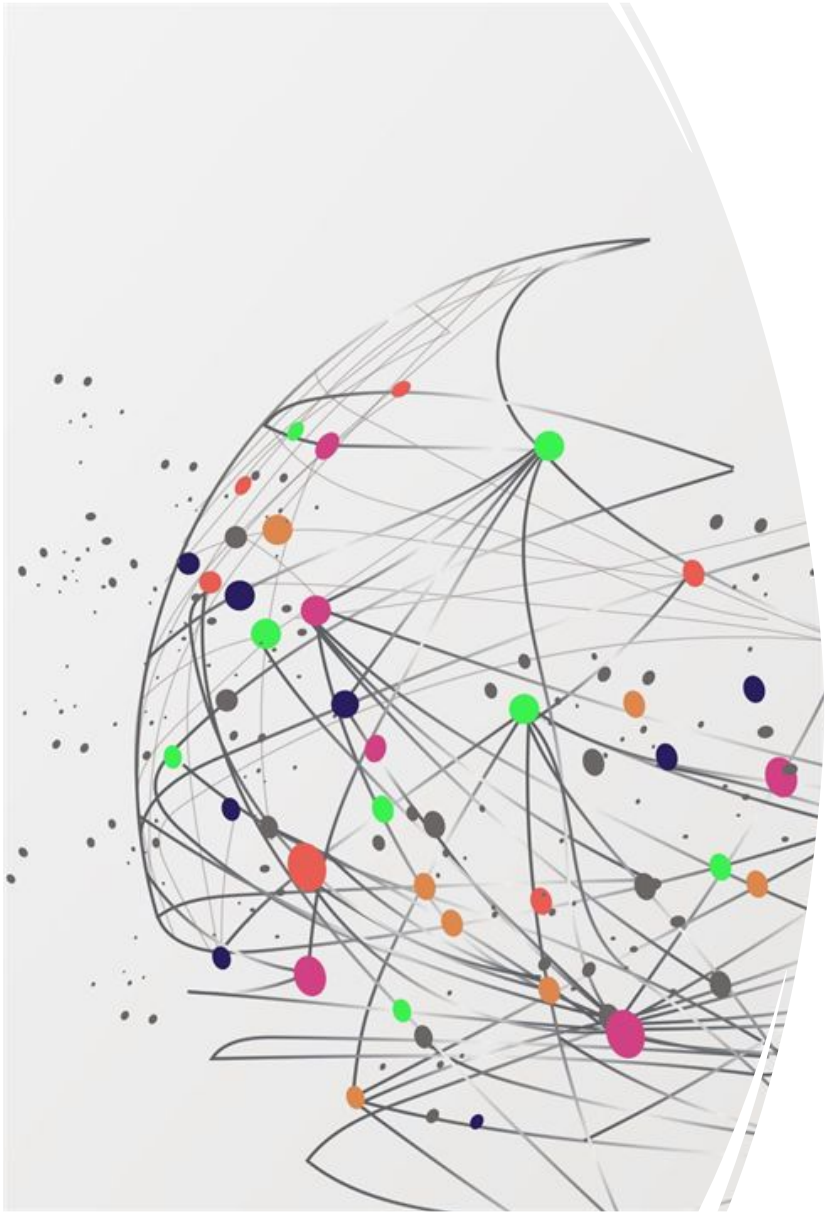
(for reasons of commercial in confidence discussions)

Lastname	Firstname	Year	DM	Active	Interests Declared	Description	Interest Type	Mitigation
Bayley	Joanna	2024/25	Yes	Yes	Declarations of Interest – Other	Director of GDOC Ltd	Direct	Seek approval from line manager
Bayley	Joanna	2024/25	Yes	Yes	Declarations of Interest – Other	Director of MDDUS and its subsidiary MSL	Direct	Seek approval from line manager
Bayley	Joanna	2024/25	Yes	Yes	Declarations of Interest – Other	Director of South-West Health Improvement Network (formerly known as SW AHSN)	Direct	Seek approval from line manager
Blair	Douglas	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
Clements (Blick)	Karen	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
Coast	Joanna	2024/25	Yes	Yes	Outside Employment	UoB has been my main employer since 2015. I am Professor in the Economics of Health & Care, with an academic role comprising research, teaching and academic leadership.	Direct	General potential CoI if University of Bristol is engaged on activities within the ICS. I am currently supervising a doctoral student who is also an employee of the ICS.
Cox	Tracy	2024/25	Yes	Yes	Nil Declaration	Mentoring Plus Charity in Bath. Volunteering and Mentoring role. Charity providing mentoring support and other support services to young people aged 7-25 yrs old.	Direct	No conflict of interest as this is a charity that operates outside of Gloucestershire.
Crofts	Marie (Yvonne)	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
Crutchlow	Emma	2024/25	Yes	Yes	Declarations of Interest – Other	I am a salaried GP at aGHAC/ML and the lead GP. G DOC Ltd is the GP provider organisation for Gloucestershire and are commissioned for various services by the ICB. I sit on the G DOC Ltd board and am the clinical director. I am clinical director of the Gloucesters Inner City PCN	Direct	I do not have a direct financial interest in GHAC/ML as I am not a partner and G DOC is a not for profit organisation and all GP practices in Gloucestershire are shareholders. I do not have a direct financial interest in G DOC as I am not a partner and it is a not for profit organisation and all GP practices in Gloucestershire are shareholders.
Crutchlow	Emma	2024/25	Yes	Yes	Declarations of Interest – Other	Married to Paul Downie who works at GHFT	Indirect	To keep all ICB information confidential
Cummings	Jane	2024/25	Yes	Yes	Declarations of Interest – Other	I am a senior advisor (management consultant) to Tendable. Tendable provides digital technology to audit and report on quality standards and improvements across the health and care sector.	Direct	I would not get involved in any potential use of this technology across health and care in the Gloucestershire ICS.

Cummings	Jane	2024/25	Yes	Yes	Declarations of Interest – Other	Clinical Leaders' Network (based in the North West of England). I am an unpaid Board member. The network supports and develops clinicians across the NW of England and in other areas and potentially this may include some ICSs. Unpaid work.	Direct	N/A
Farmer	Siobhan	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
Hutton	Mary	2024/25	Yes	Yes	Declarations of Interest – Other	Daughters partner works for Music Works, Gloucestershire - Charity in Gloucestershire.	Indirect	Contracts managed by teams under Directors so not a direct involvement.
Hutton	Mary	2024/25	Yes	Yes	Declarations of Interest – Other	Charity. Volunteer as a mentor with young people	Indirect	No direct involvement with any contracting with the Door
Hutton	Mary	2024/25	Yes	Yes	Declarations of Interest – Other	Daughter works in GHC	Indirect	Seek approval from line manager
Janjua	Ayesha	2024/25	Yes	Yes	Declarations of Interest – Other	BDO commissions Arden & Gem for consultancy support, and I collaborate with BDO in my role at Arden and Gem.	Direct	BDO commissions Arden & Gem for consultancy support, and I collaborate with BDO in my role at Arden and Gem.
Janjua	Ayesha	2024/25	Yes	Yes	Declarations of Interest – Other	NHS Arden and Gem Commissioning Support Unit. Provision of support services to NHS organisations such as transformation advice, service redesign, leadership development, team development etc.	Direct	To remove myself from discussions and decisions involving the sourcing of relevant support services where a conflict may arise.
Leech	Catherine	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
McNamara	Kevin	2024/25	Yes	Yes	Declarations of Interest – Other	Chair of the Patient Safety Collaborative for the WoE Health Innovation Network. January 2023 – present.	Direct	Declare as appropriate as per policy
Morgan	Gillian	2024/25	Yes	Yes	Nil Declaration	N/A	N/A	I have no interests to declare for the period leading up to the above date
Raghuram	Ananthakrishnan	2024/25	Yes	Yes	Declarations of Interest – Other	Gloucestershire Chest fund. local charity with majority lay members that I am chair Raising money for bursaries and equipment for patients with respiratory diseases in Gloucestershire The charity does not receive any NHS funding and raises money by charitable fund raising events	Direct	I have declared the interest with the board

Raghuram	Ananthakrishnan	2024/25	Yes	Yes	Declarations of Interest – Other	Royal college of Physicians London. elected trustee councillor on Royal college of physicians London	Direct	None required.
Raghuram	Ananthakrishnan	2024/25	Yes	Yes	Declarations of Interest – Other	Nuffield Health. respiratory outpatients and bronchoscopy/ endobronchial ultrasound- Also member of medical advisory committee	Direct	Work flexibly
Raghuram	Ananthakrishnan	2024/25	Yes	Yes	Declarations of Interest – Other	Gloucestershire Hospitals NHSFT. Consultant General and Respiratory medicine	Direct	No conflict of interests
Rule	Ellen	2024/25	Yes	Yes	Outside Employment	Convensis Conferences. Chairing healthcare conference for 1 day on integrated care 16/05 - reimbursement and expenses to attend (day travel no hospitality)	Direct	None exist - annual leave taken for conference attendance
Rule	Ellen	2024/25	Yes	Yes	Outside Employment	MTech access is a private Company providing NHS insights and Health Economics related education to the health technology and pharmaceutical sectors . I occasionally provide input to educational events based on my NHS and Health Economics expertise (circa 3-4 times per annum approximately so less than 1 day in total over the year expected)	Direct	I provide educational input via lectures that link Health Economics theory and practice, with a view to supporting the private sector to develop in a way that is consistent with NHS values and priorities. I provide insights at only a 'generic' level in lecture format i.e. to large mixed audiences of whom I do not receive a breakdown of their individual roles or organisations that they work for. I do not provide advice to any individual companies
Rule	Ellen	2024/25	Yes	Yes	Declarations of Interest – Other	I am currently studying for a PhD with the University of Bristol in Pharmaceutical Health Economics and Policy. I provide lectures (unpaid) on Masters level courses as required and am involved in both conducting my own research within the NHS, Policy and Pharmaceutical sectors (with ethics approval) and also as a steering group member on other NIHR funded research which involves working with the NHS.	Direct	Should there be a situation in which the University of Bristol was looking to bid for a contract to work with the Gloucestershire health system I would exempt myself from being involved in the decision making relating to that contract.

Rule	Ellen	2024/25	Yes	Yes	Outside Employment	Wilmington Healthcare. Short term Consultancy / Advisory assignments (usually speaking / educational events not more than 2-3 hours once every couple of months) focussed on Health Economics expertise	Direct	Non exist
Scott	Sarah	2024/25	Yes	Yes	Declarations of Interest – Other	GCC. Executive Director of Gloucestershire County Council	N/A	There are safeguards in place to ensure that the Board of the ICB makes decision that serve the best interests of population of Gloucestershire. The Board of the ICB is a unitary board. Partner members represent the perspective of the LA sector not a particular organisation (see s. 2-3 ICB Constitution)
Soutter	Julie	2024/25	Yes	Yes	Declarations of Interest – Other	University of Gloucestershire. Spouse, David Soutter, is a Member of Council	Indirect	Will declare to Chair or relevant individual if potential conflict arises due to an agenda item etc and follow Chairs direction/advice
Soutter	Julie	2024/25	Yes	Yes	Declarations of Interest – Other	Volunteer with therapy dog visiting hospitals and other organisations. Includes GHC and GHFT.	Direct	Volunteering discussed with Chair. Will notify interest at the start of meeting if agenda has potential conflict and follow chair's advice. Seek approaval from line manager



Asthma friendly schools Gloucestershire

Carol Stonham MBE

RN,MSc, Queen's Nurse

CYP Asthma clinical Lead NHS Glos ICB

Asthma Prevalence

There are 5.4 million people in the UK with diagnosis of asthma (around 15%)

01

1.1 million children are asthmatic (21%)

02

In Wales, 314,000(1 in 10) people are treated

03

In Scotland, 368,000 (1 in 14)

04

Northern Ireland 1 in 10 or 182,000 (more than the entire population of County Tyrone)

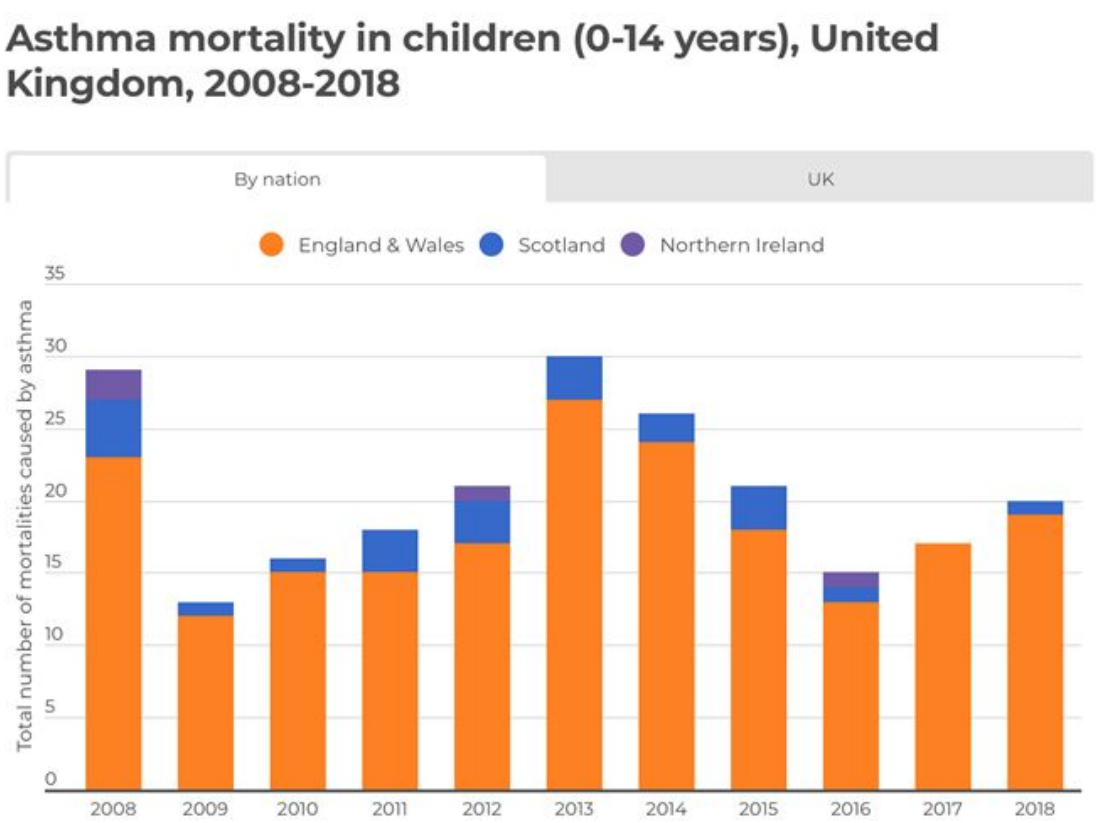
Source: Asthma UK

It’s just a bit of asthma……..

- **Asthma is the most common long term condition among children and young people**, with 1.1 million children currently receiving asthma treatment. It continues to be among the top 10 causes of emergency hospital admission for children and young people in the UK.
- **The UK has among the highest mortality rates in Europe** for children and young people with the underlying cause of asthma.
- **Emergency admissions, and deaths, related to asthma are largely preventable** with improved management and early intervention. The National Review of Asthma Deaths found that 46% of the children who died from asthma had received an inadequate standard of asthma care.
- **Emergency admissions for asthma are strongly associated with deprivation** despite the prevalence of asthma being evenly distributed. Children and young people living in deprived areas are more likely to be exposed to higher levels of tobacco smoke and environmental pollution, which may contribute to this.

RCPCH. The Stata of Child Health report (2021) Available from https://stateofchildhealth.rcpch.ac.uk/evidence/long-term-conditions/asthma/#page-section-5 [Last accessed 5th Dec 2023]

There has been a small reduction in the total amount of deaths among children and young people as a result of asthma.



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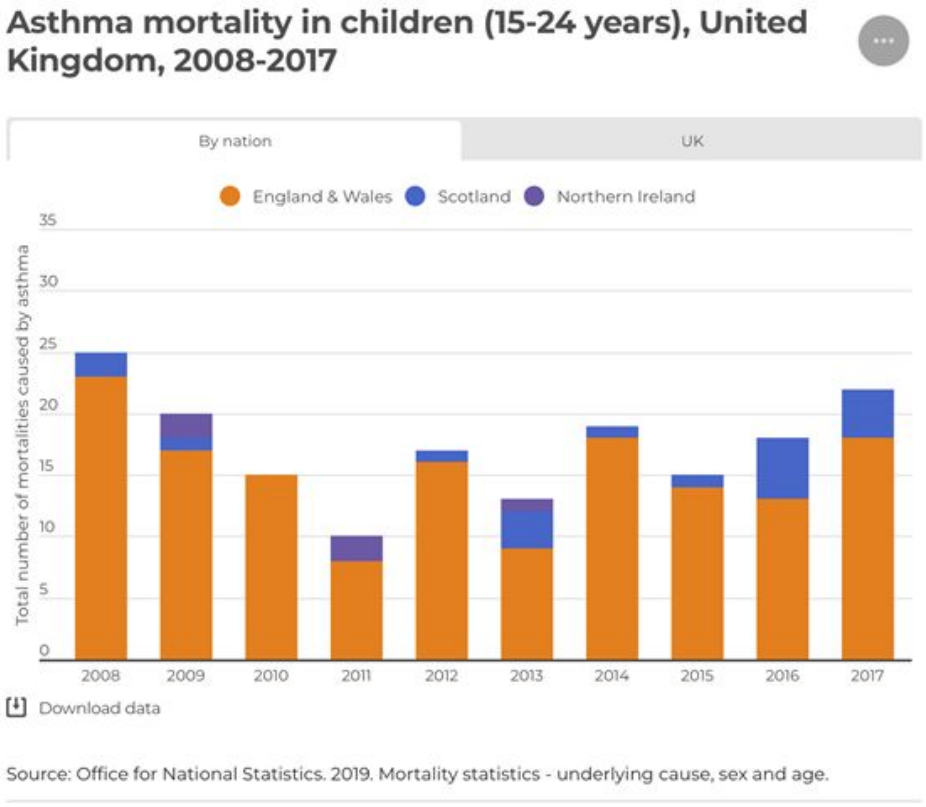


Asthma: Young people in the UK 'more likely to die'

20 February 2019 · Comments

BBC NEWS

Young people in the UK are more likely to die from asthma than those in other wealthy countries, a report has found.

Death rates for asthma in 10 to 24-year-olds was highest in the UK among all 14 European nations included in an analysis of 19 high-income countries.

The 19 countries were: The UK, the Netherlands, Denmark, France, Ireland, Portugal, Greece, Germany, Spain, Austria, Belgium, Finland, Italy, Sweden, Japan, US, New Zealand, Australia, and Canada.

What is an asthma friendly school?

Partnership between health, education and local authorities for managing CYP with asthma aged 5-18

Adoption of government policy on emergency inhalers and early years settings (education, individual healthcare plans)

Implementation of:

- Register of all students with asthma
- Management plan for each child
- Named individual responsible for asthma in each school (Asthma champion)
- Policy for inhaler techniques and care of students with asthma
- Policy regarding asthma and emergency treatment
- System to identify children missing school because of asthma, or avoiding sports or activities because of asthma
- Asthma training for all school staff - 85% target

Example checklist

Policy. School's policy should be available to view, all staff should be aware of where it is kept.

Asthma register

Emergency kits/procedure

Individual health care plan.

Whole school training

Plan for Gloucestershire

- Develop a network of asthma friendly schools across primary and secondary
- Improve care of children and young people with asthma

Beyond schools

- Glos FA
- Glos RFU
- Guides, scouts and brownies
- Glos Athletics
- Glos Cadets

Thank you for your attention.

Gloucestershire Integrated Care Public Board Meeting

To be held 2.15pm to 4.30pm on Wednesday 25th September 2024

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

Members Present:		
Prof Jane Cummings	JCu	Chair, Deputy Chair/Non Executive Director NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Kevin McNamara	KM	Chief Executive Officer, Gloucestershire Hospitals NHS Foundation Trust
Ayesha Janjua	AJa	Non-Executive Director, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Douglas Blair	DB	Chief Executive Officer, Gloucestershire Health & Care NHSFT
Jo Coast	JC	Non-Executive Director, NHS Gloucestershire ICB
Ellen Rule	ER	Deputy CEO & Director of Strategy and Transformation, NHS Gloucestershire ICB
Dr Jo Bayley	JB	Chief Executive, GDOC Ltd.
Julie Soutter	JSo	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MCr	Chief Nursing Officer, NHS Gloucestershire ICB
Participants Present:		
Dr Emma Crutchlow	EC	GP and Clinical Director of Gloucester Inner City Primary Care Network
Benedict Leigh	BL	Director of Integration, NHS Gloucestershire ICB and Gloucestershire County Council
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHSFT
Martin Holloway	MHo	Senior Independent Director and Non-Executive Director of SWAST
Graham Russell	GR	Chair, Gloucestershire Health & Care NHS Foundation Trust
Mark Walkingshaw	MW	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Ann James	AJ	Executive Director of Children's Services
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
Carole Alloway-Martin	CAM	Cabinet Member, Adult Social Care Commissioning, GCC and Chair of the Health & Wellbeing Partnership Board
Richard Smale	RS	Interim Director of System Coordination, NHS England (SW)
Nina Philippidis	NP	Deputy Chief Executive and Executive Director of Corporate Resources, Gloucestershire County Council.
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Ryan Brunsdon	RB	Board Administrator, NHS Gloucestershire ICB
Sadaf Haque	SH	GP and Cancer Lead for Gloucestershire
Rebecca Smith	RS	Associate Director, Clinical Programmes

1. Welcome and Apologies

1.1 The Chair welcomed members present. Apologies were received from Dame Gill Morgan, Siobhan Farmer, Karen Clements and Mark Cooke. The meeting was declared to be quorate.

1.2 There were two members of the public in attendance.

2. Declarations of Interests

2.1 The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)
JB declared an interest in that she had now been appointed Vice Chair of the Medical and Dental Defence Union of Scotland (MDDUS).

JCu reference the question from a member of the public (agenda item5.), which referenced Michelle Cox. JCu stated that she was chair of a charity that made awards for inequality, diversity, and inclusion, with financial support from Michelle Cox. JCu wished to make this aspect clear, prior to that part of the meeting, where this item would be discussed.

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

3.1 The Minutes of the Public Board meeting held on 31st July 2024 were approved as a true and accurate record. KM noted that in point 7.25, referring to the positivity around elective recovery and future plans noted that as the planning round progressed, more decisions were yet to be made around funding and that there was still more to do.

4. Action Log and Matters Arising

4.1 **31/01/24 Action 20: P2 beds/EoL/Dying Matters. September Update:** End of Life Care Report and final evaluation to be reported to SQC in October. Will then be reported through the SQC minutes in November and those minutes would be included in the January 2025 Board meeting papers. **Action to remain Open.**

4.2 **31/01/24 Action 21: LMNS membership and functionality. September Update:** The regional CNO would be advising the ICB CNO on this. **Action to remain Open.**

4.3 **31/01/24 Action 22: Migrant Health Report**. **September Update:** To be presented to SQC in December 2024 and to be brought back to the Board in January 2025. **Action to remain Open.**

4.4 **27/03/2024 Action 23: Social Prescribing/CEO Report. September Update:** Still to be arranged. **Action to remain Open.**

4.5 **27/03/2024 Action 24: Interim Procurement Strategy**. **September Update:** Updates were made to the TOR and presented to the Audit Committee which met in September. An updated version would be considered by the Audit Committee which has a meeting in December with the final version to be presented at the January 2025 ICB Board. **Action to remain Open.**

4.6 **29/05/2024 Action 25: Contaminated Blood Inquiry Report. September Update:** To be covered in the Board Away Day on 20th November. **Action to remain Open.**

4.7 **29/05/2024 Action 26: Countess of Chester case. September Update:** To be covered in the Board Away Day on 20th November. **Action to remain Open.**

4.8 **29/05/2024 Action 28: Dental Access. September Update:** This item will be covered within the Chief Executive Report for the November Board. **Action to remain Open.**

4.9 **29/05/2024 Action 30: Working as One/Newton Programme. September Update:** This item was covered during the Working As One Workshop held on 25th September. **Action Closed.**

4.10 **29/05/2024 Action 31: BAF and CRR. September Update:** The BAF and Risk discussion has been planned for the October 2024 Board Development session. **Action Closed**

4.11 **29/05/2024 Action 32: Hospital Mortality Rates. September Update:** This item will be covered within the CEO Report at the January Board and reported through SQC. **Action to remain Open.**

4.12 **31/07/2024 Action 34: Interface discussion. September Update:** Interface discussion between primary and secondary care to be tabled for a future Board Development meeting, date to be confirmed. **Action to remain Open.**

4.13 **31/07/2024 Action 35: CQC Interim Report. September Update:** To be covered in the CEO Report at the January Board. **Action to remain Open.**

4.14 **31/07/2024 Action 36: HPV Information. September Update:** An update from SF was read out in the meeting by JCu: Overall, there had been substantial reductions in cervical cancer numbers and incidence of CIN3 in young women following the introduction of the HPV immunisation programme in England, especially for those in the 12 – 13 year age bracket. In effect the HPV immunisation programme had successfully almost eliminated cervical cancer in women born since 1st September 1995. **Action to be Closed.**

4.15 **31/07/2024 Action 37: Lydney Health Services. September Update:** The outcome of the decision regarding the Forest of Dean was shared along with the appropriate section of the minutes. **Action closed.**

5. Questions from members of the public

5.1 A question from a member of the public was read out, together with a full response from the ICB Board, included in a log on the ICB public website, as below.

https://www.nhsglos.nhs.uk/about-us/how-we-work/theicb-board/

Question read out by TC

With Michelle Cox's, tribunal, and landmark unanimous ruling against the NHS, of direct and indirect racial discrimination, on the 15th of February 2023, what did NHS Gloucestershire Integrated Care Board have in place to seek, and have assurance and re-assurance, that NHS Gloucestershire Integrated Care Board did not have, and would not have, this disgusting racism taking place within and across all their partners? What robust and significant evidence, with open, transparent, and accountable audit measures and processes did NHS Gloucestershire Integrated Care Board have, to fully demonstrate this assurance and re-assurance?

The response read by TC, was to be sent directly to the member of the public, with any actions arising to be brought back to a future Board meeting.

6. Patient Story – Bowel Cancer Patient Interview

6.1 Geoff, a patient at Kingsway Surgery, and Sadaf Haque, his GP, talked about bowel cancer and his experiences as a patient around this, in an interview (see the link below). **https://youtu.be/js5NF872t0A**

JCu thanked Sadaf Haque and Geoff her patient for this patient story and being so open and unflinching in describing Geoff's cancer and the treatment he obtained. It was noted that this patient story was available on YouTube and also uploaded to G-Care for primary care.

7. Cancer Clinical Programme Group (CPG) Programme

7.1 Sadaf Haque, Cancer Lead NHS Gloucestershire and Rebecca Smith, Associate Director of Clinical Programmes, had structured the work on cancer around three pillars, which reflected the commitment to prevention and community/neighbourhood-based care.

7.2 The presentation, circulated to members prior to the meeting, described a collective contribution to improving cancer services across these three pillars:

1. **Making Gloucestershire a better place for the future:**
   - Improving the number of eligible patients attending an invitation for cancer screening
2. **Transforming what we do:**
   - Improving access to services for all communities
3. **Improving Health and Care Services today:**
   - Increasing the number of people receiving treatment within 62 days of referral.

7.3 There had been many local engagement events to support improvement in the number of patients eligible for screening in Gloucestershire recently, and these had especially promoted cervical and bowel screening, reaching out to various communities with talks and events across the county. Bowel screening advice with Nepalese soldiers at Imjin Barracks had seen an increase in screening from 29%, to 89% in 12 months alone.

7.4 Cancer survival had doubled in the last 50 years; in 2021 there were 11,823 people living with, or beyond, cancer in Gloucestershire. Transformation was being supported by:

- Working with communities and increasing awareness of services including local support groups and voluntary sector offers;
- Liaising around awareness with sessions from the Macmillan hub and local services and developing a package of advice for returning to work, which would support both employers and employees;
- Piloting supported self-management for people living with cancer, using digital platforms, and piloting a late-effects service for those with long-term impacts of radiotherapy treatment;
- Expanding the rehabilitation services with Macmillan Next Steps, running sessions at community centers, gyms, and GP practices throughout the county.

7.5 76.5% patients were diagnosed or given an all clear result within 28 days of referral in July 2024. Gloucestershire was on target to meet 77% by March 2025, but not uniformly across all specialties. Health and care services were being supported by:

- GP education and direct access to diagnostic tests supporting faster triage to the right clinic;
- Teledermatology pilot – educating and using dermatoscopes in primary care plus review by medical photography, ensuring all skin referrals were triaged to the correct clinic using an image;

- Implementing nurse-led models to support access to faster diagnostic tests in colorectal, gynaecology and urology;
- Funding projects in pathology to speed up sample processing and reporting;
- Moving the Lung Cancer Clinic to the Community Diagnostic Centre, co-locating CT scanners for a “one-stop shop”;
- Conducting a detailed review of the prostate pathway enabling opportunities to improve time to diagnosis.

7.6 Priorities going forward:

Early intervention and improved outcomes

- Maintain focus on improving attendance at screening including roll out of targeted lung health checks;
- Improve completeness of staging data and action opportunities for improvement;
- Implement new innovations to diagnose cancer early and offer new treatments to improve outcomes.

Transforming what we do

- Continue to work with communities to design services they can access;
- Reduce variation seen in our services;
- Deliver the actions identified in our Cancer Nurse Specialist review to create a workforce for the future;
- Explore AI and digital solutions to support our workforce and increase capacity.

Improving services

- Improved pathways and use of innovations to improve time to diagnosis and treatment to reduce the backlog of people waiting longer than 62 days for treatment.
- Work with the Cancer Alliance to access more up to date mortality data to understand where improvements were needed.

7.7 The insight and depth of effort and collaboration that had gone into this work was recognised, particularly around health inequalities. There was considerable learning that could be shared with others around culture and where further advice could be given. It was important to ensure pathway inclusivity with providers and to continue to look at the design and development of those pathways.

7.8 Prostate cancer screening was raised, and SH explained that there was currently no national screening programme for prostate cancer in place. Some people argue that PSA testing should be given to all men, as it was the best test currently available. Others feel that it is not accurate enough and that the potential risks, especially of unnecessary biopsy and treatment and the related quality of life issues, could mean that PSA testing is not necessarily a good option.

7.9 SH explained that a family history of prostate cancer was an important consideration and would definitely raise immediate concerns for her as well as those people from ethnic minority backgrounds, who would also present a much lower threshold of having a PSA test. GPs did want to diagnose prostate cancer earlier, and it was an area in which SH continued to deliver education.

7.10 RS reported that his regional colleagues would be keen to work with the ICB on culturally appropriate cancer materials being generated and being more specific about prioritisation and ambitions, particularly around inclusivity and deprivation. It was also important to recognise how important and how valuable lung health checks were, so getting the go-live date for that as soon as possible, would hugely benefit the population.

7.11 AJ felt that a conversation at a later date could incorporate prevention, awareness and what best practice looked like, as today's presentation reflected just the diagnosis and treatment element of cancers.

7.12 JB wanted to make it clear that the public did not have the impression that GPs were not complying with cancer pathways, as huge amounts of work was being carried out in primary care to identify and refer patients for treatment. JB felt that it should be recorded that improvements were needed system-wide and were not the responsibility of just one service area.

7.13 JB realised that lung checks were also of concern to many Gloucestershire GPs who had welcomed the local system investment. However, there was a potential negative effect for cardiology that had not yet been resolved, perfectly illustrating the importance of looking at these things in the round, rather than focusing on one particular initiative. Work was currently being undertaken to resolve this issue, but given the current pressures for primary care, it was important to think about the impact of initiatives, i.e., not to prioritise the outcomes for lung patients, over those of cardiology patients.

7.14 SH responded saying that it was not the intention to prioritise one area over another and recognised the hugely valuable input from primary care. The system had identified some challenges with the workload and cardiology had experienced delays in their project and it was essential to ensure that the right resources went into the right pathways for cardiology patients, enabling them to have as good an outcome as those of other patients. The commitment from primary care had been recognised and with collaborative working, both lung and cardiology patients would be able to receive equal benefits.

8. Chief Executive Officer Report

8.1 National General Practice (GP) Pilot

The Chair explained the arrangements surrounding the National General Practice pilot which had been brought to the Board today for approval of participation and commitments.

ICBs taking part in this pilot were required to obtain the approval of the ICB Board and sign the Delivery Plan for the pilot. However, the timings had not worked out for Gloucestershire ICB Board. The pilot launch event took place on 18th September, prior to the ICB Board meeting; therefore, the Chair and CEO took an urgent decision on behalf of the ICB Board to approve the pilot and therefore sign the pilot plan. This was in line with the ICB's Standing Orders referenced in the report.

8.2 MH explained the Delivery Plan's partnership approach between seven ICBs and NHS England (NHSE). The Plan would be supporting clinical leaders in 15-20 Primary Care Networks (PCNs) covering over 1 million population. This Programme would examine general practice sustainability, creating a clearer path to achieve this, together with offering a better future for practices, staff, and patients. Work would be undertaken on data collation, data tools and dashboards and would include the organisation of quality improvement sessions. The Delivery Plan would be updated in March 2025, outlining new actions for the following year.

8.3 DB raised the point around workforce in primary care, stating that the workforce and other services would need to ensure that they did not become an invisible factor in any big change implications. MH responded that work around the challenges ahead were being addressed.

8.4 Collective Action Update

Following July's ballot by the British Medical Association (BMA) a list of published 10 possible/recommended (but not mandated) actions was published for practices to consider taking, broadly grouped as:

i. Working within stricter operational parameters;
ii. Restricting digital and information sharing;
iii. Deferring improvement and transformation decisions and activities.

8.5 The ICB Primary Care team continued to work closely with the Local Medical Committee (LMC) to ensure clarity and ongoing positive relationships, and decisions so far had been pragmatic and constructive. The LMC had surveyed individual practices to gain an understanding on which actions could be taken. Through August and early September there had been no significant impacts of Collective Action, although this this had been anticipated to change through the Autumn, should practices start implementing the BMA actions.

8.6 A weekly Task and Finish Group comprising system partners had been established throughout this period, to review risks, mitigations, and management actions. There had been potential financial risks for the system, notably increasing Urgent and Emergency Care (UEC) workforce costs beyond plan; non-achievement of Elective Recovery Fund (ERF) plans; slippage on planned returns on investment and overall reduced achievement of in-year savings against plan. The Task and Finish Group would continue to regularly report to the ICB Operational Executive, to the Strategic Executive and to the Primary Care and Direct Commissioning Committee (PC&DC) on any issues arising.

8.7 Patient Safety and Quality of Care in Pressurised Services

On 26th June 2024 NHSE wrote to all ICB's, NHS Trusts and Local Authorities with a number of actions and to ask for a renewed focus on maintaining the safety and quality of people accessing pressurised services across the unscheduled care pathway. The letter asked all organisations to provide alternatives to Emergency Department (ED) attendance and admission, especially for those frail older people, better served with a community response in their usual place of residence.

8.8 The key outputs from this would be informing the ICB's winter plans this year, together with the ongoing strategic transformation of urgent care services, ensuring that safety and quality were aligned with operational performance and service delivery.

8.9 Whilst examining the improvement of safety within the urgent care pathways it had also been noted that the Standardised Hospital-Level Mortality Indicator (SHMI), for Gloucestershire Hospitals, currently at 1.158, had been above the expected limits for six consecutive months. This was a 12-month rolling average with the last full dataset covering the period April 2023 - March 2024. Based on the National Quality Board (NQB) guidance, as a system, the ICB would now be moving to 'Enhanced Surveillance.'

8.10 The immediate aim was to bring SHMI inside control levels, with a medium-term aim to reduce it to 1 and below, with AR and acute colleagues working on this. Due to the retrospective nature of this indicator being measured, it was important to note that there would be a considerable interval before improvements began to show in the data reports. System oversight for this would be through the system quality processes, and this issue would remain on the Board Assurance Framework (BAF) risk register. External peer review and support would be available via NHSE South West and regional colleagues.

8.12 Blood Pressure Checks – Know Your Numbers

8.13 Around one in three adults have high blood pressure, but many did not realise this, because symptoms, such as heart attacks or strokes, often did not present until it was too

late. This was why, the week organised by the NHS across Gloucestershire had been so important, enabling members of the public and NHS staff to take time out to have their blood pressure readings checked and then to start to make healthier lifestyle changes and/or take medication to help bring down their blood pressure. In Gloucestershire, the Outreach Vaccination and Health Team had given more than 1,250 blood pressure checks at drop-in health events over the last year, with around 150 people referred to their GP for further support.

8.14 JC observed that SHMI had been recognised as one of the safety improvements within urgent care pathways and queried a possible timeline around this. AR explained that the SHMI was a ratio which compared the actual number of deaths at a hospital to the expected number of deaths. The SHMI indicated whether these numbers were higher, lower, or as expected, compared to the national baseline.

8.15 Although the data was about six months behind, there were already initiatives and projects in place to address this, with a huge amount of progress that had already been made. The aim was also to enhance the journey patients make through the pathway and to make this a better experience for them. KM recognised that some patients may be admitted for unknown causes, and this would, along with other permutations, need to be considered when collating data for SHMI.

Resolution: The Board members noted the content of the Chief Executive Officer report and:

- ***Ratified the Urgent Decision made by the Chair & CEO to participate in the National General Practice pilot and Section 96s for Rosebank and Cheltenham Central Primary Care Networks (PCNs) to be signed.;***
- ***Confirmed the ICB's commitments to the associated issues, risks and mitigations of the National General Practice pilot.***

9. Board Assurance Framework (BAF)

9.1 TC explained that the BAF had been re-formatted with the content remaining the same, but the format was visually clearer and easier to read. All 12 strategic risks had been reviewed and the scoring for these had remained static. There were some risks around primary care for workforce, GP collective action and finances and one around cyber security. The Urgent and Emergency Care (UEC) risk would be updated following the Working as One Gloucestershire Workshop.

9.2 JSo stated that she and the Audit Committee had been very pleased with the change in format and readability of the BAF, which would enable future discussions to be more meaningful. The BAF would be examined again by both the Audit Committee and at the Board Development session in October. Work and discussions would be ongoing to understand how the BAF reflected and aligned with the risks in other partner organisations across the system.

Resolution: The Board noted the updated format and content of the Board Assurance Framework.

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

10.1 MW updated on Performance, firstly by stating that it was important to recognise that the new government would continue to place a great deal of emphasis on performance against the national targets set for the NHS.

10.2
- Elective long waits over 65 weeks were expected to be eliminated by September 2024, with weekly reviews currently being undertaken by the system and NHSE, to assure Gloucestershire's position against this target against elective standards.
- There was a continued focus on ED and preparations for the coming winter, which were well advanced in the system.
- Dashboards had shown improvements for patients with hypertension and patients with acute risk scores who were receiving lipid-lowering therapies.
- Additional capacity had been brought in for spinal surgery enabling forecast breaches to be brought down.
- Patients with No Criteria to Reside (NCTR) had been a focus for the system to support flow and improved response times across all services. GHFT had reported their lowest recorded number of patients (107) with NCTR in the first week of September. This had been a huge achievement as the average throughout during 2023/2024 had been 186.
- Continuing Health Care (CHC) had seen a deterioration in assessment times due to staffing and sickness absences. There will be a recovery trajectory to address additional support for the team.
- Urology had received additional capacity, although focus would still be required to reach Best Practice Times Pathway (BPTP). Diagnostic performance remained stable against the six-week standard and although there were areas of pressure in certain specialties, mitigations and actions had been built in to offset these.

10.3 TC updated on Workforce:
- Workforce metrics were mainly green with a small increase in the overall vacancy rate for NHS providers across Gloucestershire. This was standing at 9.4% where it had previously been at 9.2%. Social care colleagues had seen their vacancy rate reduce to 14.7% whereas it had previously been at 15.2%.
- Long term workforce planning risks were being picked up and balanced against short term financial decisions linked to the financial recovery plan. In some areas, such as apprenticeships, the level of activity expected was not being seen.
- The apprenticeship Strategy had been approved at the People Committee in July 2024 and a series of events, raising awareness of Technical (T) levels and apprenticeships had been run and well received and had included primary care colleagues, in order that they could also be aware of opportunities.
- The ICB was developing a series of careers and engagement plans for secondary schools to demonstrate that the NHS and social care were good organisations in which to work.
- Both Trusts were now under the agency cap at 3.2% with excellent work having been accomplished around controls. GHC had done well last year and GHFT had now dramatically improved their position around agency expenditure.
- A session was held around sharing inclusive practices across the health and care sector with council colleagues undertaking things like values based recruitment.

10.4 MC updated on Quality:
- A team within the ICB had attended Black Maternity Matters anti-racist training for senior leaders. A further system wide cohort would be commencing in the autumn. There had been positive engagement with local Black and Asian communities and who were supporting the coproduction of service and quality improvements.
- The Safeguarding team successfully visited Kingfisher Treasure Seekers and was assured by their safeguarding processes. The team offered the provider support and ongoing help.
- Research Engagement Network (REN) members had prepared an application to NHSE to fund their ongoing participation up to March 2025. The application

included the aspiration to extend the REN to include more VCSE organisations to increase diversity still wider.

- The Regulators' Pioneer Fund awarded the CQC a grant to develop a framework for use by Integrated Care Systems (ICS) to help them measure how well they listened to the experiences and needs of people and communities to reduce health inequalities. The CQC was working in collaboration with the Point of Care Foundation and National Voices to create this framework and the associated learning tools. NHS Gloucestershire ICB had been selected as one of four ICSs to pilot the framework this autumn.

It was thought to be a good idea to include excess mortality on the dashboard if this had not already been done.

10.5 JSo referred to the People report and observed that there were cross-overs with recruitment and retention and asked whether there was any intelligence relating to the ICB, or for health and social care organisations, as to why people did often not turn up for a job offer or were leaving very quickly after having started. This might be due to recruitment processes being very slow or the person having accepted a better job offer in the interim. JSo asked what was being done to address this.

10.6 TC responded that people not turning up on their first day had not been flagged to her and was not something that she had been made aware of. There was often quite a high Do Not Attend rate at interviews, which could be problematic. In terms of staff leaving within a year, this was a metric that was measured, and it was believed that this was currently around 19%, which indicated a fairly high turnover rate. TC stated that baseline work was being undertaken around recruitment activity and functions with a focus on the timeline on recruitment from start to finish. TC informed the Board that at each People Committee a workforce intelligence report was included in the papers and the committee comprising ICS partners discussed trends and themes around recruitment and retention. Work on recruitment activity would be reported to the People Committee and the minutes were included in the Board papers.

10.7 AR informed the meeting that he had recently attended a national conference where the work having been undertaken in Gloucestershire around workforce had been highlighted and highly commended. AR thought that as a county we did need to think about working with various providers in the health and care sector to try to map out future demand, looking at the entire sector, and examining opportunities of growing the workforce.

10.8 CL updated on Finance:

- The ICB month 5 position was a forecast outturn position of breakeven as per plan. However, the position contained a significant amount of risk, as it is predicated on delivery of a high level of savings.
- The prescribing forecast was breakeven. Prescribing data for Month 3 had been received and growth year to date had decreased, and this was not in line with the trend seen to date. There was uncertainty as to whether this would continue. The anticipated price reduction for Rivaroxaban had been notified and the risk relating to savings for prescribing had therefore reduced.
- Elective Recovery Funding - the Gloucestershire target was 107% with the system operational plan value set at 118% value weighted activity of 2019/2020. Based on Month 3 flex (interim) data the system was on track to deliver the planned over-performance.
- Continuing Health Care & Placements - adult continuing care was currently on plan and forecast was breakeven against the plan. However, there was a risk due to a very high cost placement which was currently being managed within the position.

Children's placements were currently fewer in number than last year but there remained risk within a position which could potentially change very rapidly.
- The Mental Health Investment Standard (MHIS) for 2024/2025 of £111,503m and this was forecast to be delivered.
- Working as One was delivering good results for the system.

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

11. One Plan for all Children & Young People in Gloucestershire

11.1 AJ presented on the One Plan for all Children and Young People in Gloucestershire which had been developed with children, young people, families, and partners. It had been designed to set out how, together, the vision for Gloucestershire would be achieved to be a great place for all children to grow up in and go on to live lives of choice and opportunity. AJ felt wholeheartedly that this Plan had been well written and really reflected the ambitions for the children and young people in Gloucestershire both today and for the future and it had been brought to this meeting to gain approval from the Board.

The One Plan had been developed with four sections:
- An overarching section detailing the intent and summarising the approach and findings
- A section on starting well (the first five years)
- A section on growing well (primary through to early secondary)
- A section on being well (adolescence and early adulthood to 25 years).

11.2 JCu reflected on the work that had gone into this and how it had been brought together with the collaboration of the young people and their families which had framed the vision of the Plan so successfully. DB explained that a small amount of reformatting might be needed, but the great work having been carried out in bringing this to fruition was something that the team could recognise and celebrate.

11.3 Due to the importance of the protection of children and young people, JCu queried the reporting processes, and whether that would be a regular update to the Board from the Health and Wellbeing Partnership. **Action: AJ to confirm reporting arrangements for the One Plan for all Children and Young People in Gloucestershire at the next Board meeting.** **AJ**

Resolution: The Board members:
- ***Approved and provided its support to the One Plan for all Children & Young People in Gloucestershire 2024 to 2030, as a unifying Plan, developed with children, families and partners, setting out ambitions for all children and young people in Gloucestershire.***
- ***The Board noted that there would be a signing and launch event for the One Plan for all Children & Young People in Gloucestershire, with statutory and voluntary sector partners, planned for 19th November 2024 with the Chair and Chief Executive Officer of the Gloucestershire ICB Board in attendance.***

12. Committee Updates

12.1 Chair's verbal & ARAC report from the Audit Committee held on 5th September 2024 and approved minutes from 24th June 2024

12.1.1 JSo informed the meeting that the internal audit risk was Amber, mainly due to some delayed actions on a couple of areas. There was confidence that these would be moved on by the next review undertaken on the IUC procurement and lessons learned. This was also Green and had built in some tests for processes which had come through very well, both around Conflicts of Interest and managing procurement.

12.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee held on 8th August 2024

12.2.1 AJ provided an update, stating that the meeting had been very positive, discussing GP collective action with primary care having given assurances around mitigations that have been put in place to manage this. Decisions had been made around new and existing dental contracts and the support of procuring a dental mapping tool, recognising the importance of improved access in Gloucestershire.

12.3 Chair's verbal report on the System Quality Committee held 7th August 2024 and approved minutes from 5th June 2024

12.3.1 JCu informed members that topics of discussion had been health checks, migrant health, and GP collective action and the work undertaken by primary care in supporting that. A meeting would take place shortly, which would include the End of Life Care Report and the recommendations contained therein.

12.4 Chair's verbal report on the Resources Committee held 5th September 2024 and approved minutes from 4th July 2024

12.4.1 JC said that a good part of the meeting was spent discussing the workshop, thinking about that in the context of resource application pressures going forward and discussing data sharing and how this could be taken forward in future.

13. Any Other Business

There were no items of any other business to discuss.

The meeting concluded at 16.15pm.

Time and date of next meeting

The next Board meeting will be held on Wednesday 27th November 2024, 1.45pm to 5.15pm.

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log – November 2024

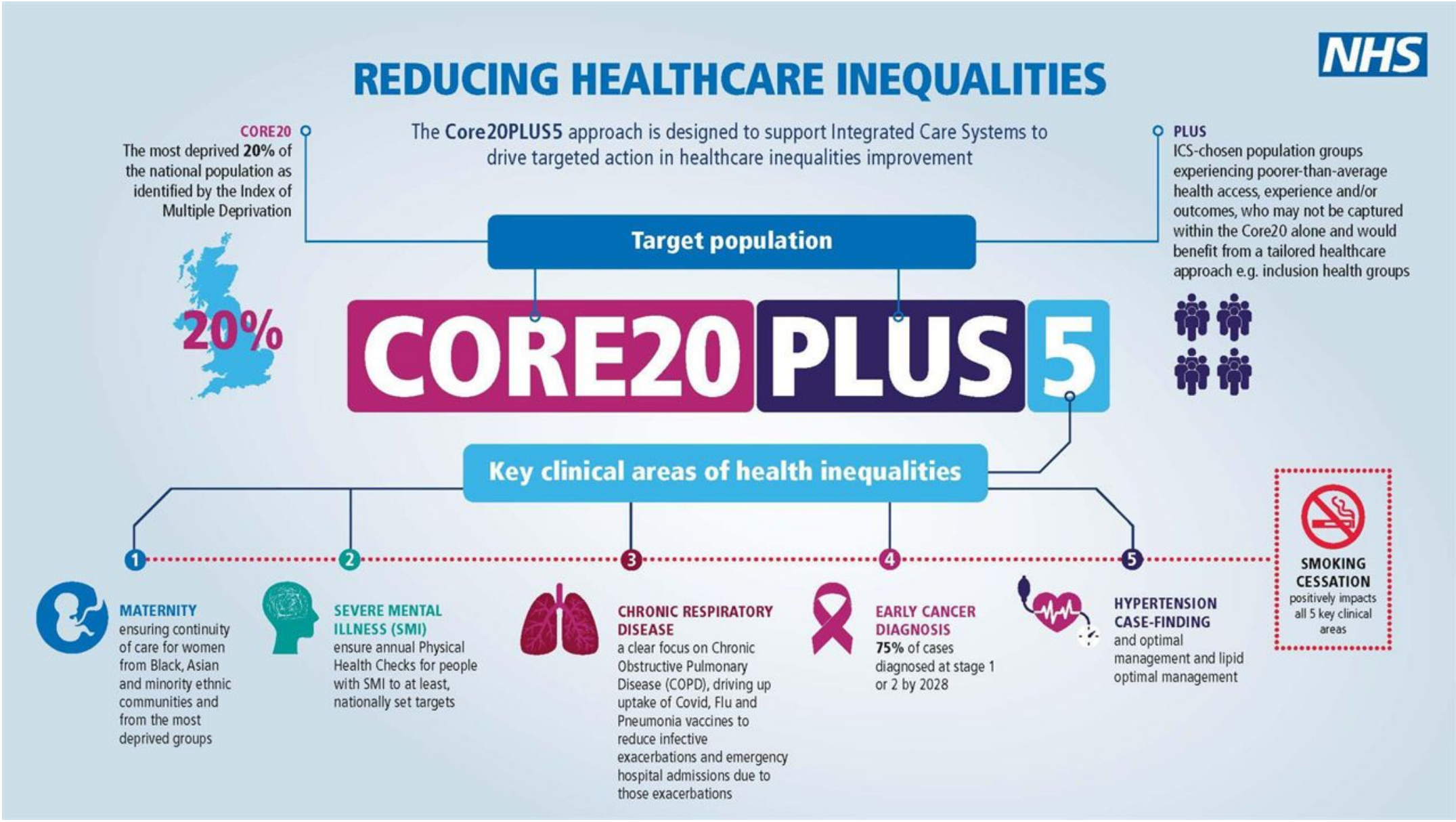
No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
20	31/01/2024	Min 8.18 P2 beds/EoL/Dying Matters	SQC	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	November 2024	**September / November 2024:** End of Life Care Report and final evaluation was reported to System Quality Committee in October. This will then be reported through the SQC minutes at the January 2025 ICB Board. However a verbal update will be provided by the Chair / Executive lead for Quality at the November Board	Open
21	31/01/2024	Min 10.12 LMNS membership and functionality	Marie Crofts	The Chair raised membership of the LMNS noting that new people had joined the ICB and asked that consideration be given if the right people were included and whether more challenge could be built in. This was important to help KM and MC to accomplish future requirements.	November 2024	**May 2024:** Following the further unannounced inspection of maternity services in March 2024 the CNO established a Quality improvement Group as part of the National Quality Board framework of surveillance, to 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. **July 2024:** The regional CNO is advising the ICB CNO on this. **September 2024:** The regional CNO is advising the ICB CNO on this. **November 2024:** November 2024: Review of LMSS remains ongoing which includes the ICB CNO and Regional Colleagues. An update will be provided to ICB Board**. Action Open.**	Open
22	31/01/2024	Min 11.2.1 Migrant Health Report	Primary Care Team	Primary Care Team to bring a detailed report on Migrant Health to a future Board meeting.	January 2025	**September 2024**: This is to be presented to the SQC in December 2024 and will be brought back to Board in January 2025. **November 2024:** This is to be presented to the SQC in December 2024 and will be brought back to Board in January 2025.	Open
23	27/03/2024	Min 8.1 Social Prescribing, CEO report	Tracey Cox	Creative Health Consortium to be placed on a future Agenda for discussion around a Patient Story.	January 2025	This topic is on the list of patient stories for the Autumn 2024. **September 2024:** Creative Health Consortium is a topic for a patient story in Autumn 2024. To remain open until presented **November 2024:** A date will be confirmed for this patient story in the new year	Open

24	**27/03/2024**	**Min 13.2 Interim Procurement Strategy**	**Julie Soutter & Christina Gradowski**	Procurement Strategy - Julie Soutter 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.	**January 2025**	**September 2024:** Updates were made to the TOR and presented in September to the Audit Committee. To go back to the December 2024 Audit Committee with the final version to be presented at the January 2025 ICB Board. **November 2024:** As above. To be brought to the January Board 2025. **Action Open.**	**Open**
25	**29/05/2024**	**Min 1.5 - Contaminated Blood Inquiry Report**	**Ryan Brunsdon**	Contaminated Blood Inquiry Report to be placed on a future Board agenda.	**November 2024**	**September 2024:** This item will be covered within the ICB Board away day on 20th November 2024. **November 2024:** This item was covered within the ICB Board away day on 20th November 2024. **Action to be Closed.**	**To be Closed**
26	**29/05/2024**	**Min 1.6 Countess of Chester case**	**Ryan Brunsdon**	Countess of Chester case to be placed on a future Board agenda.	**November 2024**	**September 2024:** This item will be covered within the ICB Board away day on 20th November 2024.. **November 2024:** This item was covered within the ICB Board away day on 20th November 2024. **Action to be Closed.**	**To be Closed**
28	**29/05/2024**	**Min 7.9 - Dental Access**	**Helen Goodey**	HG to update the Board at a future meeting to evidence ongoing progress around dental access.	**November 2024**	**September 2024:** This item will be covered within the Chief Executive Report in the November Board. **November 2024:** This item has been covered within the Chief Executive Report in the November Board papers. **Action to be Closed.**	**To be Closed**
31	**29/05/2024**	**Min 9.5 - BAF and CRR**	**Tracey Cox & Julie Soutter**	TC and JS to bring the Board Assurance Framework and Corporate Risk Register to a future Board Development session.	**October 2024**	**November 2024:** A risk appetite / risk tolerance session was held on 30th October as part of the Board Development session; part of that session looked at system strategic risk. The work around risk tolerance and risk appetite will be reviewed by the Audit Committee which will also look at the strategic risks within the BAF with system partners.	**To be Closed**
32	**29/05/2024**	**Min 10.13 - Hospital Mortality Rates report**	**Dr Raghu**	AR to bring a Hospital Mortality Rates report to a future Board meeting.	**November 2024**	**November 2024:** the SHIM data and work will be covered in the Board Awayday on 20th November included in a focus on Quality.	**To be Closed**

34	**31/07/2024**	**Min 7.25 - Interface discussion - secondary and primary care**	**PMO**	Interface discussion to be tabled for a future Board Development meeting, date to be confirmed.	**January 2025**	**September 2024:** Interface discussion between primary and secondary care to be tabled for a future Board Development meeting, date to be confirmed. **November 2024:** The date for the Development Session is yet to be determined, but the topic is on the list of items to be discussed. **Action Open.**	**Open**
35	**31/07/2024**	**Min 8.1 - CQC Interim Report**	**Marie Crofts**	Interim Report regarding the CQC to be brought back to a future Board meeting.	**January 2025**	**September 2024:** This item will be covered within the Chief Executive Report in the November Board. **Action Open** **November 2024:** This item has been covered within the Chief Executive Report in the January Board papers. **Action to be Closed.**	**Open**
39	**25/09/2024**	**Min 11.3 - Reporting for the One Plan for Children and Young People in Glos**	**Ann James**	AJ to confirm reporting arrangements for the One Plan for all Children and Young People in Gloucestershire at the next Board meeting.	**November 2024**	**November 2024: A** verbal update to be given at the next Board meeting on governance processes i.e. where updates and progress is reported for the One Plan for all Children	**Open**

Gloucester Inner City PCN

Risk Stratified approach to Integrated Care – Spotlight on Respiratory


NHS
REDUCING HEALTHCARE INEQUALITIES
CORE20
The most deprived 20% of the national population as identified by the Index of Multiple Deprivation
20%
The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement
Target population
PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups
CORE20 PLUS 5
Key clinical areas of health inequalities
1
MATERNITY
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups
2
SEVERE MENTAL ILLNESS (SMI)
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets
3
CHRONIC RESPIRATORY DISEASE
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4
EARLY CANCER DIAGNOSIS
75% of cases diagnosed at stage 1 or 2 by 2028
5
HYPERTENSION CASE-FINDING
and optimal management and lipid optimal management
SMOKING CESSATION
positively impacts all 5 key clinical areas

Systematic and Data Driven Approach

5 Step Process

1. **IDENTIFY AND RISK STRATIFY PATIENTS**
2. **MAP CLINICAL AND NON-CLINICAL INTERVENTIONS**
3. **MAP STAFF SKILLS AND EXPERIENCE – IDENTIFY GAPS**
4. **BUILD INTEGRATED NEIGHBOURHOOD TEAM**
5. **IMPLEMENT, PERSONALISE AND EVALUATE**

Spotlight on Respiratory

Why Respiratory?

- Respiratory conditions are the highest cause for emergency admissions in our network
- We have one of the highest rates of SABA(short acting beta agonist) prescribing in the county
- We have one of the highest smoking rates in the country
- We have a very high prevalence of red asthma and COPD, despite having the lowest percentage of patients over 65

Priority 1: Patients are well managed and understand their condition.

Priority 2: Fast, accurate, early diagnosis.

Priority 3: Consistent integrated approach to Respiratory Care

Current figures for Gloucestershire

- 45,919 people in Gloucestershire with a diagnosis of Active Asthma
- 12,644 people in Gloucester with a diagnosis of COPD

Building the risk stratification report and mapping interventions

High Risk

Moderate Risk

Low Risk

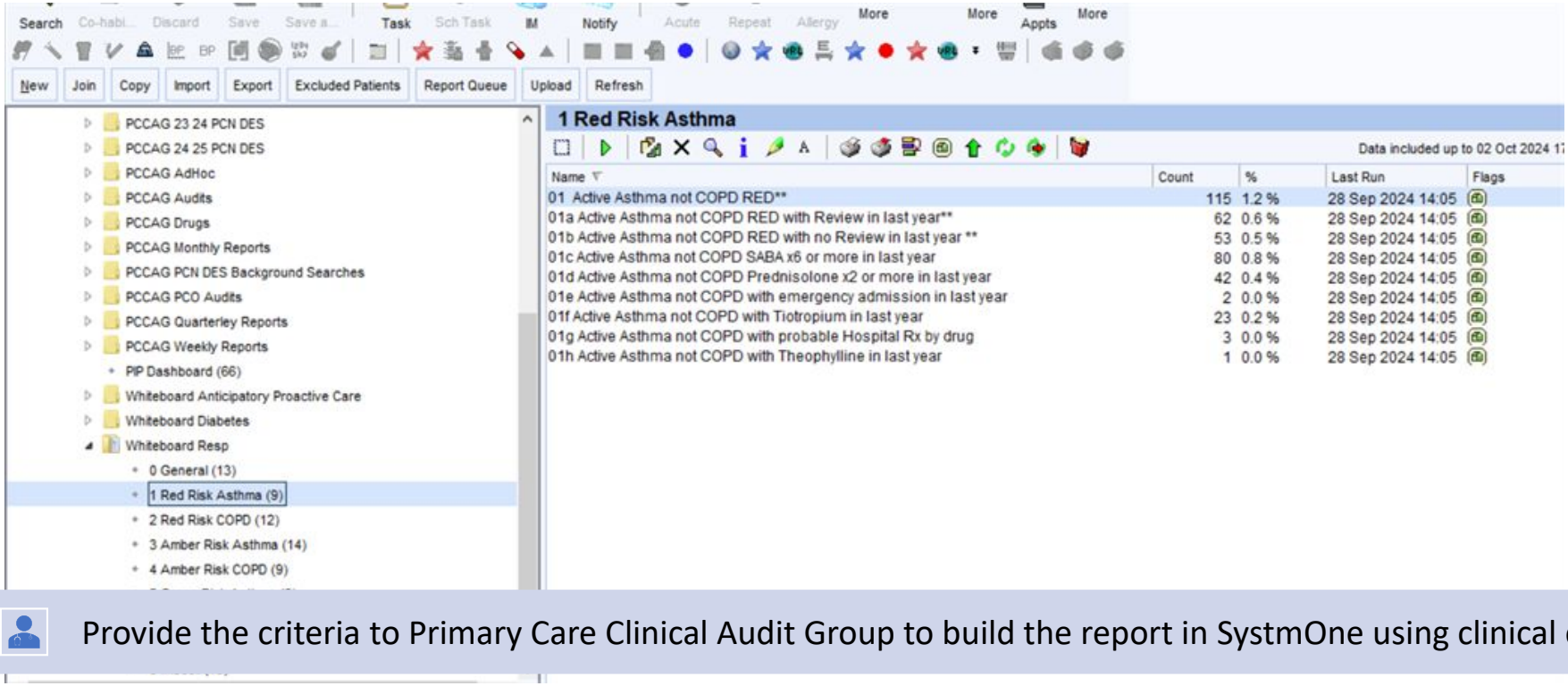
Who?

- Primary Care GP with Specialist Interest
- Secondary Care Consultant
- ICS Clinical Programme Group

What?

- Agree the criteria for Red, Amber and Green
- Agree the clinical and non-clinical interventions
- Consider existing guidance and tools
- Write and agree clinical governance

Risk Stratification Tool



Provide the criteria to Primary Care Clinical Audit Group to build the report in SystmOne using clinical codes.

Risk Stratification tool is live and updates automatically every evening.

Available to all practices and PCN’s on SystmOne

Integrated Neighbourhood Team In Action

Respiratory

Gloucester Inner City PRIMARY CARE NETWORK

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire Hospitals NHS Foundation Trust

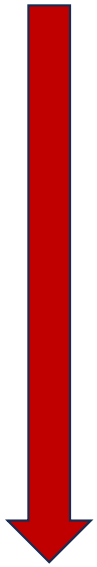
NHS Gloucestershire Health and Care NHS Foundation Trust

Sue Ryder

Community Health and Wellbeing Hub

- **PCN** – 'Hub' (Patients, clinicians, clinical and project leadership, physical space)
- **ICS** – CPG support and funding, PCN QI grant, Primary Care Clinical Audit Group report building and hosting.
- **GHFT** -Respiratory consultant twice a month MDT (Red patients)
- **GHC** - Pulmonary Rehab uptake and conversion rates
- **Sue Ryder** – PCN Palliative Physio clinics
- **Health and Wellbeing Hub –** Weight Management, Smoking Cessation, Employment, Skills and Education

Early tracking of System activity



Decrease in unplanned care

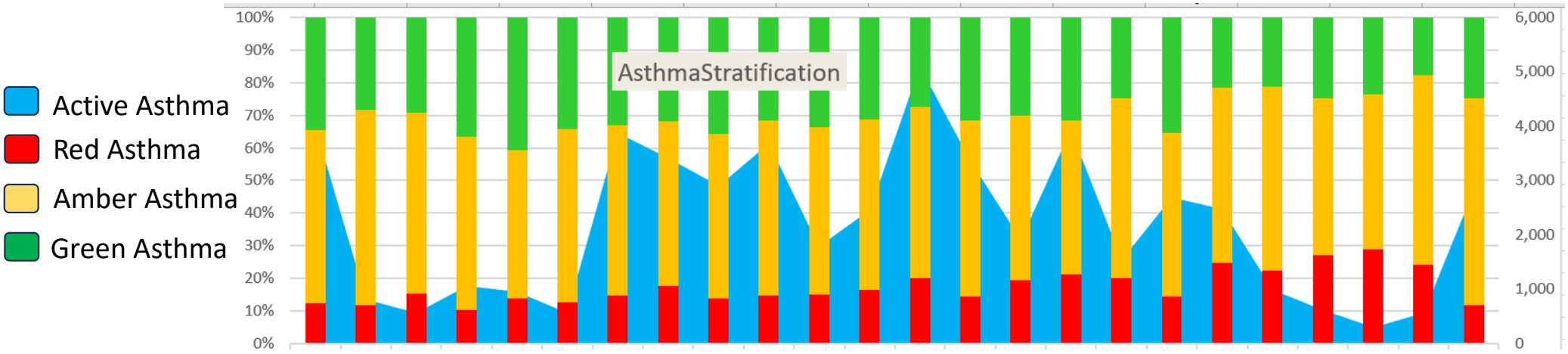
12 months Pre and 12 months Post Intervention Activity

Type of Activity
A&E Attendance
MIIU Attendance
Elective Admissions
Emergency Admission
Emergency Admission LOS
GP Contact
Outpatients
Ambulance Service Contacts
Out of Hours Attendance
111 Calls

Increase in planned care

Respiratory Emergency Admission	-26.7%
Respiratory Emergency Admission LOS	-23.5%

Picture across Gloucestershire – Asthma Example



Where next?

Risk Stratification tools built for all CORE 20 clinical priority areas and areas of high prevalence

- *Diabetes, CVD and Weight Management already completed and ready to share*

High Risk | Moderate Risk | Low Risk

CORE20 CYP - Whole Population approach - Risk Stratifying and Proactive Plans

- *We are leading this work from Gloucester Health Access Centre - opportunity to link closely with Secondary Care and Family hubs.*

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 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 on the Government's manifesto pledges for the NHS and social care.					
Key Issues to note	This report covers the following topics: • **Long Term Plan and Joint Forward Plan and Operational Plan** • **Community Health and Wellbeing Hub for Gloucester** • **Gynaecology Waits** • **Dental Access** • **National GP Pilot**					
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	
Impact on Sustainable Development	N/A
Patient and Public Involvement (PPE)	See the article on ICS Engagement Improvement Framework
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 27th November 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. NHS Long-Term Plan, Joint Forward Plan and Operational Plan

2.1 The Department of Health and Social Care and NHS England have launched work develop a 10-year NHS Long-Term Plan. This is scheduled for publication in May 2025.
The work consists of two workstreams. Firstly, an engagement workstream that includes consultation with the public, staff and organisations through https://change.nhs.uk. NHS Gloucestershire is involved in this workstream and will be engaging with members of the public through our existing People's Panel as well as through other means. We encourage people and organisations to submit a response to this. The second workstream is a series of policy groups that will help shape the content of the Long-Term Plan. This includes enabler groups (such as accountability and oversight; finance and contracting; people) and vision groups (formed around the National Voices 'i-statements' such as 'I can stay healthy and manage my health in a way that works for me').

2.2 Partners in Gloucestershire are working together to refresh the Joint Forward Plan for publication in March 2025. The Joint Forward Plan is our strategic 5-year delivery plan and describes our commitments to deliver against the three pillars of the One Gloucestershire ICS Integrated Care Strategy. Our plan is refreshed annually – the latest version of the plan (published in July 2024) can be found here. This will be a light-touch refresh next year, allowing us to develop the plan the following year once the national NHS Long-Term Plan has been published.

2.3 The Joint Forward Plan will align with our one-year operational plan submission to NHS England. We expect the publication of operational planning guidance later this year – including continued performance commitments related to planned care, urgent care, and mental health as well as requirements for systems to financially break-even. We are awaiting further information from NHS England on the details of the £22bn funding allocation to the NHS that was announced by the Chancellor at the end of October.

3. Community Health and Wellbeing Hub for Gloucester

3.1 A new community hub has opened its doors, providing health and wellbeing support to patients in inner city Gloucester. With artwork on the walls and a fresh and contemporary feel, Gloucester

Inner City Health and Wellbeing Community Hub provides a relaxing and calm space. Based within Gloucester Health Access Centre (GHAC) in Quay Street it provides a unique environment where additional services such as bereavement and anxiety counselling, stop smoking advice and benefits advice can be delivered.

3.2 GHAC is one of a group of practices in the Gloucester Inner City Primary Care Network (GICPCN). Some of the other services patients can access at the hub will include social prescribing and health checks.

3.3 The thoughtfully curated artwork in the hub has been loaned by Art Shape, a local charity which delivers therapy through creativity. The paintings, which create a restful atmosphere, will be rotated on a regular basis.

3.4 Another key element for staff at the PCN, is providing a facility for health and care practitioners to work in a more joined up (integrated) way with voluntary sector colleagues.

3.5 One of the more innovative services offered at the hub is the new 'benefits MOT' which will enable practitioners to make sure patients understand their benefits entitlement, so they get the right support.

3.6 The significance of the hub is even greater because it is dedicated to a much-loved colleague, Dr Imran Rafi, a GP at Partners in Health, who died five years ago. Dr Rafi's wife Afsheen and two children opened the hub and were moved to see a framed photograph of Dr Rafi in the hub.

3.7 The GHAC site is one of four current locations earmarked for hubs in areas where people face health inequalities (the term which describes unfair or avoidable differences in health across the population).

3.8 The Stroud Road Community Hub in Gloucester opened in June and is now thriving, offering a range of different activities and support to help residents connect and lead healthier lives. These include a crafting group, a men's mental health group and a Parkinson's café.

4 Gynaecology waits

4.1 There has recently been a national focus upon the number of women waiting for gynaecology appointments and the length of time they have been waiting. Nationally, the waiting list has doubled since the pre-pandemic period and there were more than 22,000 women in England waiting for longer than 52 weeks for their treatment to be completed at the end of September 2024 (3.9% of the total gynaecology waiting list). The national performance for Gynaecology against the RTT target (% of people waiting under 18 weeks) is 54.6%.

4.2 We have reviewed our latest data (September 2024), this shows that in Gloucestershire we do not follow this trend. There are currently 3,696 open pathways under gynaecology – this is 24% lower than the total list size in September 2019 (which was 4,832). The local performance against the RTT target is 71.9% at GHFT for Gynaecology. There are currently 32 women from Gloucestershire waiting more than a year for their pathway to be completed (0.9% of our total

waiting list) with 13 of these women waiting at our local provider GHFT, and the remainder waiting out of county. These are women on some of the most complex pathways.

4.3 Whilst it is encouraging to see that performance has not significantly deteriorated compared to the pre-pandemic position, we remain committed to working together across the system to eliminate over 52 week waits and to support our patients on our waiting list through initiatives such as the Elective Care Hub.

4.4 We have also reviewed cancer wait times target for people referred with suspected gynaecology and found that performance is just below the 75% Faster Diagnosis target (for cancer to be diagnosed or ruled out within 28 days of referral) at 69.7% throughout 2024/25 to date. Performance improvement work is underway within cancer services at GHFT, focussing in November specifically upon the Best Practice Timed Pathway for Gynaecological cancers. Performance against the 62-day treatment target (for people to being cancer treatment within 62 days of referral with suspected cancer) for gynaecological cancers has improved in 2024/25, at 72.7% to the end of September 2024.

5. Dental Access update

5.1 In Gloucestershire, there are 62 primary care dental contracts and 10 primary care orthodontic contracts. This was initially affected by three contract hand backs in June 2023, however this has remained steady. In October 2024, the units of dental activity (UDAs) achieved within these contracts was at 64% in the South West, and in Gloucestershire slightly higher at 71%. This is the anticipated delivery across the full year of 2024-25. In May, it was reported that activity being delivered remains lower than pre-pandemic, this is still the case with it previously averaging over 80% delivery across the South West for many years before 2020. Work has been undertaken to meet and support contractors who are consistently underdelivering their contacted UDAs and the ICB aim to ensure that achievement rates of contracted work continues to increase.

5.2 The ICB have recently commissioned new routine NHS access from a dental practice in one of our Core20Plus5 areas. The provider is mobilising currently and working with us to help ensure that people living locally to the practice are able to access this new capacity. The ICB have also been able to utilise the national flexible commissioning opportunity for additional Urgent Care dental appointments and stabilisation access for patients who do not have a dentist. Approximately 60 urgent appointments a week are now available in locations across the county for people who do not have a dentist, urgent weekend appointments are for when the practices are closed. This has increased from 9 a week in early 2023, patients without a dentist do need to call NHS111 to access these urgent care appointments. Patients are triaged by dental nurses in the local urgent dental care triage team. We aim to continue to commission further appointments for urgent care. Approximately 230 Stabilisation appointments per week, are also available for onwards referral after an urgent appointment for people who do not have a dentist. These sessions provide up to 1 year of dental treatment, this is new access that has been commissioned to stabilise dental needs and complex mouth issues.

5.3 The list of patients waiting for oral surgery at GHFT has been reviewed with suitably qualified dentists from primary care working at acute trust sites to treat long waiters. The ICB has invested

in additional Intermediate Minor Oral Surgery (IMOS) capacity enabling GHC to offer a 5 day a week service and in addition to this the ICB is currently in the process of commissioning further IMOS from primary care providers.

6. **National Pilot GP Test Site**

6.1 Gloucestershire ICB is one of seven ICBs selected as a national test site to pilot and help inform the national conversation around developing a sustainable model for general practice into the future and how to create a clearer path to achieve this to offer a better future for practices, staff, and patients. The pilot is looking to understand the current gaps in information around; demand and resource capacity against 2028/29 levels, workload across five core functions of general practice (On-the-day demand, LTC management, population health management, screening, and immunisations & care for complex cohorts) and understanding the funding gap associated with this.

6.2 As well as understand how additional clinical staffing combined with other positive actions and interventions within a quality improvement approach could help close any gap. The GP Pilot programme aims to work with general practice to collect the necessary information and data that will provide a clearer, shared understanding of the gap, causes and potential solutions. The outputs of the Programme and learning will be used to inform both ICB and national strategies.

6.3 The pilot launched in September 2024 and is due to run until March 2027. Nationally there are 22 PCN Test Sites covering roughly 1 million population, the 2 PCN Test Sites for Gloucestershire, selected through a national selection process are: Rosebank PCN & Cheltenham Central PCN.

6.4 To date baselining exercises are being undertaken to help inform the pilot. This includes baselining ICB and PCN data, of which the PCN Test Sites have successfully completed their first audit week of 2024/25 with their second one due at the end of November. PCN Interventions are currently being agreed for commencement in 2025 alongside recruitment of additional staffing.

6.5 As part of the pilot, Dr Claire Fuller and Professor Tim Briggs undertook a tour of all 7 ICBs during the week of 4th November. Gloucestershire had a successful visit on Monday 4th November, which focused on the PCN Test Sites and how they want to progress within the pilot, as well as an in depth discussion with system partners on the Primary Secondary Care Interface and how this is currently being improved locally and plans for the future. A second national visit will be planned for early 2025 to review progress.

7. Recommendation

7.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Board Assurance Framework**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	Risks are reviewed by Directorates and Executives each month.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	ICB Operational Executive	19/11/2024	Strategic Executive	21/11/2014			
Executive Summary	The BAF was refreshed earlier in the year with the risks aligned to the three pillars, the strategic objectives, and priorities for 2024/25. For each of the sub-committees of the ICB • System Quality Committee • Resources Committee • People Committee • Primary Care & Direct Commissioning Committee A cut of the BAF risk and corporate risks related to that committee are included in the committee papers at each meeting. The discussion on those risks appears early in the agenda to set the frame and tone and to ensure that the committee cross checks the risks being discussed at the committee meeting with those that appear on the CRR and BAF.						
	Where modifications need to be made to the risks following the committee meeting these are followed up after the meeting and incorporated within the BAF and CRR. It should be noted that the Audit Committee receives the full BAF and CRR at each of its meeting and provides feedback on the risks, including the controls, assurances, and action plans. The next meeting of the Audit Committee is on 5th December.						
Key issues	Since the last BAF report in September to the Strategic Executive and to the ICB Board there has been a Board Development session (30/10/2024) on risk appetite and risk tolerance and system wide strategic risks within the BAF. Board members discussed the risk appetite and a proposal to include risk tolerance within the BAF and asked that the Audit Committee review this in more detail and align with our system partners. The Risk Appetite framework was considered and at this point in time it was decided to retain the categories and descriptions until GHFT had undertaken their review of risk management following a reappraisal of their Trust Strategy. This would allow the system governance leads to meet and align their risk processes and produce an annual joint risk report for the ICB Board.						

<table>
<tr><td></td><td colspan="4">The key changes for the BAF report are as follows
There are 13 strategic risks on the BAF
• 9 Red rated risks
• 4 Amber rated risks.
There has been one change in the risk scores for this reporting period.
The following changes have been made:
• BAF 1 Health Inequalities risk has been reviewed with updates to the Director's report and actions.
• BAF 3a workforce risk has been reviewed, the actions and Director's report have been updated. The BAF risk was reviewed at the People Committee on 17th October 2024.
• BAF 3b Equality, Diversity, and Inclusion has been reviewed actions and Director's Report updated. The BAF risk was reviewed and discussed in detail at the People Committee 17th October 2024, with the risk score increased from 12 to 15.
• BAF 4 Quality Risk has been reviewed with significant updates on System Mortality in the Director's Report.
• BAF 6 Primary Care Risk has been reviewed and the risk description added to as well as the actions which have been updated.
• BAF 7 Recovery and Productivity risk has been reviewed. Wording adjusted in the 'Due to' and 'Impact' descriptions. A control, gap in control and an action were added. The Director's report has been updated.
• BAF 9 Financial Sustainability: this risk has been reviewed there are no updates to the contents or scoring.
• BAF 10 Estates Infrastructure: this risk has been reviewed there are no updates to the contents or scoring.
• BAF 11 Emergency Planning Resilience and Response (EPRR) Risk reviewed, and Director's report updated with information around the 'NHSE Core Standards Assurance Process (please see board paper agenda item 14).</td></tr>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">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</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">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.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">Risk around finance have been included within this report.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">The ICB Constitution requires the ICB to have appropriate arrangements for the management of risk.</td></tr>
</table>

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 • 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
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Strategic Risks – Board Assurance Framework

November 2024 Summary

Pillars	ID	Entry Date	Strategic Risk	Last Updated	Lead	Original Score (IxL)	Current Score (IxL)	Target Risk (IxL)	Committee	Note
1: Making Gloucestershire a better place for the future	**Strategic Objective 1:** *Increase prevention and tackle the wider determinants of health and care.* **Strategic Objective 3:** *Achieve equity in outcomes, experience, and access.*									
	BAF 1	13/11/23	The failure to promote and embed initiatives on health inequalities and prevention.	14/11/2024	Director of Op. Planning & Perf.	**12** (4x3)	**12** (4x3)	**8** (4x2)	Resources ICP System Quality	*Current score unchanged.*
2: Transforming what we do	**Strategic Objective 2:** *Take a community and locality focused approach to the delivery of care.*									
	BAF 2	14/11/23	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.	16/09/2024	Director of Primary Care & Place	**12** (4x3)	**12** (4x3)	**4** (4x1)	System Quality	*Current score unchanged.*
	Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*									
	BAF 3a	01/11/22	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.	14/11/2024	Director of People, Culture & Engagement	**16** (4x4)	**20** (5x4)	**5** (5x1)	People	*Next review at People Committee 2025*
	BAF 3b	15/02/24	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.	14/11/2024	Director of People, Culture & Engagement	**12** (4x3)	**15** (5x3)	**4** (4x1)	People	*Score increased Next review at People Committee 2025*
	Strategic Objective 5: *Improve quality and outcomes across the whole person journey.*									
	BAF 4	07/11/23	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.	14/11/2024	CNO & CMO	**15** (5x3)	**16** (4x4)	**4** (4x1)	System Quality	Current score unchanged
3: Improving health and care services today	**Strategic Objective 6:** *Address the current challenges we face today in the delivery of health and care.*									
	BAF 5	13/11/23	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.	17/09/2024	Deputy CEO / Director of Strategy & Transf.	**20** (5x4)	**12** (4x3)	**8** (4x2)	Resources	*Current score unchanged.*

	BAF 6	15/11/23	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.	18/11/2024	Director of Primary Care & Place	**16** (4x4)	**20** (5x4)	**5** (5x1)	PCDC	*Current score unchanged.*
	BAF 7	01/11/22	Failing to deliver increased productivity requirements to meet both backlogs and growing demand.	14/11/2024	Director of Operational Planning & Perf.	**12** (4x4)	**16** (4x4)	**4** (4x1)	Resources System Quality	*Current score unchanged*
	BAF 8	01/11/22	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes.	13/09/24	Director of Integration	**12** (4x3)	**12** (4x3)	**4** (4x1)	People	*Current score unchanged.*
	BAF 9	01/11/22	Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity.	13/11/2024	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 10	30/01/23	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.	13/11/2024	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 11	01/11/22	EPRR - Failure to meet the minimum occupational standards for EPRR and Business Continuity.	14/11/2024	Chief Nursing Officer (CNO)	**12** (4x3)	**16** (4x4)	**4** (4x1)	System Quality Audit	*Current score unchanged.*
	BAF 12	15/02/24	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.	17/09//24	Chief Clinical Information Officer	**20** (5x4)	**20** (5x4)	**10** (5x2)	Audit	*Current score unchanged.*

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

Key Changes since September 2024 report

1	Health Inequalities risk has been reviewed with updates to the Director's report and actions.
2	Community and locality transformation there is no update for November
3A	People and Culture risk has been reviewed, the actions and Director's report have been updated. The BAF risk was reviewed at the People Committee on 17th October 2024.
3B	Equality, Diversity, and Inclusion has been reviewed actions and Director's Report updated. The BAF risk was reviewed and discussed in detail at the People Committee 17th October 2024, with the risk score increased.
4	Quality Risk has been reviewed with significant updates on System Mortality in the Director's Report.
5	Urgent and Emergency Care risk, there are no updates to this risk for November

6	Primary Care risk had been rearticulated. The risk remains at a score of 20 in light of collective action so the cause / impact narrative has been enhanced, there is more detail on the controls, assurances and actions as well as an updated Director's report.
7	Wording adjusted in the 'Due to' and 'Impact' descriptions. A control, gap in control and an action were added. The Director's report has been updated.
8	Mental Health services This risk has been reviewed by the Mental Health Team and there are no changes to be made for the November Report.
9	Financial Sustainability: this risk has been reviewed there are no updates to the contents or scoring.
10	Estates Infrastructure: this risk has been reviewed there are no updates to the contents or scoring.
11	Risk reviewed and Director's report updated with information around the 'NHSE Core Standards Assurance Process'.
12	Cyber Security risk has been reviewed and there are no changes to this risk for November.

**NB. Target risks aligned to current risk impact.*

BAF 1 — Risk of failure to promote and embed a health inequalities and prevention approach.

Entry date:	**13/11/23**	**Last updated:**	**14/11/2024**
Owner:	**Mark Walkingshaw, Director of Operational Planning and Performance**		
Committee	**ICP, Resources, System Quality**		
Aligned with System Partner Risk(s):	**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 12) May 2024**		
Aligned with ICB Risk(s):			

Pillar 1: *Making Gloucestershire a better place for the future.*

Strategic Objective 1: *Increase prevention and tackle the wider determinants of health and care.*

Strategic Objective 3: *Achieve equity in outcomes, experience, and access.*

Key Priorities 24/25: *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.*

Reduce unfair and avoidable differences in health and care – including improving outcomes for specific groups of our population.

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
12 (4x3)	**12** (4x3)	**8** (4x2)	**Appetite**	**Cautious**

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.

Current Controls *(to mitigate risk):*

1. Prevention Delivery Group and EAC-I oversight.
2. Health inequalities embedded in transformation programmes. This includes activity in Gloucester City (“Core20”), race relations (“PLUS”) and 5 nationally identified clinical areas.
3. Health inequalities is a standing item at the Planned Care Delivery Board.
4. Integrated Locality Partnerships take a place-based approach to identify priorities for addressing the root cause of health inequalities.
5. System representation at Regional Inequalities Group and links with local and regional networks.
6. Consideration of health inequalities as part of service development and change through application of Equality and Engagement Impact Assessments.
7. Health Inequalities annual statement – reviewing the status of specified metrics as defined by NHSE.

Known Gaps in Controls

1. Some gaps remain in data quality and data sharing between ICS organisations.
2. Lack of a social value policy to guide proportionate universalism in funding allocations.
3. No routine or consistent collection of evidence or reporting of how successfully interventions are addressing health inequalities.
4. Health Inequalities annual statement does not cover all programme areas and inequalities and requires development to provide review of progress in reducing health inequalities.
5. Equality and Engagement Impact Assessments are not completed routinely in all parts of the system

Current Assurances *(of controls effectivity):*

1. Health inequalities measures built into strategic outcomes framework with Board-level assurance.
2. Regular reporting to System Resources Committee & Strategic Executive.
3. Quarterly activity reporting to NHSE.
4. Oversight by SROs.
5. Children’s’ CPG to have oversight of the data for the Core20PLUS5 for CYP.

Known Gaps in Assurances

1. Coordinated reporting on both longitudinal health inequalities and medium-term control impact (e.g., Core20Plus5.
2. Public reporting of health inequalities now in place but requires iterative development.
3. Monitoring effectiveness and impact of interventions.
4. Governance and accountability structures in development for the prevention and health inequalities agendas.

8. Organisational level self-assessment and peer review tool. 9. ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery. 10. Commitment to patient participation in all workstreams.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Review of referral process and elective waiting list has commenced with clinical input from the PHM Clinical lead for Health Inequalities (Dr Charlie Sharp) – ongoing work. 2. 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 – roll out of demographic information to be included on all system dashboards. 3. Further develop Statement on Inequalities to reflect progress in reducing inequalities over time, and widen the metrics and populations covered by the review. Next publication July 2025. 4. Project to increase and improve engagement with underserved communities continuing following the evaluation of the first phase. Funding for the remainder of 2024/25 is in place. 5. EAC-I has been re-established and will provide governance and oversight of work taking place across the system to tackle health inequalities 6. NHS Gloucestershire ICB is a test site for the development of the ICS Engagement Improvement Framework, which will enable systems to measure how well they listen to, and act on, the experiences and needs of people and communities to reduce health inequalities. The framework will be launched in February 2025	1. The returns on the Health Inequalities Framework for the ICS have been completed by system partners and key themes are being identified. This will set the parameters for the aligned 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. This will be presented at the January 2025 board meeting. 2. The Gloucestershire Statement on Health Inequalities has been presented at several system and internal meetings to raise awareness, and a development meeting was held on the 25th September to agree priorities and next steps with Public Health and system BI colleagues. Monthly steering group meetings have been arranged to drive forward this work, and there is good system collaboration for a joint approach to the statement for 2024/25. 3. The ICS Health Inequalities Intelligence Group is being reconvened to work collaboratively to build the intelligence around health inequalities across the system and ensure a coordinated approach to health inequalities analysis – dates are being circulated with system partners. 4. An intern supporting the Health Inequalities team has reviewed the national Major Conditions Strategy and identified areas of focus for Gloucestershire, including specific review of Spirometry access and inequalities associated with this in line with recommendations for respiratory associated conditions. 5. Specific focus on Gloucester Inner City in underway as Targeted Lung Health checks are rolled out – this will include support for patients with incidental findings in addition to those identified as having suspected cancer funding has now been agreed through the s256 joint funded monies to support targeting health inequalities. The go live date for TLHC has been confirmed for January 2025. 6. Focus on the Darzi review and findings associated with Health Inequalities will be a focus as we commence the 2025/26 operational planning round. We are currently liaising with programmes to ensure the health inequalities focus in the operational plan is up to date and covers all planned work for the next financial year.

Relevant Key Performance Indicators
Health inequalities narrative and system outcome measures 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.
NHSE Statement on Inequalities – system annual reporting

BAF 2	**Risk that 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.**

Entry date:	**14/11/23**	**Last updated:**	**16/09/24**
Owner:	**Helen Goodey, Director of Primary Care & Place**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	*There are no correlating risks.*		
Aligned with ICB Risk(s):	*Risk of instability and resilience in general practice.*		

Pillar 2: *Transforming what we do.*

Strategic Objective 2: *Take a community and locality focused approach to the delivery of care.*

Key Priorities 24/25: *Continue to support improvements in outcomes for people at every stage of life – delivering care that is closer to home and person-centred*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
12 (4x3)	**12** (4x3)	**4** (4x1)	**Appetite**	**Cautious**

Due to:	**Impact:**
Multiple and competing demands to transform services, couple with increased 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.	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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. 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. 2. UEC prevention workstream adopting a population health approach to support those at greatest need and risk of deterioration. 3. Working with BI colleagues to understand our cohorts. 4. 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.	1. Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. 2. Sufficient change management resource to deliver sustainable change across the ICS in the timeframe required. 3. Permission & time for operational staff to actively engage.	1. Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG). 2. Ongoing monitoring.	1. Further development of the performance and benefits realisation trajectories required. 2. Outcome measures to be reviewed at The Gloucestershire Neighbourhood Transformation Steering Group on 18th September.

5. All PCNs/Neighbourhoods included within the programme.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Board development session at end of October agreed an approach to support integrated working using the prevention of frailty as a worked example. **2.** 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. **3.** A proposal on implementation together with a roll plan and timeframes presented at GNTG meeting in January. **4.** All PCNs/Neighbourhoods included within the programme (rather than the initial three pilot areas). **5.** Update paper including challenges, outcomes measures and an Integrated Neighbourhood Teams framework for Gloucestershire written for review by Gloucestershire Neighbourhood Transformation Group in September. Board update delayed until December.	**1.** Decision made to remove programme from Working as One due to the revised PCN Network Contract Specification. **2.** All 15 Neighbourhoods included in the programme. **3.** Post the PCN away day which focussed on Integrated Neighbourhood Team development and the ICS support offers, a Stocktake is underway of INTs through a PCN lens Eight maturing Integrated Neighbourhood Teams and seven where more intensive development support is required. **4.** Support from One Gloucestershire Improvement Community remains in place. Improvement Community was 1 of 20 successful applicants out of 190 that applied of the Health Foundation's Q Exchange programme funding. This will be used to support coaching for neighbourhood teams **5.** Support for Neighbourhood estates solutions remains available from Community Health Partnership (CHP). Plan for Connect Gloucester in development based on INT operating model. **6.** Integrated Locality Partnership (ILP) work plans aligned to focus interventions to support pre frail and mildly frail people. Dual reporting to Gloucestershire Neighbourhood Transformation Group and EAC-i. **7.** Two PCNs have expressed interest in the National GP Pilot designed to test new ways of working in GP Practices and build on delivery of the Fuller Stocktake. PCNs are expected to utilise proactive population health management for the care of complex or frail patients. Initial event taking place in London on 18th September

Relevant Key Performance Indicators
Ill health prevention Outcomes data (November 2023 IPR Report) and Ageing well KPIs.

BAF 3a	**Risk of 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.**

Entry date:	**01/11/22**	**Last updated:**	**10/11/2024**
Owner:	**Tracey Cox, Director of People, Culture and Engagement**		
Committee	**People**		
Aligned with System Partner Risk(s):	**GHFT SR16:** *Inability to attract and recruit a compassionate, skilful, and sustainable workforce* ***(risk rating 20, Sept 24)*** **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 16) May 2024** **GHC ID12:** *There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target* ***(risk rating 9, May 24).***		

Pillar 2: *Transforming what we do.*

Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*

Key Priorities 24/25 : *Increase staff retention, provide good training and development opportunities of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):

PCE 2: *Social work placement assessment*

PCE 5 : *CPD /WDF funding*

PCE 15: *System wide AP strategy without enabling infrastructure as ICS AP Lead Role secondment ends Dec 24*

PCE 22: *Leadership Development Support*

PCE 28: *Industrial Action*

PC&P 16 – Community Pharmacy

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
16 (4x4)	**20** (5x4)	**5** (5x1)	**Appetite**	**Cautious**

Due to:	**Impact:**
High levels of vacancies across key staffing groups. Risks to future staff pipelines e.g. apprentices and graduates in key staffing groups	Increased pressure on existing staff, impacting staff morale and wellbeing, impacting service delivery in key areas and future bank and agency targets

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Utilisation of all available resources from NHSE monies for Continuing Professional Development and leadership development to support staff training & development. 2. Some leadership learning and development programmes in place. 3. People Promise Leads in both Trusts focusing on all aspects of People Promise elements and best practice.	1. Lack of an adequately defined and resourced system-wide and medium-term plan for staff relating to leadership development (Mapping of current leadership development approaches and offers completed the ICS, options for future being developed).	1. Reporting to the People Board, People Committee, and the Board of the ICB. 2. On-going monitoring of progress on key workforce metrics through Integrated Performance Report.	1. Implementation details relating to supporting delivery of NHS Workforce Plan. 2. Reduced funding for workforce transformation in 2024/25..

4. System level delivery plans focusing on agreed priority areas for action in 24/25 for each Steering Group **5.** Robust organisational plans in place for EDI, retention and temporary staffing spend reduction. **6.** Colleague Communications & Engagement. **7.** System-wide careers and engagement team (2-year FTC) focused on promoting careers in health and care. **8.** Apprentice Strategy developed. **9.** Strategic Partnership Board with UoG.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. People Promise Leads and work programmes 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 spends 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 e.g. GHFT's Workforce Sustainability programme aimed at transforming it's recruitment process. Roll out of system wide recruitment promotion campaign 'Be in Gloucestershire'. **5.** H&WB strategy and Learning & Development proposals to be developed and key initiatives for staff including proposed staff housing hub. **6.** Continued focus on System Leadership with a programme of conferences and events for leaders across the system.	**1.** Peoples Promise Managers presented work programmes to October People Committee. Agreement on areas where a system approach would be beneficial e.g. pension awareness and menopause policy and resources. **2.** EDI focus at Board Development session on 20th November. All organisations recently completed SW EDI audit. **3.** ICS Temporary staffing group in place to bring shared system oversight and sharing of initiatives and best practice. Agency spend remains within agreed cap of 3.2% for 2024/25. **4.** Recruitment: We Want You project team has transitioned into a new service arrangement with the commencement of two system careers engagement officers. **5.** HWB strategy approved by People Committee. Regional conversations to establish housing hub ongoing. Housing Officer came into post November 24. **6.** One Glos Leadership event took place on 23rd October 2024 and was well received, planning for future event in early part of 2025/26.

Relevant Key Performance Indicators
Staff Engagement Score (Annual)
Sickness Absence rates, Staff Turnover % & Vacancy Rates
Bank and Agency Usage
Apprenticeship levy spend and placement numbers

BAF 3b	**ED&I: 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.**

Entry date:	**01/03/24**	**Last updated:**	**10/11/24**
Owner:	**Tracey Cox, Director of People, Culture and Engagement**		
Committee	**People**		
Aligned with System Partner Risk(s):	**GHFT SR17** *Inability to attract a skilful, compassionate workforce that is representative of the communities we serve, (Culture & Retention.)* **(Risk rating 20, Sept 24)** **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 9, May 24)**		

Pillar 2: *Transforming what we do.*

Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*

Key Priorities 24/25: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):	**PCE 26:** *ICS Workforce supply*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
12 (4x3)	**15** (5x3)	**6** (3x2)	**Appetite**	**Increased**

Due to:	**Impact:**
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.	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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. One Glos People Strategy priority and commitment to ED&I as an underpinning theme 2. Reporting through the ICS People Governance Groups 3. Monitoring from the Equality and Human Rights Commission on the Public Sector Equality Duties. 4. Annual reporting against Workforce Race Equality Standards, Workforce Disability Standards & gender pay gap with corresponding action plans. 5. ED&I Task and Finish group.	1. Lack of systemwide targets for: a. Recruitment. b. Movement between pay bands. c. Insufficient frequency in metrics related to engagement and staff experience. d. Significant volume of data but more granular analysis required to support improvement plans	1. Reporting to the People Board, People Committee & relevant Committees of providers. 2. Reporting to the ICB Board. 3. Audits undertaken by Internal Auditors	1. People Committee requested further system wide focus and commitment to discuss improvement trajectories.

Actions to Mitigate Risk & Implementation Dates	**Directors Updates on Actions to Date (Updated Quarterly)**

1. All NHS partners engaged in Equality Delivery System framework.
2. All NHS partners have action plans in response to 6 high impact actions in national EDI Improvement Plan.
3. System wide commitment to support agenda prioritising:
    a. Data collation and presentation,
    b. anti-discrimination policy and practice &
    c. recruitment/career progression.
4. Relaunch of SW Regional EDI work programme and action plan being developed with nominated CEO/HRD leads.
5. Increasing Board level focus

1. EDS2 discussions relating to preparatory work for 2024-25 requirements initiated. ICB has refreshed its EDI web based information in line with Public Sector Equality Duty requirements.
2. Regional focus on 90-day challenge for greater diversity in senior nursing roles, with three projects:
    a. Talent management (Gloucestershire lead)
    b. Appraisal / career conversation (BSW lead)
    c. Application and recruitment process (Cornwall lead)
3. Inclusive recruitment workshop held with all partners on 1 August, areas of good practice shared and gaps in inclusive processes explored along with collaboration opportunities. Individual organisational level action plans progressing focusing on anti-discrimination approaches and reporting of incidents.
4. SW Regional EDI audit took place in November with requirement for all providers and ICBs to participate in a regional questionnaire.
5. Board level focus on EDI - 20th November development day. Planning for future session at system NEDs meeting.

Relevant Key Performance Indicators
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 and Staff Survey results for each organization.

BAF 4	**Risk that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients.**

Entry date:	**07/11/23**	**Last updated:**	**17/07/24**
Owner:	**Marie Crofts, Chief Nursing Officer & Ananthakrishnan Raghuram, Chief Medical Officer**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	**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) May 2024**		

Pillar 2: *Transforming what we do.*

Strategic Objective 5: *Improve quality and outcomes across the whole person journey.*

Key Priorities 24/25: *Increase support for people living with major health conditions – shifting to a more preventative approach and earlier diagnosis.*

Aligned with ICB Risk(s):

- **Integration 13:** *Midwifery Staffing Levels.*
- **Integration 15:** *Antenatal Screening*
- **Integration 28:** CQC *community & mental health inspection reports*
- **Integration 30:** *Paediatric Palliative Care Support at Home*
- **Integration 32:** *Post Partum & Massive Obstetric Haemorrhage*
- **Integration 34:** *Antenatal Scanning capacity*
- **Integration 40:** *Purchasing of Specialist Equipment*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged (since July update)
15 (5x3)	**16** (4x4)	**4** (4x1)	**Appetite**	**Zero/Minimal**

Due to:	**Impact:**
Lack of robust oversight and intelligence to ensure high quality care is delivered by organisations.	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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput 2. Reporting from and attendance at Provider Quality Committee. 3. Learning from Case Reviews. 4. System Quality Group.	1. New PSIRF will turn on the previously mentioned Patient Safety System Group. 2. Colleagues leading the work on the System Safety, Effectiveness and Experience groups will be meeting to ensure new groups are aligned. 3. Until groups are in place and functional existing control methods will continue as a risk mitigation.	1. Reporting to the System Quality Committee. 2. Quality Assurance discussions. 3. Intelligence gathering through data relating to all aspects of quality. 4. Contract Management Boards. 5. Regulatory reviews.	1. 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 PSIRF and alignment of groups (System Safety, Effectiveness and Experience groups) are working.

5. System Effectiveness Group. **6.** System IPC Group **7.** System Mortality Group **8.** Rapid Review and Quality Improvement **9.** Groups where appropriate for specific service areas challenged. **10.** Weekly safety huddle within ICB now routinely in place.	**4.** Triangulation of data across the system through quality dashboards not in place currently.		

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
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. TOR to triangulate data drafted.	**1.** PSIRF now in place although early days of new approach. Some enhanced measures and reporting in place, beyond PSIRF oversight, with maternity services owing to the level of surveillance and concerns **2.** Internal ICB Quality and Clinical Gov group to bring together triangulated data more formally across the system to promote learning and ensure focus support on challenged areas. First meeting has taken place and TOR drafted. **3.** **System Mortality**: While 'crude mortality' is matching the English average of 2.8%, the national NHSE data tool shows that the Summary Hospital-Level Mortality Indicator (SHMI) for Gloucestershire Hospitals is currently at 1.156. This is a 12-month rolling average covering the previous 12 months up to May 2024. This has been above the expected limits for eight consecutive months. Other data sources suggest that SHMI is now within control levels in Gloucestershire Royal Hospital but is continuing to rise in Cheltenham General Hospital. The impact of the move of the take from Cheltenham to Gloucester needs to be assessed and this will be reviewed monthly at System Mortality group meeting chaired by the ICB CMO. Based on National Quality Board (NQB) guidance, we have move to 'Enhanced Surveillance' led by Gloucestershire ICB with support from NHSE Southwest and regional colleagues. A system mortality QIG is in place with support from regional colleagues and external support from a colleague in another ICB. The regional team have written to the acute provider and offered a mortality insights visit. This is being discussed at QIG on 25th November and a timeline will be agreed there. The ICB is overseeing a number of actions looking at improving quality of depth of coding and improving clinical pathways. Our immediate aim is to bring SHMI inside of control levels, with a medium-term aim to get it down to 1 and below. Due to its retrospective nature, there will be a time lag before improvements begin to show. ICB oversight is through the System Quality processes and mortality remains on the Board assurance framework risk register. **4.** Quality Improvement Group (QIG) remain in place for maternity services and currently subject to enhanced surveillance owing to Section 31 notice. **5.** Significant challenges within UEC and GHFT risk rated at 25.

Relevant Key Performance Indicators
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.

BAF 5 — Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.

Entry date:	**13/11/23**	**Last updated:**	**17/09/24**
Owner:	**Ellen Rule, Deputy CEO and Director of Strategy and Transformation**		
Committee	**Resources**		
Aligned with System Partner Risk(s):	**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.*		

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Support improvements in the delivery of urgent and emergency care.*

Aligned with ICB Risk(s):

U&EC 1: *Risk of insufficient access to alternative pathways to ED*

U&EC 3: *Workforce & Delivery Priorities*

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&EC 4: *Risk of insufficient system Resilience*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
20 (5x4)	**12** (4x3)	**8** (4x2)	**Appetite**	**Zero/Minimal**

Due to:	**Impact:**
Insufficient improvement capacity and / or capability, insufficient staff engagement, or prioritisation of available resource on operational flow pressures.	Continued pressure on our staff, performance commitments and system finance plan. Risk patients will have a poor experience of urgent and emergency care services.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Strong system wide governance for system operational issues (daily and weekly rhythm including Exec oversight), supported by System Control Centre.	**1.** Enhanced outcome and performance reporting across governance structure (to be enabled by digital platform).	**1.** Ongoing monitoring of system wide priorities including operational planning targets via TEG/SEG.	**1.** Further development of the performance and benefits realisation trajectories required for some measures, with a focus on quality and outcome measures.
2. Strong operational governance through system meetings (e.g., UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG).	**2.** Agree funding for improvements as part of the 24/25 operating and financial planning process	**2.** Reporting to the Board of the ICB on key metrics via Integrated Performance Report.	**2.** Impact of operational demand on the ability to continue at pace with the Working as One Transformation Programme
3. Transformation capacity and capability all in place since August 2023 including Board, Steering Group and workstreams in place including Benefits Oversight and Assurance Group.		**3.** NHSEI Reporting.	
4. Agreed reporting on priority improvements in place.		**4.** Benefits Realisation for Working as One Programme in place.	
5. Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver improvements within UEC system flow.			

6. Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. **7.** System wide operating plan to align with Transformation priorities for 2023/24. **8.** Agreed UEC Transformation Programme in place including Working as One across all system partners. **9.** Annual Winter Plan to be developed and in place to communicate to patients about where to access services during winter.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
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). **2.** Benefits realisation being developed, Programme metrics to be finalised by December 2023. **3.** Communication and Engagement plan developed, core narrative and supporting materials to be shared in November 2023 (action to remain open). **4.** Improvement trials targeted to areas where performance improvements are needed (ongoing action with regular review at UEC CPG).	**1.** All workstreams have a trial mobilised or are in further iterations of trials (as at July 2024) Hospital Flow workstream is progressing into sustain phase with LOS reductions seen, whilst continuing to consider where further improvement cycles could support. **2.** 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. Automated reporting has been developed, under review prior to roll out across the system **3.** In line with the target date of November 2023 Working as One communications and engagement plan in place and core narrative shared and regular bulletins are distributed across the system. Action remains open whilst we continue to explore the impact of comms material and how we can increase reach. A Working as One Workshop will be held on 25th September inviting system partners. **4.** Integrated Hub went live on 19th February (4-week trial) to improve hospital flow and reduce no criteria to reside. Options Appraisal for continuation to be considered at August Exec Programme Board. **5.** 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. **6.** Implemented schemes through winter support resilience and reduce reliance on beds.

Relevant Key Performance Indicators
IPR Reporting for Acute, Winter monitoring and Ambulance Metrics.

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.**

Entry date:	**15/11/23**	**Last updated:**	**17/09/24**
Owner:	**Helen Goodey, Director of Primary Care and Place**		
Committee	**Primary Care & Direct Commissioning**		
Aligned with System Partner Risk(s):	**GHC ID8** *There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities* **(Risk rating 9)**		
Aligned with ICB Risk(s):	**PC&P 7:** *Financial Challenges within Primary Care* **PC&P 9** *Current and future GP Training Capacity* **PC&P 10:** *Primary Care Sustainability* **PC&P 11:** *Future Business Models for Primary Care* **PC&P 13***: Primary Care & Secondary Care Interface* **PC&P 14:** *Collective Action* **PC&P 18***: Special Allocation Scheme* **PC&P 19:** *PCN FOD Split* **PCE 13:** *New to Primary Care Fellowship Funding* **PCE 37***: Decline in GP Numbers*		

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
16 (4x4)	**20** (5x4)	**4** (4x1)	Appetite	**Cautious**

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Support a resilient and accessible primary care for the public and increasing workforce recruitment and retention.*

Due to:

Practices are facing new financial challenges due to the increase in costs associated with staffing, (including the recently announced increase in National Insurance employers' contributions), 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.

It should also be noted that general practice national collective action, commenced on the 1st of August 2024, following the BMA ballot results to proceed will see a gradual introduction of a possible 10 BMA Actions, which will move primary care to a new normal rather than action for a set period of time.

Note that there is a new risk for Community Pharmacies, who are also experiencing cost of living pressures similar to general practice but also due to drug shortages and pricing. Community Pharmacy Action took place on the 16th September 2024. The National Pharmacy Association undertook a ballot which received near a unanimous vote in favour of collective action, expected in the new year.

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 is unable to deliver core services due to complete saturation or through taking steps to manage down capacity or through collective action, this will also have an impact on patient care and experience.

Risk to ability of Community Pharmacy to deliver core services (83% of NHS income) and other clinical services (17% of NHS income) including Pharmacy First, Blood Pressure Monitoring, Contraception etc, Impact to wider system, particularly GP providers.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**

1. Primary Care Team continues to provide on-going support to practices, to identify mitigations and provide resilience funding where appropriate. 2. Resilience and Sustainability of General Practice Sub Group (to the PC strategy group) established. 3. A standard operating procedure (SOP) has been developed to ensure a fair and consistent approach with good governance. 4. An independent accountant working with the practices and ICB finance team to review the position and put in controls where appropriate. 5. There is a monthly review of practices to assess the issues that have arisen and where additional support may be needed. 6. A 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. 7. Workforce data is analysed on a monthly basis to ascertain early any problems with staffing and support is provided to practices where required. 8. Partners Survey to understand current position on retirements. 9. Primary Care Audit undertaken to understand what is driving increased demand. 10. ARR underspend process completed to enable PCNs to maximise recruitment. 11. A Primary Care Strategy is in place with associated plans. 12. ICB & LMC working with secondary care colleagues (GHFT) to brief them on national primary care industrial action and potential impact to their services. 13. A Secondary Care/Primary Care Interface Group (senior leads level) in place and reviewing delivery of the national 4 key areas of focus and the impact of collective action. 14. Collective Action Task & Finish Group established and meeting weekly, with wide attendance including ICB, GHFT, GHC, SWAST. The BMA have released 10 areas of potential collective action which are being monitored by the Task & Finish Group and mitigating actions put in place/being scoped, including monitoring UEC data, practice appointment data, optimiseRX usage, complaints, practice websites and phone messages and any patient safety implications 15. Regional Collective Action IMT meetings in place and meeting weekly. 16. Working closely with the LMC on collective action. Currently awaiting results of survey conducted with practices by local LMC on areas of action they will undertake. LMC have confirmed that they will not be supporting action around data sharing restrictions from the BMA 10 actions, therefore the LMC have advised practices to sign the JUYI 2 data sharing agreement and to keep the necessary elements of GP Connect on.	1. Details on the level of industrial action to determine which areas of work/system this will impact.	2. The Primary Care Operational Group receives regular reports on practice resilience and the schemes and initiatives to support practices including workforce reports. 3. The Primary Care and Direct Commissioning Committee receives those reports from PCOG and provides oversight and scrutiny 4. The Primary Care Resilience and Sustainability subgroup has been established to further develop the ICB response to struggling practices 5. The Collective Action Task & Finish Group is monitoring the situation with regard to collective action 6. Working with the LPC to understand Community Pharmacy issues and community pharmacy event to be held in October 2024 to support the community pharmacy voice within primary care across the system	1. Volume of shared care and additional 'discretionary' activity, are both unknown with regard to potential industrial action.
Actions to Mitigate Risk & Implementation Dates		**Directors Updates on Actions to Date (Updated Quarterly)**	

1. Further Admin and Reception Staff Training Events planned on conflict resolution and customer service.
2. Primary Care Induction Sessions - supporting knowledge and training of those new to general practice
3. Working with ICS 'We Want You' Programme to support promotion of Primary Care roles to secondary school age children.
4. Collaborating with Gloucestershire College on T-Level Placements & working on bespoke apprenticeship opportunities with practices.
5. The Collective Action Task & Finish Group are working with the Primary and Secondary Care Interface Group to ensure a shared understanding of collective action.

1. National announcement that General Practice will receive a 7.4% uplift to the GMS contract for 2024/25.
2. National announcement that newly qualified GPs will be claimable via ARRs with additional funding (value to be confirmed) expected within Q3 of 2024/25.
3. Working closely with the LMC to understand the potential impact to general practice capacity, due to the sustainability challenges.
4. Regularly surveying practices to understand impact to capacity, particularly urgent on the day care.
5. Resilience and Sustainability sub group & Collective Action Task and Finish Group - focussed on understanding the impact on general practice and ensuring we are developing action plans to support mitigations.
6. Financial Awareness Training is in place for all partners and practice managers.
7. Setting up one meeting for all four contractor group committees with the ICB to discuss constraints and opportunities to delivering primary care in the county.

Relevant Key Performance Indicators

Reporting on Access to Primary Care and Quarterly surveys and data relating to primary care.

BAF 7 — Risk of failing to deliver increased productivity requirements to meet both backlogs and growing demand.

Entry date:	**01/11/22**
Last updated:	**14/11/2024**
Owner:	**Mark Walkingshaw, Director of Operational Planning and Performance**
Committee	**System Quality, Resources**
Aligned with System Partner Risk(s):	**GHC 3** *There is a risk of demand for services beyond planned and commissioned capacity.*
Aligned with ICB Risk(s):	

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Increase 12 (3x4) to 16 (4x4)
12 (4x3)	16 (4x4)	4 (4x1)	Appetite	Cautious

Due to:

Waiting list backlogs built up during COVID as elective services were stood down for long periods of time. On-going workforce pressures in key diagnostic and treatment specialties make recovery more difficult.

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 bigger than 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 challenging in nature.

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.

Current Controls *(to mitigate risk):*

1. 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.
2. Weekly check and challenge meetings in place at GHFT to focus on longest waits by specialty and instigate immediate remedial actions.
3. 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.

Known Gaps in Controls

1. Stratification of waiting list based on other health and socioeconomic factors under development.
2. Specific plans for improving C&YP access to elective services in development.
3. Elective recovery plans for Gloucestershire patients treated at out of county NHS providers subject to further development.

Current Assurances *(of controls effectivity):*

1. Performance Reporting to the Planned Care Delivery Board, System Resources Committee and the ICB.
2. Elective recovery planning and oversight provided by the Planned Care Delivery Board (PCDB) with escalation via Programme Delivery Group and ICS Execs as required.
3. Weekly 65wk wait delivery meetings with NHSE in place.

Known Gaps in Assurances

1. Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.
2. Lack of visibility of delayed follow ups at ICB contract, performance and quality meetings.

4. Additional elective activity commissioned with Independent Sector providers both for new referrals and transfer of long waiters from GHFT where required. New providers entering the market via the Provider Selection Regime (PSR) process.
5. Additional capacity commissioned with GHFT in key long waiting specialties as part of annual planning process using ERF funding stream.
6. Work continues with primary care through the Referral Optimisation Steering Group (ROSG) 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.
7. Operational and transformational delivery monitored by system Planned Care Delivery Board. Reallocation of ERF slippage undertaken here.
8. 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.
9. Clinical harm reviews undertaken for all long waits.
10. Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.
11. New payment models introduced at GHFT to support willingness of staff to undertake additional weekend activity.

4. Lack of specific plans to address the delayed follow up backlogs and associated clinical risk.
5. Longer term sustainability plans needed in some key specialties.

4. 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.
5. Regular contract and performance management governance structures in place to review performance and associated recovery plans with all independent sector providers.

Actions to Mitigate Risk & Implementation Dates

1. Commitments made in the 24/25 Operational plan monitored through Planned Care Delivery Board (ICS level meeting with GHFT represented).
2. Additional capacity investments via ERF agreed and underway. Delay in delivery may provide opportunity to reallocate any ERF slippage (PCDB to agree).
3. Additional elective activity planned for 2024/25 (e.g., endoscopy, WLI GLANSO lists as well as insourcing and outsourcing).
4. Additional pathways continuing to be rolled out at the CDC to fully utilise available estate.
5. Additional activity commissioned from ISPs as part of 24/25 operational planning.
6. 3rd Cath Lab being commissioned for 24/25 – go live date delayed, currently planned for January 2025.
7. Patient Engagement Portal phased implementation underway.
8. Renewed OP transformation programme underway at GHFT including roll out of patient portal and Going Further Faster GIRFT initiative.
9. ROSG and Interface meetings established to improve communication and flow between GPs and specialists recognising the potential workload shift.
10. Primary/secondary care interface group established and work programme underway.

Directors Updates on Actions to Date (Updated Quarterly)

1. Operational plan being delivered and monitored by PCDB. ERF to continue through 2024/25 with system aiming to achieve significantly higher recovery than the 2023/24 position in addition to 5% productivity increase. M3 freeze position is above plan which will generate additional income for the system if sustained.
2. ERF schemes have been approved and funding provided to GHFT for delivery. Delays in the sign off process have meant that some schemes will be compromised and may not deliver within the necessary timescales. Slippage can be reallocated to other schemes that can deliver within year.
3. Additional 2x daycase theatre capacity at CGH now operational. Refurbishment of theatres at GRH complete and now operational.
4. GHFT theatre utilisation improvement project continues good progress with decreases in time lost to early finishes and late starts, and overall improvement in % utilisation continues towards 85%. Focus now on community theatre utilisation.
5. New project established to look at utilisation and productivity of community hospital outpatient and theatre capacity. PID completed and initial scoping and data collection work underway. Project group established and meeting monthly.
6. ICB has received 4 applications from new ISPs under the PSR process to provide additional elective activity to Gloucestershire ICB. Two new contracts being issued imminently to include additional Dermatology, ENT and Orthopaedics at a range of community sites.
7. Further work underway to refresh the endoscopy business case with options appraisal as to best use of community sites.

	8. Patient Engagement Portal (PEP) gone live with phase one. **9.** Going Further Faster GIRFT initiative has started and being rolled out in 19 outpatient specialties. Handbooks and self-assessment checklist have been shared and programme underway. Gloucestershire also part of NHS Confederation Interface Improvement Collaborative (Advice and Guidance Optimisation). **10.** Interface principles document has been published and being advertised to both GPs and Consultants. MedFit notes now available for inpatients with a plan to bring outpatient fit notes online next.
Relevant Key Performance Indicators	
Elective recovery as a % of 2019/20.	Long waiters' performance.
ERF achievement.	% of diagnostic tests completed within 6 weeks.
Early diagnosis rates for cancer.	Faster Diagnosis Standard (% patients receiving diagnosis or all clear within 28 days of referral.
% of patients with cancer receiving first definitive treatment within 31 and 62 days	

BAF 8	**Risk of failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes.**

Entry date:	**01/11/22**	**Last updated:**	**13/09/24 (reviewed)**
Owner:	**Benedict Leigh, Director of Integration**		
Committee	**People**		
Aligned with System Partner Risk(s):	**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)**		

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Improve mental health support across health and care services.*

Aligned with ICB Risk(s): **Integration 06:** *Tier 4 Eating Disorder Beds*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
12 (4x3)	**12** (4x3)	**4** (4x1)	**Appetite**	**Cautious**

Due to:	**Impact:**
Number of vacancies across CAMHS and adult mental health services and difficulties in recruiting to vacant posts.	Waiting list for treatment remains high for children and adult's Urgent referral to treatment times have improved and routine waits have reduced but there are a number of people waiting over a year.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Eating Disorder Programme including system wide prevention through to crisis workstreams established. **2.** CAMHS recovery plan including within service provision and system wide to support improvements. **3.** Neurodevelopmental business case and plan in place. Project team established to oversee recommissioning of ADHD/ASC pathway. **4.** 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.	**1.** 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. **2.** No significant gaps identified as a monthly meeting is in place with CAMHs and a system wide multiagency meeting monitors progress bi-monthly. **3.** No significant gaps in the Adult Mental Health Transformational programme. **4.** ICB PM resource that supported CMHT will now be used to support UEC mental health programme which was previously reported as a gap.	**1.** Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput. **2.** Waiting times for urgent and non-urgent referrals are reducing for eating disorders. **3.** There is in place a significant recruitment and retention plan to tackle issues around capacity. **4.** Robust governance arrangements in place for community mental health with experts by experience included. **5.** Neurodevelopment Project Team established between GHC/ICB to oversee development of new pathways including working on shared care issues between primary/secondary care.	**1.** No gaps in assurance.

	5. Shared care arrangements for ADHD prescribing between primary/secondary care.		

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. 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. 2. Proposal to commence 3-year contract for both TIC+ and Young Gloucestershire to enable security and retention of staff and ensure business continuity. 3. Regular reporting to the Children's Mental Health Board and Adult Mental Health Board. 4. SEND inspection complete and ICB SEND programme board established. 5. Work is progressing in this area.	1. 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. 2. Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy. 3. 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. 4. Data and intelligence challenges remain, particularly in the area of understanding demand changes and modelling future impact.

Relevant Key Performance Indicators
Improving Access to Psychological Therapies
Eating Disorder Access
Perinatal mental health -% seen within 2 weeks
CYP access
CMHT Access
APHC for SMI

BAF 9

Risk of having insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity.

Entry date:	**01/11/22**	**Last updated:**	**13/11/2024**
Owner:	**Cath Leech, Chief Finance Officer**		
Committee	**Audit, Resources**		
Aligned with System Partner Risk(s):	**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 25)**		
Aligned with ICB Risk(s):	**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).*		

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
16 (4x4)	**16** (4x4)	**8** (4x2)	**Appetite**	**Open**

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Creating a financially sustainable health and care system.*

Due to:	Impact:
- 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	- 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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Governance in place in each organisation and System-wide Financial Framework in place **2.** Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC. **3.** Financial plan aligned to commissioning strategy. **4.** ICS single savings plan in place managed by PMOs & BI teams across the system forming part of the monthly finance review process. **5.** Contract monitoring in place.	**1.** Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. **2.** Methodology on realisation of productivity benefits not in place. **3.** 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. **4.** Monitoring of workforce numbers is incomplete currently across the system.	**1.** Reporting into Board of the ICB and relevant Committee for each organisation. **2.** Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position. **3.** 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.	**1.** 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.

6. Robust cash systems monitoring early warnings. 7. System Plan in place and further development in progress. 8. 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.		4. Annual internal audit reviews on key financial controls.	

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. 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. 2. 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. 3. Working as One Programme Board focus on the delivery of benefits with significant focus on trajectories and the actions required to enable recurrent savings in addition to the quality and operational benefits	1. 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 2. Actions to identify non recurrent and other measures to help close the financial gap in the plan for 24/25 progressing, PMO support in place. 3. Workforce monitoring for budgeted and worked WTE progressing with monthly reporting and monitoring within organisations and to the system in development, initial reporting at M3 planned. 4. Weekly meetings with CEOs and DoFs to monitor progress of plans for working as one programme

Relevant Key Performance Indicators
Delivery of Full year efficiency target
Achievement of Elective Services Recovery Fund Target
Delivery of in-year breakeven financial position

BAF 10	**Risk that 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.**

Entry date:	**30/01/23**	**Last updated:**	**10/09/2024**
Owner:	**Cath Leech, Chief Finance Officer**		
Committee	**Audit, Resources**		
Aligned with System Partner Risk(s):	**GHFT: SR10:** *Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.* **(Risk score 16)**		
Aligned with ICB Risk(s):			

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
16 (4x4)	**16** (4x4)	**8** (4x2)	**Appetite**	**Open**

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Due to:	**Impact:**
- 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).	- 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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Governance in place in each organisation. **2.** Monthly review of whole-system financial position by Directors of Finance with reporting into relevant Committee for ICB, GHFT, GHC. **3.** 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. **4.** Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed. **5.** EPRR in place, to support any critical infrastructure failures within provider organisations. **6.** Mature Provider estates planning forums to manage risk and capital planning oversight. **7.** This risk will form part of the ICB infrastructure plan.	**1.** Longer term strategic plan which delivers sustainably for the system	**1.** Reporting into Board of the ICB and relevant Committee for each organisation. **2.** 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.	**1.** 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	Directors Updates on Actions to Date (Updated Quarterly)
1. ICS Health Infrastructure Plan (HIP) in progress with support from NHSPS. **2.** 5-year capital plan developed and longer term look as part of the infrastructure strategy **3.** Disposals across the system identified and included in the capital plan. **4.** Developing a '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. **5.** 24/25 capital programme agreed including additional capital available for 24/25 with focus on mitigating highest risks.	**1.** Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed. GHFT CEO chairing the meeting **2.** ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS, initial draft completed and submitted, next steps to finalise the strategy and develop an implementation plan in progress.

Relevant Key Performance Indicators
Delivery of in-year breakeven capital financial position.

BAF 11 — Risk of failure to meet the minimum occupational standards for EPRR and Business Continuity.

Entry date:	**01/11/24**	**Last updated:**	**19/09/24**
Owner:	**Marie Crofts, Chief Nursing Officer**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	**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)**		

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB.*

Aligned with ICB Risk(s):

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
12 (4x3)	**16** (4x4)	**4** (4x1)	**Appetite**	**Zero/Minimal**

Due to:	**Impact:**
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.	Unable to fulfil our responsibilities as a Category One responder, and effectively lead a robust, effective and coordinated system response to a major incident.

Current Controls *(to mitigate risk):*

1. EPRR on-call manager training.
2. EPRR exercises.
3. Oversight of EPRR through the Local Health Resilience Partnership.

Known Gaps in Controls

1. Insufficient internal debriefs have been performed for exercises that the ICB has participated in or that lessons learned have not been embedded.
2. 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.
3. Insufficient resources within the EPRR team (the team are currently reviewing capacity and benchmarking against other ICBs.)

Current Assurances *(of controls effectivity):*

1. Reporting to Quality Committee.
2. NHS England system assurance review and provider assurance process against national standards.
3. BDO Internal Audit Report (November 2023) moderate assurance for design and effectiveness.

Known Gaps in Assurances

1. BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium recommendations (November 2023).
2. 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

1. 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.
2. A full programme of training has been set up, with a dedicated EPPR training manager in place.
3. 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.

Directors Updates on Actions to Date (Updated Quarterly)

1. 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.
2. 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.

4. 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.	**3.** Review if all areas of previous partial compliance against core standards taking place to ensure compliance this year or identify any gaps. **4.** Band 4 admin/EPRR assistant now being recruited to support team. **5.** Exec briefing session planned to reiterate Cat 1 responder duties and responsibilities and update. **6.** NHSE core standards assurance process has taken place and ICB rated as 'partially compliant'. Although much progress had been made on the previous areas needing improvement it was felt other areas needed focus. The new EPRR manager will address these in the coming months.

Relevant Key Performance Indicators
N/A

BAF 12 — Risk of failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.

Entry date:	**15/02/24**	**Last updated:**	**17/09/24**
Owner:	**Paul Atkinson, Chief Clinical Information Officer**		
Committee	**Audit Committee**		
Aligned with System Partner Risk(s):	**GHFT SR12** *Failure to detect and control risks to cyber security.* **(score Red 20)** **GHC ID 8 Cyber** *There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data (**score 12 May 2024**)*		

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
20 (5x4)	**20** (5x4)	**10** (5x2)	Appetite	Zero/Minimal

Pillar 3: *Improving health and care services today.*

Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*

Key Priorities 24/25: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):

Due to:	Impact:
Cyber-attacks from organised groups targeting the NHS. These attacks can take the form of: - Malware - Phishing (via email to staff) - Password access through data breaches. Firewall vulnerabilities and application exploits	- Loss of access to systems and associated downtime, with potentially limited ability to recover - Demands for money to recover data (ransomware attacks) Increased clinical risk due to delivering healthcare without access to patient records

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Cyber Security action plan in place, reviewed annually. Gaps in security and investment identified. 2. Monitoring systems in place and dedicated countywide NHS cyber security team hosted by GHFT. 3. Backup systems and disaster recovery in place and regularly updated. 4. Rolling cyber security delivery programme to improve position. 5. Investment in cyber tools and software. 6. Regular phishing tests and firewall tests (planned system hacks.) 7. Regular security updates and patches.	1. Insufficient in-house expertise in cyber security team. 2. Inability to recruit specialist cyber staff because of cost (market forces). 3. Disaster recovery planning around support systems (out of IT control) not consistently in place. 4. Operating model of cyber-technical & cyber-governance currently not optimal. 5. Volume of cyber-security issues requiring resolution. 6. ICS-wide incident response processes not fully operational.	1. External audit completed by BDO identified no new/unknown risks or issues. Next audit scoping in progress 2. External penetration testing conducted annually by GHC and ICB and findings managed. 3. GHFT/CITS penetration test completed in June and findings being managed 4. ICB board cyber development session took place in December followed by invitation to complete online training. 5. Facilitated session with audit committee and digital leads occurred 7th March. Annual cyber incident response exercise took place on 12th March.	1. Annual schedule and scope of penetration testing for coming years to be agreed. 2. Not all third-party suppliers provide multi-factor authentication in line with national policy. 3. Risks associated with software supply chain difficult to evaluate.

8. Monitoring and reporting via ICS Digital Executives and the ICB Audit Committee; ICS Cyber Operational Group. **9.** NHS national monitoring (alerts) and NCSC alerts. **10.** Mandatory training and communications and engagement with users on prevention.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Board level awareness of risk and issues. **2.** Rationalisation of detection and prevention tooling. **3.** Introduction of targeted monitoring and alerting across key systems and entry points. **4.** 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. **5.** Removal of all end-of-life software and hardware.	**1.** The desktop cyber exercise was well attended. Report and action plan generated and being managed at cyber operational group. **2.** Following publication of the national cyber security policy Gloucestershire's strategy is in production **3.** Good progress is being made on removal of end-of-life software and hardware.

Relevant Key Performance Indicators

N/A

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

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

Agenda Item 10

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 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 November 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 M07 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** **Shofiqur Rahman** **Quality:** **Rob Mauler** **PMO:** **Jess Yeates**	**Role Title**	Senior Performance Management Lead Director for People, Culture & Engagement Finance Programme Manager Deputy CFO (Interim) Senior Manager, Quality & Commissioning ICS PMO Coordinator		
Sponsoring Director (if not author)	**Performance:** **Mark Walkingshaw** **Workforce:** **Tracey Cox** **Finance:** **Cath Leech**	**Role Title**	Director of Operational Planning & Performance Director for People, Culture & Engagement Chief Finance Officer		

	<u>Quality:</u> **Marie Crofts**		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

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Integrated Performance Report

November 2024

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Integrated Performance Report Contents

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Feedback from Committees

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

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System Resources Committee

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

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Health Inequalities	**LIMITED**	Committee reviewed BAF1 and undertook a deep dive into the system work underway on health inequalities. This included consideration of how the framework developed for health inequalities is being utilised across the system. This included a review of submissions by programmes / organisations and development of health inequalities objectives for organisations.	Committee discussed the importance of embedding the framework into transformation programmes. Priority outcomes and schemes will form part of the Joint Forward Plan refresh. Template from programmes will be summarised into a report presented to the ICB in November.	March 2025 November 2024
Performance	**LIMITED**	The Committee discussed progress that had been made in 62 day waits for cancer treatment – with work on reducing patients waiting for Urology having an impact on the overall position. Elective Recovery performance remains strong in the first quarter of this year but will continue to be monitored. GHFT continue to work to reduce long-waiters with particular focus remaining on ENT, Oral and Cardiology. The Committee heard about improvements in Urgent and Emergency Care (following transformation work). The new IUCS service will go live in November.	Continued focus on reducing the treatment backlog for cancer treatment across the system. The reduction of long elective waits remains a focus on the system. Continued preparation for winter – Board will receive the Winter Plan in November 2024.	January 2025 for a further review of progress
Finance	**LIMITED**	Committee heard an update that the system and all organisations are forecasting a breakeven outturn position. Year to date income and expenditure compared to plan is in a £1.6m favourable position. There remain key risks including GP collective action, delivery of savings (including Working as One) and winter pressures.	Actions are continuing to deliver against the single savings plan for 2024/25. This includes reducing the system financial pressure by mitigating schemes that are high risk to delivery.	January 2025 for a further review of progress

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

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People Committee

Accountable Non-Executive Director	Karen Clements
Meeting Date	17 October 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
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 presented their work programmes to the Committee.	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.	Throughout 2024/25
Long-term Workforce plans impacted by short-term financial pressures	**NOT ASSURED**	All organisations experiencing reduction in available development opportunities (apprenticeships, lack of placements for those in university courses etc)	Other opportunities (e.g. T-Levels) to be considered Discuss as Board Development Session	Throughout 2024/25
Equality, Diversity & Inclusion	**LIMITED**	Review of BAF and strategic risk relating to ED&I, decision to raise score	Participation in SW Leading for Inclusion SW EDI Work programme and delivery group	End 2024

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

Issues referred to another committee

Topic	Committee
Short-term financial pressure impact on Long-Term Workforce Planned	Board Development session

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	2 October 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Mortality	**LIMITED**	The Standardised Hospital-Level Mortality (SHMI) indicator remains outside of control levels. Issues relating coding and care quality were explored, as well as variation based on day of admission.	SHMI Quality Improvement Group in place with a large programme of work.	Ongoing
Migrant Health Position	**SIGNIFICANT**	One hotel remains open in county with 30 new arrivals at the end of September. Five ladies were in the early stages of pregnancy. Beachley Barracks took in 60 Entitled Persons at the end of September which has increased pressure on local GPs. Lydney practice has registered 148 in the last month alone.	Ongoing management and reporting to Quality Committee.	Ongoing
ASC CQC Inspection	**SIGNIFICANT**	The CQC have competed their on-site inspection. High level feedback had been received about staff and system relationship which reflected the Council's self-assessment.	Draft report expected in November, after which it will be fed into the transformation and improvement plan.	November
Safeguarding Annual Report	**LIMITED**	The 2023-20244 Annual ICB Safeguarding Report for both Children and Adult Safeguarding was received by the Committee. It was noted that Gloucestershire was still below the numbers of Designated Doctors in several areas despite significant investment.	Further risk factor exploration needed.	December
2 week-wait Breast Services	**LIMITED**	Breast cancer 2 week wait referrals had increased from 2022/2023 to 2023/2024 by 5.6%. Since October 2023, the breast service had been consistently under achieving the 93% national target 2 week wait target.	Further reviews needed and an updated requested at the February Meeting.	February

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

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- Roll out of the new Integrated Urgent Care Service (IUCS) commences this month, with the go live date of 19th November. This service will bring together NHS 111, a local GP led Clinical Assessment Service and the Primary Care Out of Hours service) which will play a key role in supporting joined up urgent care advice and support across the county 24/7.
- The Elective 65 week wait position has improved significantly in line with national expectations. At the end of October, there were just 8 over 65 week waits at GHFT (down from over 500 in July). The national standard for the latter half of 2024/25 is zero 65ww by end of Q3/maintained thereafter. As a system we are committed to 0 by the end of November for providers in our county.
- Good progress continues in the roll out of COVID and Flu seasonal vaccines – over 45% of the target population for COVID vaccination have already received their vaccine, co-administration rates for COVID and flu vaccines are higher than in 2023/24 and the programme has delivered more vaccines in the first 20 days of roll out than were delivered in the first 5 weeks of the 2023/24 campaign.

Areas of Focus

- Long waits for community mental health have been reviewed by the system in response to a national ask – encouragingly for Gloucestershire the number of over 52-week waits is small and predominantly due to data quality issues. The area where over 52-week waits are a concern is Autism and Neurodevelopmental services – long waits in these services are being experienced across the country and locally investment has been made into Neurodevelopmental service development to help address the issue.
- Ambulance handover delays continue to be an area of local and national focus. A timely handover process has been agreed between SWAST and South West regions to enable patients with the longest waits to be safely handed over more promptly, freeing up resource to focus on community responses. A local system Standard Operating Procedure (SOP) has been developed for managing ambulance handover delays. This has been produced in collaboration with GHFT who also have an internal escalation SOP outlining full details and actions to be completed at each point in the process.
- 28-day Faster Diagnosis performance has declined in September 2024 due to outpatient and surgical capacity in the skin specialty. Referrals with suspected skin cancer were also higher over August impacting on performance. The service has recovered, with the overall 28-day performance target (75%) expected to be delivered in October 2024.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Funding Opportunities

- EOI submitted for £20k to support attraction, recruitment and widen participation of support workers

Strategy & Planning

- Review of Joint Forward Plan/medium term plan commenced

System-wide Development Programmes

- Successful second system wide leadership event held 23rd October – 160+ attendees from 30+ local organisations

Education & Training

- Supported internship student from Glos Coll commenced at the ICB across business admin/comms/WWY team
- T-Level student industry placements to start within the ICB, primary Care and Social care

People Team

- ICS housing hub officer commenced 22nd October

Areas of Focus

Strategy & Planning

- Commencement of 25/26 annual ops planning – guidance potentially to be released in December

System-wide Development Programmes

- Agree delivery plan for system first-time manager programme commencing early 2025
- Discuss and agree date and topic for next ICS leadership conference

International Recruitment

- Redefine the pastoral care support arrangements.

Programme Delivery

- Progress support worker initiatives if EOI successful
- Discuss and agree shorter TRAC application form for support workers, including neurodiverse stakeholders
- Submission of NHSE Q3 update reports

Education & Training

- County-wide Circle 2 Success careers fair in November. Aiming to attend as a system with representation from each organisation.
- System level work experience offer being developed
- Expansion of Careers, engagement offers

Staff Housing Hub

- Establish stakeholder relationships and assess need data more systematically

Quality – Safety, Experience and Effectiveness

Quality

Please note: The Quality report is updated bimonthly.

Key Achievements

- The GICB IPC Nurse has been nominated for an award with the Florence Nightingale Association for the Primary Care Sustainability Project.
- The ICB was selected by the CQC, working with the Point of Care Foundation and National Voices to pilot a Health Inequalities Engagement Framework codesigned to help ICSs measure how well they listen to the experiences and needs of people and communities to reduce health inequalities. The ICB hosted two workshops with community partners and people with lived experience to test the draft self-assessment framework.
- New Quality Alert forms are currently in development with positive early feedback on our improvements.

Areas of Focus

- The ICB PALS team has experienced an increase in abusive and aggressive behaviour from members of the public contacting the service. In response the following message has been added to email signatures and recorded on the PALS Voicemail: *Over recent months some contacts to our PALS team have been hard to manage, and we have had a number of calls/emails where there has been a significant increase with unacceptable behaviour from patients and family/carers. We fully recognise that when concerns or complaints are raised about services some may be upset and distressed and understandably emotions can run high. We offer a compassionate and caring service even within our limitations these comments can be personal and upsetting to staff.*
- The second People's Panel survey (1118 local residents) focussed on non-medical support for health and wellbeing. There was a response rate of just over 30%. Results have been shared with the Healthy Communities and Individuals Team to inform the VCSE Partnership Model Development.

Finance and Use of Resources

Finance

Key Messages: Month 07 2024/25

Statement of Net Income & Expenditure Position (£'000)			
Month 7 2024/25 – August	**Month 7 Plan Surplus / (Deficit)**	**Month 7 Actual Position Surplus / (Deficit)**	**Month 7 Variance to Plan Favourable / (Adverse)**
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	(7,741)	(2,404)	5,337
Gloucestershire Health and Care NHS Foundation Trust (GHC)	198	211	13
Gloucestershire Integrated Care Board (ICB)	0	(0)	(0)
System Surplus / (Deficit)	**(7,543)**	**(2,193)**	**5,350**

- The system financial plan included a significant amount of financial risk, in particular, the level of savings including the Working As One savings, to achieve breakeven. Delivery of savings has slipped and a number of pressures have emerged, particularly in Continuing Health Care (CHC) and high cost placements, ongoing mitigations remain in varying stages of development and the risk to delivering the breakeven position is very high.
- The year to date income and expenditure position is £5.4m favourable to plan. This is attributable to non-recurrent benefits and some planned savings being delivered earlier than anticpated within GHFT, the position should revert back to plan at month 8. Further year to date GHFT non-recurrent benefits are offsetting cost pressures relating to pay, non pay drugs and clinical supplies.
- There is ongoing work to mitigate the financial position, measures are mainly non recurrent, identification of recurrent savings is ongoing, however, these are now unlikely to impact 2024/25, those progressed should though impact earlier in 2025/26. The forecast assumes full reimbursement of elective recovery funding over delivery.
- Year to date capital expenditure is £12.9m below the plan due to slippage in some schemes. The full year forecast is for expenditure to be £0.3m below plan. The System had planned to deliver a £2m underspend and carry this forward to 2025/26, however, it is now unlikely that this will be approved by NHSE, alternative plans are now being progressed by provider organisations to ensure we maximise the System capital allocation
- Agency costs for both GHFT and GHC remains below 3.2% national cap.

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Improving Services & Delivering Outcomes (Our Performance)

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Detail of Key Achievements & Areas of Focus

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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	314.9	253.6	311.6	405.3	281.4	283.1	308.4
	0.4	Infant mortality	Infant mortality rate	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	16.3	15.2	23.9	19.0	14.8	23.6	18.5
	1.2	ACEs	% of Children reporting 'When you are worried about something, is there a trusted adult you can go to for help?'	86.8	86.1	85.0	81.7	81.5	86.8	84.3
	1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm RATE per 100k	120.2	131.1	80.9	126.5	135.0	107.3	114.5
	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 (including severe obesity), 23-24	17.9	16.3	23.0	22.5	18.1	20.5	19.9
	1.6	Early Years and Best Start in Life	Infant mortality rate	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 (2020-2022)	N/A	N/A	N/A	N/A	N/A	N/A	562.9
	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	76.4
	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+) - %	17.0	9.0	12.0	5.5	13.7	6.3	10.5
	2.8*	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations - %	31.5	N.A	N.A	10.3	N/A	N/A	15.8
	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.	68.1	72.3	68.6	63.9	72.3	67.9	68.5
	2.10	Blood pressure exemplar theme	% 58.4	55.5	58.4	58.1	61.3	59.2	54.9	58.4

Please note:
Indicators 2.9-2.10 show Locality (population based on registered GP practice) rather than District level data

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	103.1	107.1	122.3	108.5	101.4	99.3	106.4
	3.2	Improve access to primary care	Primary care: GP headcount per 100k population	82.4	88.9	70.6	81.2	88.5	78.5	82.7
	3.3	Improve support for people with mental health conditions	% SMI register health check uptake	82.6	74.3	81.1	76.5	84.2	80.1	79.8
	3.4	Support Improvements in delivery of UEC	A&E attendances – rate per 1000	21.8	12.9	14.1	23.3	13.7	17.1	18.5
	3.5	Support Improvements in delivery of UEC	Emergency admissions – rate per 1000	8.7	8.5	9.3	9.6	8.9	9.1	9.0
	3.6	Support Improvements in delivery of UEC	Long lengths hospital stay (proxy of availability of out of hospital support).	43.8	57.0	71.6	48.0	49.2	67.8	54.6
	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:
Indicators 3.1-3.6 show Locality (population based on registered GP practice) rather than District level data
Indicator 3.7 is under review to develop an outcome indicator that has more timely updates

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	2021-2023
0.4	Infant mortality	Infant mortality rate	2020-2022
1.1	Physical Activity	Percentage of physically inactive adults	2022/2023
1.2	Adverse Childhood Experiences	Percentage of Children and Young People reporting' When you are worried about something, is there a trusted adult you can go to for help?'	2024
1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm (Directly Standardised Rate)	2022/2023
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 (including severe obesity)	2023-24
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	2020-2022
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	2022/2023
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+)	2023
2.8	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations	2023
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 March 2024
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 March 2024

Improving Services & Delivering Outcomes

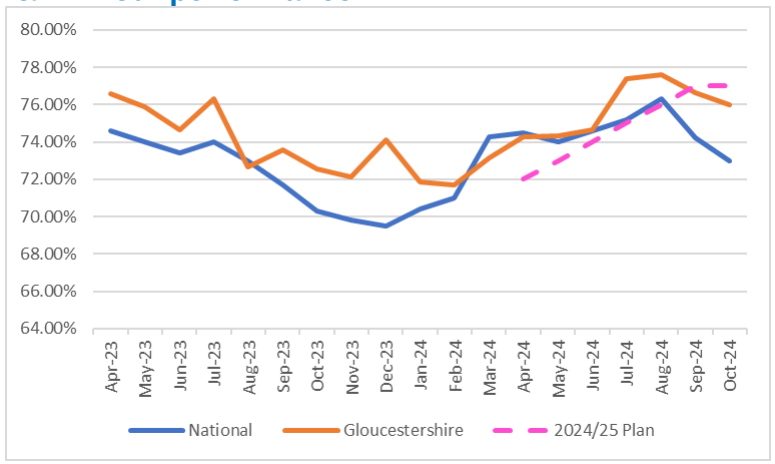
ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
3.1	Improve access to care and reduce backlogs	Rate of people on waiting list (WLMDS).	November 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*	May 2024
3.3	Improve support for people with mental health conditions	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	September 2024
3.5	Support Improvements in delivery of Urgent and Emergency Care	Emergency admissions - Rate per 1000 population	September 2024
3.6	Support Improvements in delivery of Urgent and Emergency Care	Long lengths of hospital stay over 21 days (Rate per 100,000 population)	September 2024
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	2020

Improving Services & Delivering Outcomes

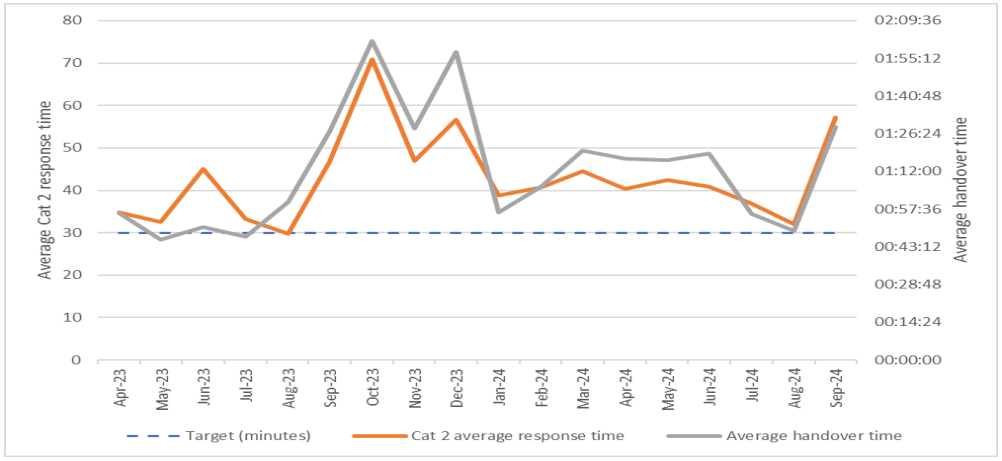
Urgent & Emergency Care - Focus

A&E 4-hour performance



- Gloucestershire performance has improved broadly in line with our operational plans. Compared to the national position Gloucestershire's performance has remained more stable since the summer.
- In October, 60.9% of patients in Type 1 settings were seen, treated, and admitted/discharged within 4 hours, a slight reduction on September performance, was a result of variable performance week to week. The overall Gloucestershire system achieved 75.9% within this timeframe – with MIIUs settings achieving 99.5%. Performance has now stabilised with type 1 performance improving to 62.8% across the first 10 days of November.

Ambulance Cat 2 and handover



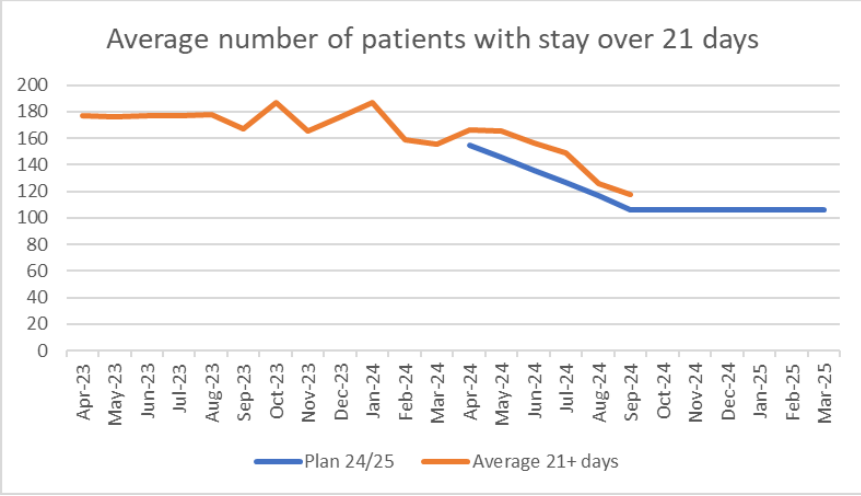
- Ambulance average response time for Category 2 incidents was 57.2 minutes in October 2024, increasing on the September average (38.4 mins) and above the 30-minute ambition (interim performance target for 2024/25). Handover delays also rose slightly across the month, to a total of 3,764 hours lost, and an average handover time of 89 minutes (up from 57 minutes in September).
- A local system Standard Operating Procedure (SOP) has been developed for managing ambulance handover delays. This has been produced in collaboration with GHFT who also have an internal escalation SOP outlining full details and actions to be completed at each point in the process.
- A timely handover process has been agreed between SWAST and South West regions to enable patients with the longest waits to be safely handed over more promptly, freeing up resource to focus on community responses.

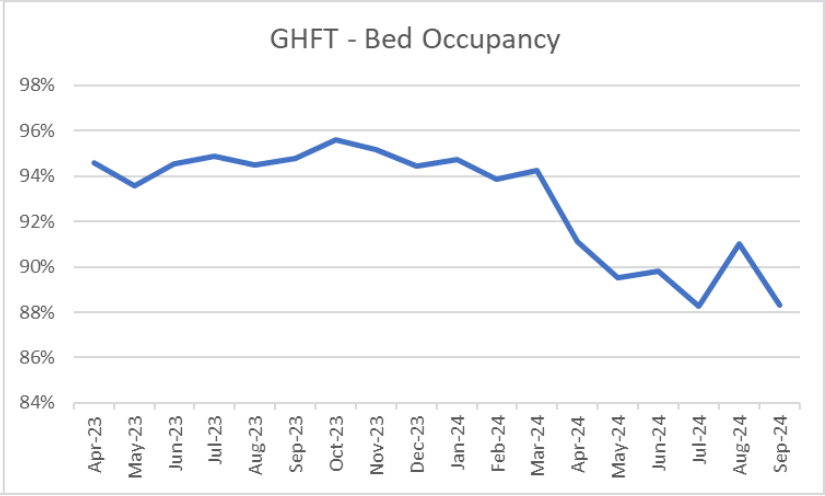
Improving Services & Delivering Outcomes

Urgent & Emergency Care - Focus

Patient Flow

- Focus on patient discharge has continued to see patients with long length of stay as a lower proportion of hospital beds than in previous years (latest average is 18% of the bed base) and an overall reduction in bed occupancy.
- The Working As One programme has been identifying key operational actions to help support delivery of performance, specifically focussing on a quality and improvement approach. As the infrastructure around this programme begins to be stepped down in the coming months the system will ensure focus on these requirements is maintained to ensure long term benefits can be delivered and sustained across the whole system.
- The Integrated flow hub has launched a new standard operating procedure: "No Criteria to Admit" – this aims to promote discharge out into community where a patient is not acutely unwell but may not be able to stay at home. It will help to ensure facilities such as the Community Assessment and Treatment Unit (CATU) are used in a timely manner and people are not admitted to hospital unnecessarily.
- A test and learn is being carried out on identification of people 48 hours prior to their being ready for discharge – this aims to pre-empt the pathway decision and quickly commence any actions necessary to ensure a prompt discharge and minimise delays.





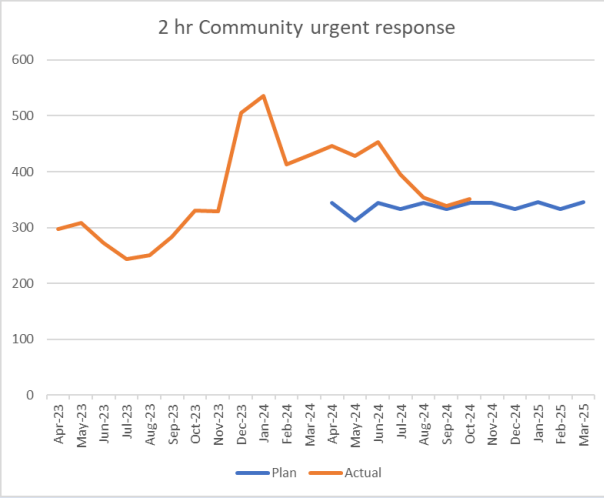
Improving Services & Delivering Outcomes

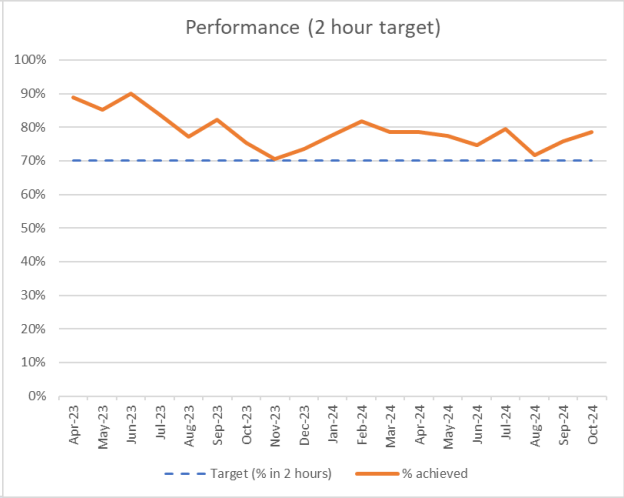
Urgent & Emergency Care - Focus

Integrated Urgent Care Service (IUCS)

- The new Integrated Urgent Care Service launches on the 19th November with final preparations underway for testing to meet national assurance standards, staff training, and the TUPE of some existing staff from the previous provider. There is good resilience within the service with excellent shift fill for the launch and strong engagement from local clinicians enrolling to work in the service.
- Pathways are being designed to promote alternatives to acute hospital care where this is appropriate, with particular focus on "consult and complete" within the Clinical Assessment Service (CAS). Co-location of specialist roles within the CAS, for example the inclusion of a specialist paramedic, are also expected to ensure patients are guided to the most appropriate outcome for their condition.

Urgent Community Response





- The Urgent Community Response (UCR) service continues to meet planned activity levels for 2024/25, and consistently meets the 70% standard for proportion of referrals which are responded to within 2 hours.
- The service has identified opportunities to release additional capacity to enable more people to be reached; these will now be scoped to better understand the feasibility and develop a timeline to implementation.
- An MIU pathway for injurious falls is under development to ensure people can be seen in community settings where possible.

Improving Services & Delivering Outcomes

Cancer

- 62-day performance remained stable in September at 67.0% but missed the 70% interim recovery target (patients treated within 62 days of referral), with many the total breaches of the 62-day target occurring in the Urology pathway (42/98 breaches – 33 of which were prostate). The Urology specialty has halved its 62-day PTL since the start of the financial year, this has reduced from 175 in March to 64 as of 30/09/2024 which is essential for sustainable performance against this target.
- The system is committed to deliver the interim national recovery target of 70% against the 62-day standard in March 2025. Overall actions plus specialty/tumour site level action plans have been established specifically to address 28-day and 62-day performance and improve cancer awareness in our population, including: operational focus and continuous quality improvement projects, specific additional capacity and workforce in specialties failing to meet national standards, public awareness campaigns and targeted events to population groups less likely to come forward with cancer symptoms or attend routine screening.
- Another key target for 2024/25 is the increase in the Faster Diagnosis Standard (FDS) threshold (people receiving a diagnosis or all clear following a cancer referral within 28 days of the referral being made), from 75% of patients to 77% by March 2025. Performance against this standard deteriorated in September with 70.9% patients meeting the target, equating to 746 breaches. This was well below the planned trajectory for September (77.0%). Skin performance continued to drive the overall service performance, with increased referrals over the summer months and a lack of outpatient and surgical capacity throughout August and September. Urology, Gynaecology, Head and Neck, Haematological cancers and Non-specific Symptom services also failed to meet the 75% threshold in September. October data is not yet fully validated, but early projections show that there has been recovery of performance, particularly in skin, with performance overall expected to meet the planned trajectory.
- 31-day treatment performance declined slightly in September 2024 to 92.5%, with skin and prostate treatments accounting for the highest number of breaches (7 in skin, 10 in prostate).
- Work is continuing to progress in the cancer services review of Best Practice Timed Pathways, with improvements seen in the Breast pathways after focus on this specialty. First appointments are now being booked to day 13, down from day 21 from referral, and the specialty continues to meet the 28-day FDS standard. In November, Urology is the focus for the Best Practice Timed Pathway workstream, with the aim to see 60% of all referrals within the best-practice times at each contact point of the pathway – this will help to sustain performance improvement.

Improving Services & Delivering Outcomes

Cancer – patient experience focus

- While we review the performance of all waiting times against standard targets, every patient is managed through their cancer pathway with clinical priority-based decisions to ensure those needing treatment most urgently receive it - this approach promotes the best patient outcomes. Care navigators who track patients through their pathways and book appointments to meet targets are in place across cancer teams, and Cancer Nurse Specialists offer dedicated support and advice to patients diagnosed with cancer – also supporting surveillance programmes which contribute to early diagnosis.
- Where there are delays in the pathway for a patient, this can be for several reasons, including because they choose to not attend follow-ups or wish to have second clinical opinions elsewhere. Every patient waiting longer than 104 days for treatment has a harm review carried out to ensure the any harm caused by delay is identified, process issues are picked up, and opportunities to improve pathways are identified.
- In addition to clinical treatment for their cancer, patients receive wider support, including for prehab/rehab (see https://web.glos.nhs.uk/elearning/demo/video_demo/cancerprehabfootage/index.html for a patient story detailing how important this is for individuals in preparing and recovering from surgery, chemotherapy and radiotherapy).
- Patients in Gloucestershire with suspected cancer symptoms are predominantly treated and supported by the cancer and oncology services at GHFT. This is a centre of excellence for cancer care, with the main Regional Cancer Centre in Cheltenham a bespoke facility which has been providing specialist cancer care for people in our community for more than 60 years. The current building was opened 25 years ago and has enabled hundreds of thousands of local people to receive simply the best care there is to offer in the UK.
- Due to the phenomenal developments in cancer diagnosis, treatment, support and research, the service has outgrown its buildings in Cheltenham. The environment in which care is provided makes an enormous difference. All research and evidence show that when care is provided in a bright, spacious healing environment, the experience of patients and families is substantially improved. A fundraising appeal (Big Space Appeal) is being led by Cheltenham and Gloucester Hospitals Charity and supported by Gloucestershire Hospitals NHS Foundation Trust to improve the Cancer Centre. Together £8.3m has been successfully raised, which is almost half of the total £17.5m cost. The new facilities are over and above what the NHS alone could provide and will enhance the medical expertise and cancer treatment currently provided for patients by the Trust.

Improving Services & Delivering Outcomes

Elective Care

- As recovery of the elective waiting list and in particular long waits for treatment continues to be a national focus, it is encouraging to see the improvements that have been made in reduction of 65 week waits. At the end of September, there were 55 over 65 week waits at GHFT (down from over 400 in August), with 52 of these Gloucestershire registered patients. An additional 23 Gloucestershire patients were waiting over 65 weeks across a number of out of county providers and independent providers. Validated data for October will be released at the end of November, so the full out of county position is not available, but GHFT have confirmed there were 8 breaches of 65 weeks which were driven by complexity (including complex diagnostics and patient choice). Weekly focus calls with NHSE on elective long wait assurance have now been stood down because of this positive position.
- The national standards for the second half of 2024/25 have now been informally confirmed as zero 65ww by end of Q3/maintained thereafter and as a system we are committed to 0 by the end of November for providers in our county. GHFT are committed to significant reduction in 52 week waits by the end of December, and to maintain improvement through the remainder of the financial year. Mitigation plans for specialties with the largest numbers of potential long waiters are well under way, including some outsourcing/insourcing for cardiac investigations, ophthalmology, and ENT.
- RTT performance was 66.2% in September (% of the waiting list under 18 weeks). The overall waiting list increased by 140 to 78,536 patients, with variation between specialties – for example, the ENT waiting list reduced by over 400 patients. 52-week waits reduced from 3.2% of the total waiting list to 2.3%.
- Bench-marking of the elective waiting list size has shown that Gloucestershire is similar to other systems within our peer-group – with 116 open elective pathways/ 1000 people registered in the ICB. The range for Gloucestershire's 5 closest peer systems is from 112-122 open pathways (this includes each open pathway for patients on more than one elective list).
- Elective recovery fund update: M6 2024/25 Flex is currently calculated based on the baseline used for the 23/24 calculation with an uplift for 24/25. The 24/25 baseline will be finalised by NHSE therefore may be subject to change. Current performance is showing Value Weighted Activity at 116.7% of 2019/20 including pathways avoided to the end of M6 (this includes activity recovery overall of 113.8% at GHFT, and all avoided pathways using Advice and Guidance). This is likely to increase when finalised data is available (The operational plan commitment for ERF in 2024/25 is to reach 118% of 19/20 levels, so the system remains on target). GHFT and IS providers are exceeding the planned levels of activity, with underperformance driven by out of county providers.
- The roll out of the patient portal at GHFT has helped contribute to a drop in DNA levels to below 5% over the last 3 months – this is a reduction to below our peer group average where previously the system performance was similar to the peer average.

Improving Services & Delivering Outcomes

General Practice

- 374,291 appointments were delivered in general practice in Gloucestershire in September 2024 – stable to activity in September 2023 (whereas nationally there has been a 3.9% decrease in activity). Same day appointments made up 40.9% of these – 142,402 appointments across the month. Appointment activity continues to be well above the operational plan for 2024/25.
- Appointments booked within two weeks in September were 72.2% across all appointment types and were 80.5% for the categories of appointment typically booked within 14 days (operational planning target is 75%).
- GP collective action continues to be monitored by the primary care team – focussing on tracking UEC data, practice appointment data, complaints, practice websites and phone messages, and any patient safety implications to determine any local impact. The ICB is also working with the LMC to understand the extent of the action to be taken by local GPs, including awaiting LMC survey results from practices.
- Good progress continues in the roll out of COVID and Flu seasonal vaccines – over 45% of the target population for COVID vaccination have already received their vaccine, co-administration rates for COVID and flu vaccines are higher than in 2023/24 and the programme has delivered more vaccines in the first 20 days of roll out than were delivered in the first 5 weeks of the 2023/24 campaign.

Dental

- For secondary dental care (Oral Surgery waiting list), a recent audit has identified that nearly 50% of the list are suitable for Tier 2 IMOS primary care delivery - procurement of a short-term Intermediate Oral Surgery (IMOS) service within Primary Care Dental practices has therefore been approved which is likely to start from February 2025 until March 2026.
- Units of Dental Activity (UDAs) delivered in county have been rising throughout 2023/24 to 72% by the end of the financial year. Current performance for dental practices in Gloucestershire shows 65% of contracted dental units are delivered (to July 2024). The newer sessional access initiatives continue to increase in capacity with Stabilisation increasing to approximately 237 appointments per week in October (200 in July 2024) and Out Of Hours Urgent Care appointments increasing to approximately 60 appointments per week in October (50 in July 2024).

Improving Services & Delivering Outcomes

Diagnostics

- Diagnostic performance remains stable to the August 2024 position in September, with 16.4% patients waiting over 6 weeks for a test, compared to 16.2% in August. GHFT performance was 18.0%, a slight deterioration (0.4%) on the previous month. Modalities failing to meet the recovery target for this year's operational plan (10% or less of patients waiting more than 6 weeks for their diagnostic) were Colonoscopy, Echocardiography, Flexi Sigmoidoscopy, Gastroscopy, Cystoscopy, Peripheral Neurophys, and Urodynamics, however MRI and Non-obstetric Ultrasound have also seen a deterioration in performance (albeit still achieving under 10% of patients waiting over 6 weeks).
- Patients waiting over 13 weeks have risen slightly to 609 patients in September – with Colonoscopy and Echocardiography the two modalities with the highest numbers of patients waiting over 13 weeks, however there are specific plans to improve performance in these areas. The waiting list has remained stable across the ICS, and at GHFT, with no change to the August position overall.
- For Endoscopy, weekend waiting list initiatives are in place for the remainder of 2024/25 to maintain performance against the national diagnostic targets, with a business case under development for additional capacity in the Forest of Dean to go live in 2024/25, and a longer-term ambition to increase to 6 day working across the service by 2027.
- Echocardiography activity in September was the highest level seen in 2024/25 to date, resulting in the overall waiting list decreasing by 250, however 61% of patients waiting for Echocardiography have been waiting more than 6 weeks at GHFT. Direct access to Echocardiography is being scoped as part of the overall review of the service, with an initial meeting planned for November.
- There has been an increase in imaging activity from all referral sources and across all modalities comparing 19/20 and 23/24. Referrals from the emergency department and outpatient settings are the biggest drivers of increase in demand. The highest increase is seen in CT and MRI modalities, which is impacting significantly on imaging turn-around times and unplanned activity in these modalities is higher than for Gloucestershire's peer group. As urgent ED and inpatient scans are prioritised for reporting, suspected cancer referral, GP and outpatient requested scans are failing to meet any of their reporting timescale targets. The Diagnostic CPG are reviewing the data with the UEC clinical lead to determine some possibly quality improvement tests to address this issue.

Improving Services & Delivering Outcomes

Mental Health

- Access to perinatal mental health services continues to exceed targets, with a rolling 12-month access rate of 672. Performance against the 2-week assessment threshold was 22.3% in September, because of many referrals made in August when staff annual leave absence was high. All referrals were seen within 6 weeks, and a service recovery plan has been drafted with expected recovery of assessment performance times by February 2025.
- Out of Area placement days have risen in September and October, with 36 and 63 days reported as inappropriate placements in each month respectively. The total bed days reported as inappropriately out of area in 2024/25 to date is 175, a reduction on previous years, however recent increases show the pressure the system is under and the demand for acute placement.
- CYP access continues to be strong across all providers, with latest national data showing access exceeded our target (8190 against the 7340 target in July 2024). Compliance with the 4-week waiting time target has improved in September from the August position of 55.9%, rising to 86.4% (above the 80% target) - capacity in the service had been reduced by workforce constraints including vacancy and training and holidays over the summer, but is seeing a much-improved position in September with more than 90% of appointments offered within 4 weeks.
- The Talking Therapies service continues to demonstrate strong recovery rates, achieving 50.4% in September 2024. Overall recovery was 67.3% in September, exceeding the target of 67%. The reliable recovery rate (for patients meeting caseness at the start of their therapy course) was slightly lower at 46.5%. This was within normal variation, and the service averages 51% over the last year for this metric. The service is currently working to understand the drivers for reliable recovery performance in anticipation of a planned rise in this target to 50% in 2025/26.
- Long waits for community mental health have been reviewed by the system in response to a national ask – encouragingly for Gloucestershire the number of over 52-week waits is small and predominantly due to data quality issues. The area where over 52-week waits are a concern is Autism and Neurodevelopmental services – long waits in these services are being experienced across the country and locally investment has been made into Neurodevelopmental service development to help address the issue. The new CYP service is now fully recruited and going live, however due to the continuing increase in referrals into the service, current focus is on screening of referrals to ensure urgent cases are prioritised and patients not requiring a full assessment can be signposted to more appropriate support.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Recruitment and Retention

- Independent Social Care sector international recruitment applications have slowed down, scope of this project to be expanded to include displaced workers who already in the UK.
- Independent social care and primary care collaborating pastoral care for internationally recruited staff.
- Both Trusts remain under the 3.2% agency spend as % of total pay spend cap. As at M6 GHC remains at 2.1% and GHFT 3%.
- Stakeholder workshop to discuss and agree shortened TRAC application form to simplify the process, support wider diversity of applicants (neurodiversity and care leavers specifically).

Innovation

- Staff housing hub project formally commenced – The initial focus will be to establish a stakeholder group and build relationships, obtain a better understanding of staff need and begin to develop a database of housing supply
- Agreement whether commence Digital Staff Passports (for NHS trusts) in next cohort needs to be reached. This has been delayed until January 25 earliest start and an issue with this was raised in last meeting. There is 3m lead in time required between cohort start and actual 'go live' phase which, if cohort starts in January, would be beginning April. This is when medical staffing teams start to receive junior doctor August starter information and teams do not have the capacity to run two processes in parallel. If cohort does not commence in January then unlikely we will be able to join until after August. This is a regional collaboration so will need alignment with local ICSs.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Valuing and looking after our people

- A comprehensive review of Health and Wellbeing services has been launched, with the following objectives:
  1. To understand the need for HWB interventions and services for our staff
  2. To baseline the HWB services available to our staff
  3. To evaluate the effectiveness of services from the perspectives of
     - service user experience,
     - service outcomes and
     - value for money/return on investment
  4. To identify areas of best/good practice that can be shared/expanded
  5. To identify gaps in service provision that need addressing
  6. To identify opportunities for collaboration with associated benefits and risks

- Review timescales are to produce a report with recommendations by February 2025

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Education Training and Development

- Several T-Level industry placement students are being planned for the ICB and Primary care in digital, finance and business admin. Currently going through selection process
- T-Level in health with a focus on social care is being delivered by Cirencester College for the first time. Several providers have expressed an interest in hosting a T-Level student placement. Currently going through the selection process.
- Apprenticeship & Careers website – information collation started. One Glos website being populated.
- Care Leavers Covenant –Final report and exec summary completed. Moving to implementation and monitoring phase. Working with GCC and supporting agencies to mobilise
- ICS work experience strategy and 'one stop shop' being developed with methodology support from QSIR team
- New offers from ICS careers engagement team includes coaching and application advice

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

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

- ICS Leadership conference held 23rd October – The Theme was 'Turning Uncertainty into Opportunity'. Over 160 delegates from over 30 local ICS partner organisations attended. Average delegate feedback for the event was 4.3 (out of 5). Positive feedback themes from attendees were:
    - **Networking and Collaboration Opportunities**: Emphasis on the value of networking, including interactions across agencies and systems, with some attendees expressing initial nervousness.
    - **Engaging and Inspiring Speakers**: Positive responses to keynote and guest speakers who were described as engaging, powerful, and thought-provoking.
    - **Opportunities for System-Level Discussion**: Discussions focused on system-wide issues, facilitated by panels and interaction with leaders, allowing insights from various organisational levels.
- Collaborative Leadership programme for first time leaders, two pilot cohorts agreed planned for delivery 2025. This will complement organisational programmes.
- Regional workforce planning support being explored for nursing, pharmacy and ARSS roles in primary care
- Digital workforce strategy in final stage of development, projects focused on Essential Digital Skills, Learning Management Systems, Technology Enhance Learning

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One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The POD Quality Report for Q2 has been received from the SW Collaborative Commissioning Hub (CCH). The CCH report that 8 General Pharmaceutical Council inspections were undertaken for Glos. ICB with all standards met in 6 of the pharmacies inspected. Actions plans are in place for the 2 pharmacies that did not meet all the required standards. 1 dental safeguarding concern was reported in Q2.

Maternity

- The Quality Improvement Group (QIG) chaired by the CNO continues following the CQC section 31 warning notice. The service remains rated inadequate and is on increased surveillance, under the National Quality Board Guidance. The QIG remains bi-weekly, progress is being seen in the 5 workstreams, Included in the QI programme are also 2 other areas identified as a concern, antenatal screening and scanning capacity. There has been a focus on Scanning capacity for reduced fetal movement, as national standard of a scan within 24 hrs was not being met, waiting times have improved, however this remains a priority area and is being closely monitored through the QIG. The service remains on the NHSE Safety Support Programme. The trust also reports all progress monthly to the CQC. The trust have redesigned the Maternity governance structure & this is being tested.
- Maternal Mortality Review was unable to be supported by NHSE, enrollment onto NHSE Framework has taken place and it is hoped to go out to the framework for formal procurement of a provider to complete the review.

Urgent and Emergency Care

- The new Integrated Urgent Care Service (IUCS) is due to go live on the 19th November 2024. The service is made up of 3 components, NHS 111, Clinical Assessment Service and Out of Hours GP service, which all aim to ensure a seamless patient experience with access to a clinician when required. The new service will be run by GHC in partnership through a sub-contract arrangement with Integrated Care 24 (IC24), a social enterprise organisation who specialise in urgent care services. IC24 deliver all aspects of the NHS 111 service and jointly deliver the Clinical Assessment Service. GHC is the lead provider of a single IUCS contract with Gloucestershire's ICB.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Badgernet Maternity Information System interface with GPs and SystmOne

- The ICB/LMNS have been working closely with GHT and the LMC to resolve the interface issues from Badgernet to GPs and SystmOne. Good progress has been made to resolve issues around data flows to ensure GP's have vital information about pregnant women. However there remain some outstanding issues which the system is progressing.

Community and Mental Health

- GHC have made a sustained improvements in the quality and safety of the care being provided at Berkeley House in line with requirements of the CQC Section 31 notice from October 2023. This has been evidenced through submissions to the CQC and ICB and tested through the routine visits by advocates and commissioners/case workers. At the last Quality Improvement Group (QIG) it was proposed to step-down from QIG to an Enhanced Oversight Group, in order to retain the system commitment to supporting Berkeley House, its service users and staff. Nursing, Therapies and Quality services, are developing an integrated performance report to reduce duplication and ensure a blended approach to reporting. The long-term ambition is to integrate the Performance and Quality Dashboards into a single report.
- Community Hospitals has seen a decline in the number of bed days lost due to housing, this has dropped each month since July, the last 3 weeks of Sept have seen no bed days lost due to Housing.
- A deep dive into restrictive practices was given at the November Quality Committee to provide assurance. The suicide prevention strategy was presented at GHC Quality Committee's and approval was given to adopt the Gloucestershire Suicide Prevention Strategy 2024-2029.

Migrant Health

- A large local property under consideration for use as widening dispersal accommodation is no longer available for use to accommodate asylum seekers.
- The MOD has made the decision to cease the use of Beachley Barracks for Afghan resettlement in order to accommodate the return of the regiment who have been deployed to Cyprus. The site will be handed back to the British Army on 31st March 2025 and will cease to admit more Afghan EP's from November 2024. The remaining contingency hotel remains is at capacity of 65%

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

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).
- In September and October 2024 six PSIIs have been opened; three each for GHFT and GHC. These six PSIIs will go forward for a full investigation with the respective Trusts' boards holding oversight, as is policy under PSIRF.

Quality Alert

- We have now tested a new form to enable Primary Care colleagues to submit 'Quality Alerts'. During our initial testing phase, we have seen a small increase in numbers of forms being submitted including one issue categorised as potential major harm.

- This alert focused on the length of time patients on anticoagulants were waiting for DVT scans. This has been raised with CPG colleagues and with the Trust to investigate and resolve.
- As we develop the Quality Alert process further, we hope to be able to provide further intelligence to drive service and patient safety improvements.

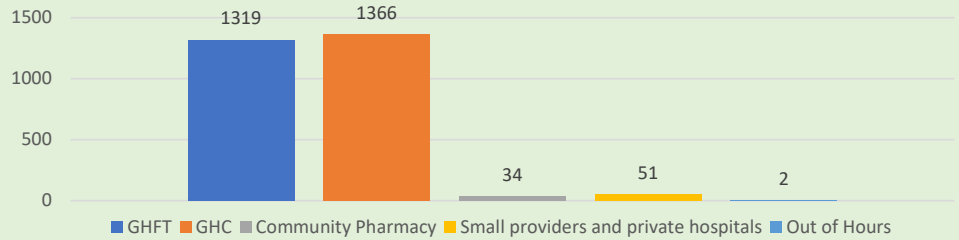
Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

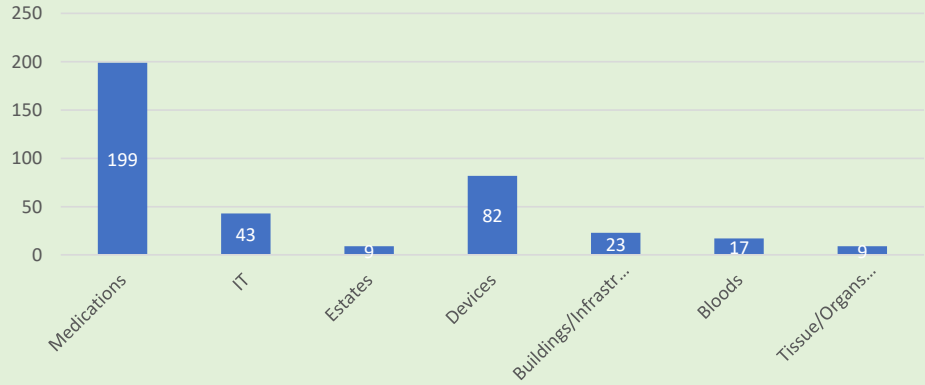
Safety

Learn from Patient Safety Events (LFPSE)

- NHS England have launched the first version a new tool that will eventually enable the ICB to look at whole system data. While LFPSE is aimed at delivering Machine Learning of all incidents across the whole of England, we have now started to receive Gloucestershire data. Events are increasing each month with 2772 events being reported in October 2024. The breakdown is in the chart below:



- Reporters are asked to classify events and while the majority go unclassified the theme of medication events are consistently the highest classified.



Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April - August 2024 [latest available data]

		Apr-24 Provider	May-24 Provider	Jun-24 Provider	Jul-24 Provider	Aug-24 Provider	Sep-24 Provider	Oct-24 Provider	Nov-24 Provider	Dec-24 Provider	Jan-25 Provider	Feb-25 Provider	Mar-25 Provider	
GHT Inpatients	% Positive	92%	92%	93%	94%	93%								
	% Negative	4%	3%	4%	3%	3%								
GHT A&E	% Positive	79%	78%	76%	79%	81%								
	% Negative	14%	16%	16%	14%	13%								
GHC Mental Health	% Positive	86%	80%	94%	81%	89%								
	% Negative	6%	9%	3%	10%	7%								
GHC Community	% Positive	95%	93%	86%	94%	95%								
	% Negative	2%	3%	8%	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

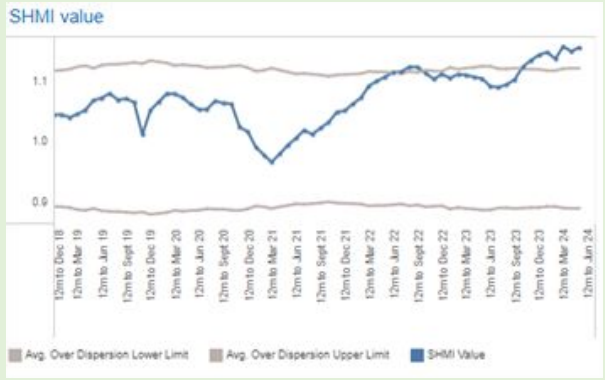
Mortality Focus

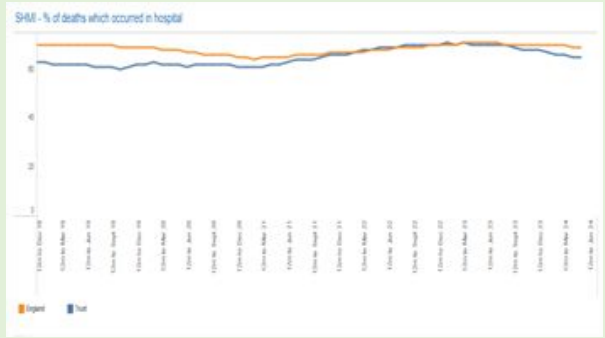
- Mortality data from NHS England runs six months behind and covers the period up to May 2024. There are three metrics we pay close attention too:
  - Crude Mortality (top chart opposite)
  - Summary Hospital-Level Mortality Indicator (middle chart opposite)
  - In and Out of hospital deaths (bottom chart opposite)

- The **Crude Mortality rate** is not adjusted for age, sex or other demographic factor and so caution must be taken when looking at it in isolation. The current Crude Mortality rate is at 2.8%, which is below the 'all England' rate of 3.1%. This is not a cause for concern.

- The **Summary Hospital-Level Mortality Indicator (SHMI)** is currently outside of control levels and has been for the last eight months. The latest data shows the Trust's SHMI to be at 1.156. The continued increased SHMI rate is a matter of intense scrutiny with a Quality Improvement Group set up to support our system diagnostic and focus on improvement. Key workstreams include:
  - Primary diagnosis audit
  - Dementia coding review
  - Excess mortality clinical audits/improvement plans
  - Weekend admission variation
  - ED Delay related Harm data review

- Of particular concern is the split in site SHMI rates with GRH running at 1.14 and CGH running at 1.19.
- **In Hospitals deaths** are relatively low at 65% compared to the England rate of 69%. This is likely to be positive indicator.





One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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NHS

ICS Finance Report

Month 7 2024/25 – October 2024

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Finance and Use of Resources

Key Financial Performance Indicators: Dashboard (1)

	Month 7			Previous Month Variance	Month 7 Actual		
	Plan	Actual	Variance		GHC	GHFT	GICB
Overall System Financial Performance			Surplus / (Deficit)				
Year to Date (£m)	(7.54)	(2.19)	**5.35**	**1.63**	0.21	(2.40)	(0.0)
Year End Forecast (£m)	0.0	0.0	**0.0**	**0.0**	(0.0)	0.0	0.0
Efficiency Plan Status							
Year to Date Delivery (£m)	49.08	49.49	**0.41**	**(0.50)**	8.48	19.49	21.53
Year to Date Delivery (%)	100%	101%	**1%**	**1%**	99%	125%	86%
Forecast Outturn Delivery (£m)	93.24	93.24	**0.00**	**0.00**	13.00	37.40	42.80
Forecast Outturn Delivery (%)	100%	100%	**0%**	**0%**	100%	100%	100%
System Capital			Over / (Under)				
YTD spend against total CDEL (£m)	29.19	16.24	**(12.9)**	**(9.60)**	2.10	13.81	0.33
FOT spend against total CDEL (£m)	56.20	55.92	**(0.28)**	**(2.00)**	8.42	46.36	1.14

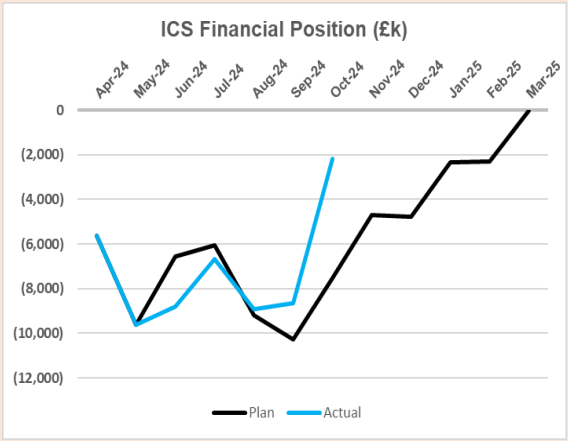
Finance and Use of Resources

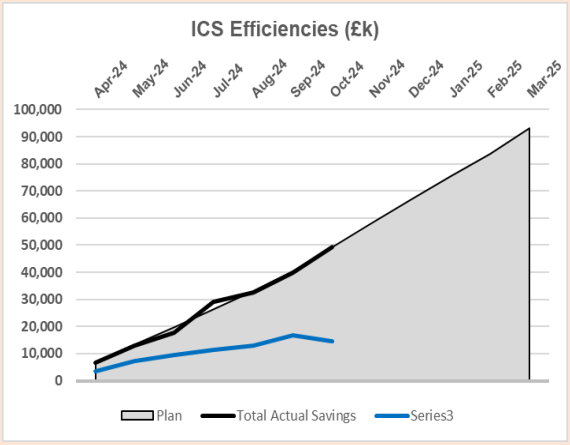
Key Financial Performance Indicators: Dashboard (2)

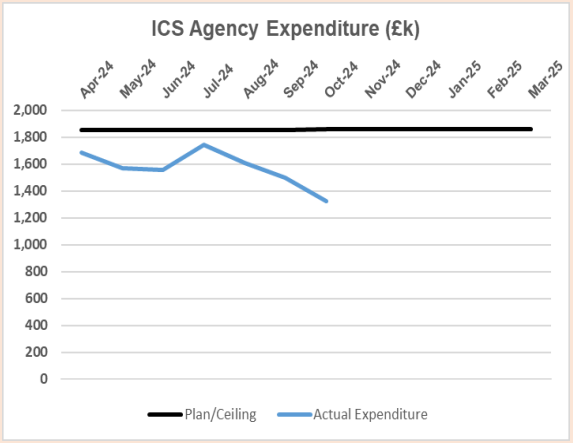
	Month 7 Plan	Month 7 Actual	Over / (Under)	Previous Month	Month 7 Actual GHC	Month 7 Actual GHFT
Workforce						
Year to Date Agency expenditure v Cap (£m)	11.2	9.7	(1.5)	(1.1)	2.5	7.2
Forecast Outturn Agency expenditure v Cap (£m)	22.3	20.5	(1.8)	(1.8)	4.9	15.4
YTD Agency spend as % of total Staff costs	3.2%	2.7%	(0.5%)	(0.5%)	2.1%	2.9%
Liquidity (Cash)						
Year to Date Cash Balance v Plan (£m)	86.9	112.6	25.7	8.8	44.8	67.9
Forecast Outturn Cash Balance v Plan (£m)	81.2	89.4	8.2	8.2	52.4	37.0
Other Key Financial Indicators						
Better Payment Practice Code (no. organisations not complying with 95% payment volume and value targets)			1			
Elective Recovery Fund fully coded flex performance v 19/20 baseline			118.1%	113.6%		

Finance and Use of Resources

ICS Financial Performance Overview: Analysis (1)







Key risks to delivery of the financial plan

- Delivery of the Working as One programme savings.
- Increased CHC and Placement costs
- Delivery of the system savings plan.
- 24/25 pay award being fully funded by NHSE.
- ERF activity over performance not being fully funded by NHSE.
- Collective GP industrial action

System Financial Position

The System set a challenging plan including a high level of savings to deliver a breakeven financial plan. Savings schemes have progressed, however, there is slippage and the value of recurrent savings is lower than needed by the system to maintain or improve the underlying financial position. The financial risk remains significant.

The year-to-date variance is a surplus of £5.4m. This is due to non-recurrent benefits within the by GHFT being delivered earlier than planned. These benefits are offsetting other GHFT pay overspends in nursing, non-pay overspends in the medicine division drugs and clinical supplies. A pressure has emerged within the ICB within Continuing Health Care & Placements which is currently under review. All organisations are forecasting breakeven by year end. Recovery actions are in place within organisations to manage expenditure in line with plan and identify schemes for unidentified savings.

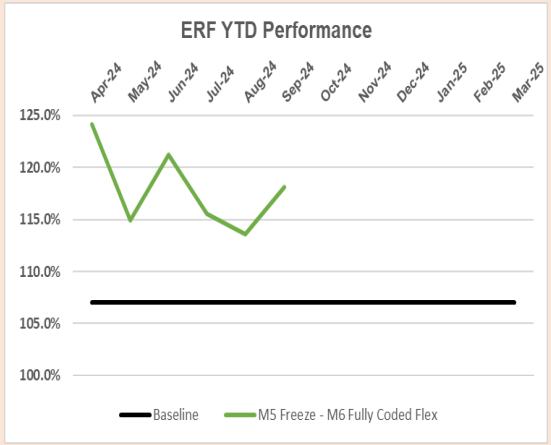
Efficiencies: the working as one savings has slipped, work is underway to assess the level of recurrent savings based on updated trajectories and no- recurrent mitigations are being progressed. The recurrent level of savings for the year is 44% of total savings which is below the value required to maintain the underlying financial position.

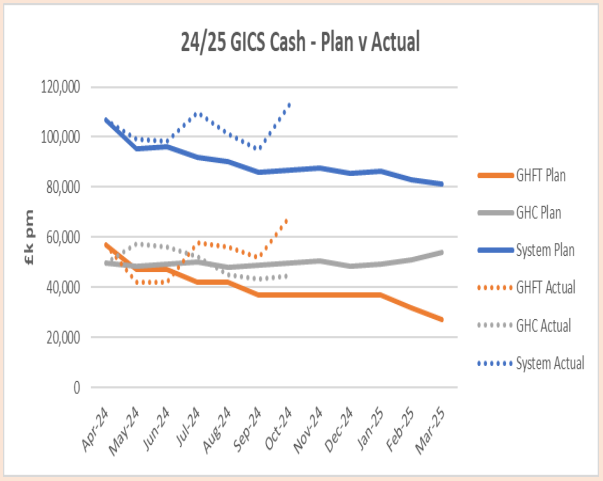
Agency: M7 agency expenditure was £1,323k. The year-to-date expenditure versus total pay bill is 2.7% for GHFT and 2.1% for GHC.

Finance and Use of Resources

ICS Financial Performance Overview: Analysis (2)

Full Year Charge Against Capital Allocation (£m)	
System Capital Allocation	44.7
Disposal	2.0
Nationally Funded Schemes	0.9
IFRS 16 Leases	8.6
Operational Capital Allocation	**56.2**
Forecast System Capital expenditure	(44.7)
Disposal	(1.7)
Forecast NHSE Schemes expenditure	(0.9)
Forecast IFRS 16 Leases expenditure	(8.6)
Forecast Capital Expenditure	**(55.9)**
Forecast Variance to Capital Allocation	**0.3**





Better Payment Practice Code (BPPC)

Target = 95%

Organisation	YTD Volume %	YTD Volume Achieved ?	YTD Value %	YTD Value Achieved ?
GHC	82.2%	N	90.0%	N
GHFT	98.6%	Y	97.0%	Y
GICB	97.0%	Y	99.7%	Y
System Average	**95.4%**	Y	**98.1%**	Y

Capital

Capital expenditure is planned and forecast to be £0.3m below the capital allocation.

Elective Recovery Fund (ERF)

The national target for Gloucestershire 107% value weighted activity (VWA) compared to 19/20 activity. The ICS plan is 118% VWA of 19/20 activity.

The early year position showed a significant delivery over baseline. Subsequent performance has reduced. Within the M6 flex position there are a number of uncoded episodes of care which once coded may generate an additional c£1.36m to ERF achievement and improve the position at 117% VWA.

Cash

The year-to-date system cash position is positive against the plan. Cash forecasts are under regular review by organisations given the challenging financial position.

Better Payment Practice Code

The system is achieving target in respect of YTD volume of invoices paid. GHC is below target due to focus on clearing old invoices and tightening up on procedures for receipting that is impacting short term performance. There is an action plan in progress within GHC

Finance and Use of Resources

System Financial Risk: Overview

Key Financial Risks & Issues	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position. The Working as One programme savings are now forecast to slip by c£6m.	Savings monitored monthly through the Programme Delivery Group and Strategic Executive meetings as well as via internal governance routes, monitoring being strengthened. Working as One Programme Board focus on the delivery of cashable savings and implementation plan to deliver savings. The identification of further non recurrent savings in progress to mitigate the impact of non-delivery of recurrent savings.
The ICB & Systems plan are dependent on delivery of the elective activity as per the plan; the Elective Recovery plan is 118%, the overall value of the additional elective recovery funding (ERF) above the baseline value is c£18.5m. The plan is currently on trajectory; however, escalation pressures could impact on delivery. The range of risk is c£4m - £5m.	Elective plan recovery is monitored at the Planned Care Programme Board (System group) and mitigating actions are discussed and agreed, in addition, Resources Steering Group also monitor to look at the overall financial impact and potential other mitigations.
Two new significant NICE TAs are in progress and, if issued will lead to large financial costs for all ICBs both in terms of drug and service costs. The risk of impact in this financial year is reducing with more significant impact potentially in 2025/26.	The potential impact on services and costs is being reviewed based on available information, the system is responding to consultations as they are issued.
Primary Care: high risk of contract hand back due to growing operational & financial pressures. Indicative direct costs £0.6m-c£1m per practice.	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices is underway to identify issues early and work with practices on mitigating actions which can include investment in training and additional support.
GP collective action has started, the impact of which is could be significant. Direct financial risks include prescribing savings, c£1.1m, advice and guidance ERF, £3.5m.	Planning for industrial action across the system is managed within organisations and across the system drawing on experience from 23/24 to minimise impact. GP collective action impacts are being assessed.
ICB delegated POD (Pharmacy, general Ophthalmic, and Dental) budget activity flagging a potential overspend risk, c£800k	Activity being validated with delegated host organisation.
Publication of new MH White paper; this is assessed to impact now in 2025/26	Circa £1m of additional costs in respect of more staff to deal with new processes outlined in paper.
2024/25 Pay Award national funding not covering full cost of impact on system pay expenditure.	Organisations are calculating the forecast impact of the pay award on staffing expenditure; this will be collated and compared to the system allocation

Finance and Use of Resources

System Efficiencies

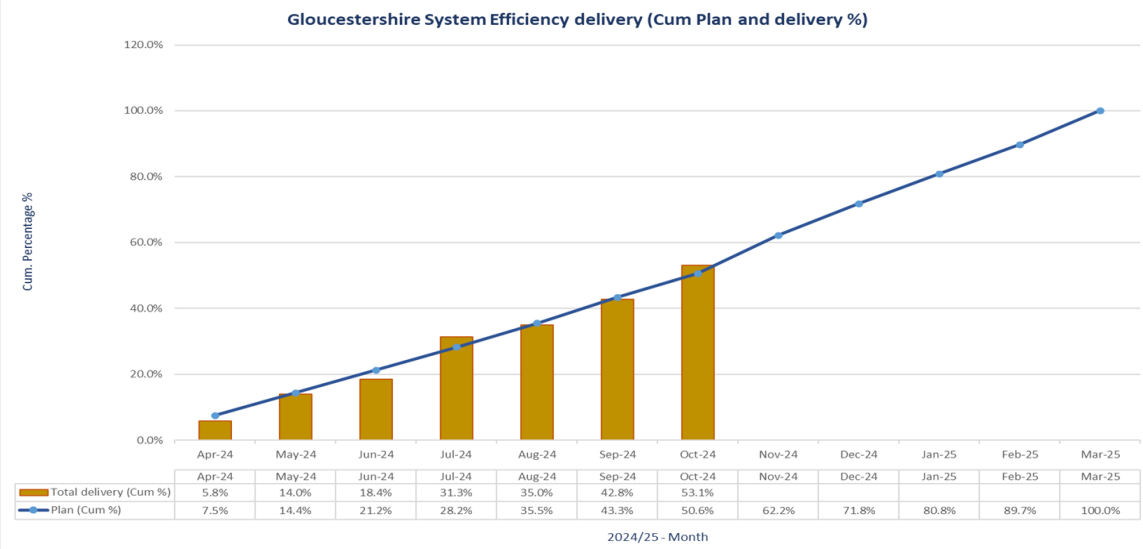
GLOUCESTERSHIRE SYSTEM SAVINGS SUMMARY

	PLAN	FORECAST							
Organisation	Savings requirement	Forecast Savings	Unidentifed	Identified Schemes Total	High	Medium	Low	Recurrent	Non-Recurrent
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gloucestershire Hospital's NHS Foundation Trust	37,389	37,389	-	37,389	6,973	5,350	25,065	10,900	26,489
Gloucestershire Health & Care NHS Foundation Trust	12,980	12,981	1,849	11,132	1,849	1,813	9,319	7,319	5,662
ICB	29,578	29,578	-	29,578	1,500	10,686	17,392	13,694	15,884
System-Held - (Incl. part of £15m Recovery)	13,293	13,293	-	13,293	5,675	2,019	5,599	9,175	4,118
Gloucestershire System Financial Savings Plan - 2024/25	**93,240**	**93,241**	**1,849**	**91,392**	**15,997**	**19,868**	**57,375**	**41,088**	**52,153**
Percentage (%) of Forecast identified				**98.0%**					
Percentage (%) of Forecast - Risk Rating					**17.2%**	**21.3%**	**61.5%**		
Percentage (%) of Recurrent v Non-Recurrent								**44.1%**	**55.9%**

Finance and Use of Resources

System Efficiencies: Performance

	System Plan	System Actual	Over / (Under) Delivery	GHC	GHFT	GICB
Efficiency Plan Delivery (YTD £k)	40,399	39,902	**(497)**	77	2,856	(3,429)
Efficiency Plan Delivery (YTD %)			**99%**	101%	125%	84%
Efficiency Plan Delivery (FOT £k)	93,240	93,240	**0**	0	0	0
Efficiency Plan Delivery (FOT %)			**100%**	100%	100%	100%



System Savings
System savings for the Working as One Programme are forecast to slip against the in year plan, by circa £6m.
Non recurrent mitigating actions being identified by all partners. The focus remains delivery of the full recurrent savings.

ICB
The medicines management programme is forecast to deliver additional savings of £1.5m in respect of national price changes for Rivaroxaban. Key risk to delivery is the potential impact of GP Collective action.

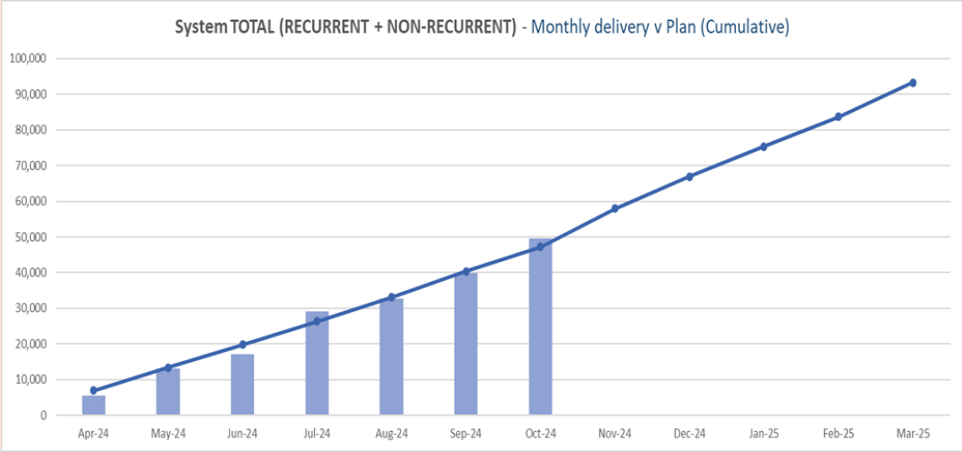
GHC
GHC is slightly behind plan on the delivery of efficiencies at month 7. Recurrent savings delivered at month 7 were £3,658k, behind plan by £339k. Non recurrent savings delivered at month 7 were £4,818k, ahead of plan by £284k. Overall FOT efficiencies remains breakeven versus plan although there remains a risk to the delivery of the full recurring savings target.

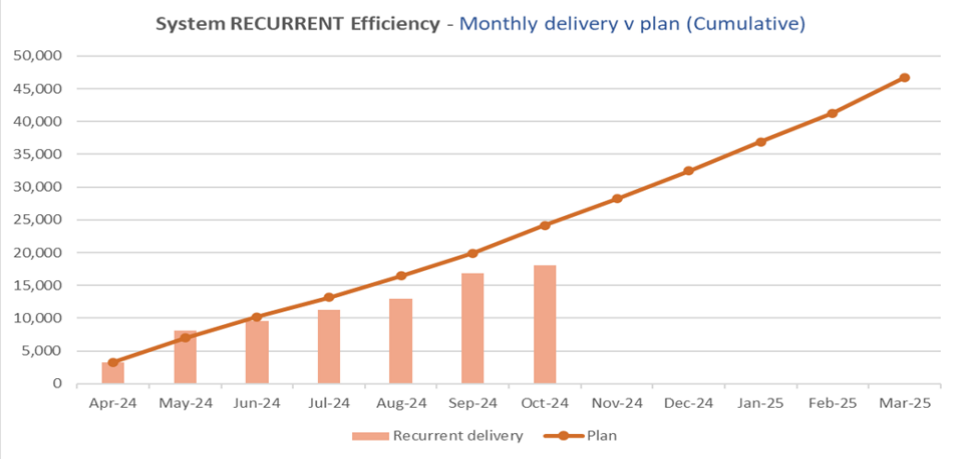
GHFT
Ahead of plan ytd by £3.9M. This is mainly due to earlier than anticipated delivery on cross-cutting workstreams, and additional benefits delivered on a non-recurrent basis. Full year programme is weighted into H2, in addition to being red rated. Full year forecast for FSP delivery is 100%, recognising there continues to be significant delivery risk from Working As One Programme. GHFT continuing to engage with Divisions and Transformational colleagues to scope efficiency programmes to support a longer-term recurrent financial sustainability agenda.

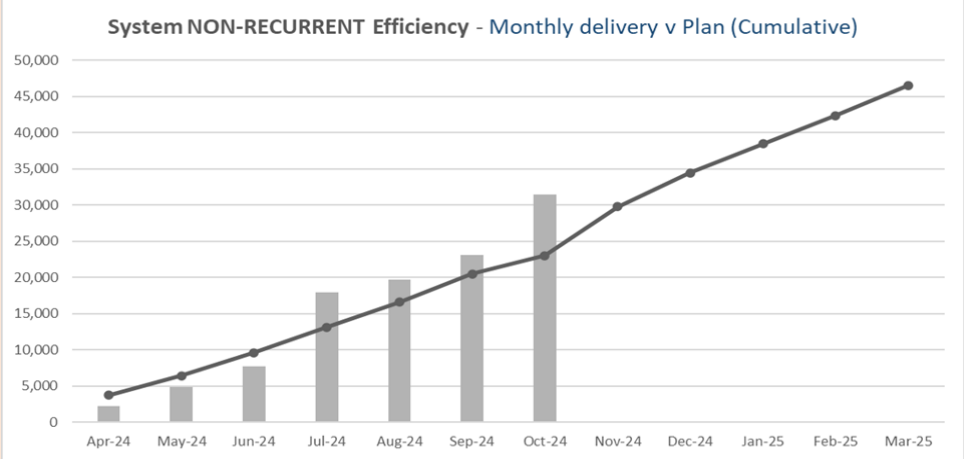
Finance and Use of Resources

System Efficiencies: Recurrent Performance

These charts show how recurrent system savings delivery is cumulatively lower than planned. Non-recurrent savings delivery is cumulatively higher than plan, currently supporting the in-year system position.







Finance and Use of Resources

Cash Management: Provider Cash Holdings

Number of Days Cash Cover for Operating Expenditure (£'000)

	October 2024	March 2025
GHFT	67,855	37,000
GHC	44,753	52,928
Cash & Cash Equivalents	**112,608**	**89,928**
GHFT	75,474	52,862
GHC	30,834	26,070
In Month Net Operating Expenditure	**106,308**	**78,932**
GHFT	28	22
GHC	45	63
System Days Cash Cover	**32**	**35**

One of the system measures of effective cash management is the number of days cash cover for operating expenditure. A reasonable system target is 30 days cover.

The GHFT forecast cash balance as at year end is on a deteriorating projection of only 22 days cash cover.

GHC cash at the end of month 7 is £44.754m which is slightly behind plan but is forecast to be above plan at year end.

Finance and Use of Resources

System Capital: Performance

	YTD (£k)			
	GHC	GHFT	ICB	System
DIGITAL	518	3,410		3,928
MEDICAL EQUIPMENT	77	713		790
ESTATES	690	7,315		8,005
OTHER	685		328	1,013
NBV OF ASSET DISPOSALS		(77)		(77)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**1,970**	**11,361**	**328**	**13,659**
IMPACT OF IFRS 16	130	1,516		1,646
Total Charge against Capital Allocation (including impact of IFRS 16)	**2,100**	**12,877**	**328**	**15,305**
NAT. PROG. GRANTS, DONATIONS & OTHER		2,160		2,160
Total Expenditure against Additional Funding	**0**	**2,160**	**0**	**2,160**
Gross Capital Spend Total	**2,100**	**15,037**	**328**	**17,465**
Gross Capital Spend Total	**2,100**	**15,037**	**328**	**17,465**
Less Donations and Grants Received		(1,074)		(1,074)
Less PFI Capital (IFRIC12)		(349)		(349)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)		199		199
Total Capital Departmental Expenditure Limit (CDEL)	**2,100**	**13,814**	**328**	**16,242**
Over / (Under) Plan	**(2,176)**	**(10,771)**	**0**	**(12,947)**

	FOT (£k)			
	GHC	GHFT	ICB	System
DIGITAL	3,515	7,020		10,535
MEDICAL EQUIPMENT	903	9,342		10,245
ESTATES	4,426	19,795		20,780
OTHER	1,201		1,114	2,315
NBV OF ASSET DISPOSALS	(2,281)	(77)		(2,358)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**7,764**	**36,080**	**1,114**	**44,958**
IMPACT OF IFRS 16	659	7,412		8,071
Total Charge against Capital Allocation (including impact of IFRS 16)	**8,423**	**43,492**	**1,114**	**53,029**
NAT. PROG, GRANTS, DONATIONS & OTHER		4,699		4,699
Total Expenditure against Additional Funding	**0**	**4,699**	**0**	**4,699**
Gross Capital Spend Total	**8,423**	**48,191**	**1,114**	**57,728**
Gross Capital Spend Total	**8,423**	**48,191**	**1,114**	**57,728**
Less Donations and Grants Received		(1,575)		(1,575)
Less PFI Capital (IFRIC12)		(600)		(600)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)		341		341
Total Capital Departmental Expenditure Limit (CDEL)	**8,423**	**46,358**	**1,114**	**55,895**
Over / (Under) Plan	**(281)**	**(0)**	**0**	**(281)**

GHC

Capital spend is behind plan but is expected to catch up during the year. There is a risk relating to the planned disposal of the Hatherley Road site which may result in the proceeds not being received until 25/26. Other disposal plans are progressing well, and mitigations are being sought should delays materialise.

GHFT

Headline drivers of the YTD position being £10.7m behind plan:
Right of Use Assets - £3.9m - Driven by two contracts - CT/MRI Services (£2.0m) and Cirencester Lease (£1.1m).
A number of capital projects have experienced cost changes or slippages for a variety of reasons which has impacted the year to date position and has put the Trust's achievement of a breakeven forecast outturn at significant risk.

ICB

The ICB capital plan relates to GP IT and minor improvement grants is planned to take place from quarter 3 onwards.

The system is forecasting an underspend of £0.3m against the system capital resources. The original system plan was an underspend of £2m against the CDEL with a plan to carry this forward, NHSE guidance is now indicating that this is unlikely to happen, the system is therefore working to spend the capital allocation in year

Finance and Use of Resources

Elective Recovery Fund (ERF): Overview

- ERF data reported in month 7 is based on the month 5 freeze (fixed), and month 6 flex (interim) position.
- NHSE have still not yet released the granular baseline data for 24/25 reporting, so all performance is based on those baselines issued for 23/24 with an uplift for 24/25.
- The national baseline for Gloucestershire is 107% value weighted activity (VWA) against the 2019/20 baseline and Gloucestershire's plan is 118% VWA of the 2019/20 baseline.
- The Out of County position now only refers to contracted providers (low value activity is now excluded).

			Apr	May	Jun	Jul	Aug	Sep		YTD (Flex)	YTD (Freeze)
Total ERF Performance	Total ICB (incl. A&G)	Plan	13,407,518	14,449,579	13,536,801	15,313,917	13,540,940	14,091,373			
		% Target	107.0%	107.0%	107.0%	107.0%	107.0%	107.0%			
		Actual 2019/20	12,530,391	13,504,279	12,651,216	14,312,072	12,655,085	13,169,508	#	78,822,550	65,653,042
		FLEX - 2024/25	*14,436,061*	*14,353,621*	*14,176,396*	*15,911,657*	*14,465,274*	*14,079,548*		91,971,419	
		FREEZE - 2024/25	*15,565,529*	15,509,047	15,325,621	16,545,639	14,946,034				77,891,871
		% of 19/20	124.2%	114.8%	121.1%	115.6%	118.1%	*106.9%*		116.7%	118.6%
		Variance (Plan)	£ 2,158,011	£ 1,059,468	£ 1,788,821	£ 1,231,723	£ 1,405,094	-£ 11,825			

- September position is low at 106.9%, however, year to date position is 116.7% there is therefore a risk to delivery of the overall system plan
- Within the September position there are 708 episodes of care currently generating a UZ code, these could generate an additional c£1.36m to the overall ERF achievement, thereby increasing the September position to 117%.

Finance and Use of Resources

System Workforce: Worked WTE

Worked WTEs per Organisation (PWRs)					
	GHC	GHFT			System Total
		GHFT (excluding GMS)	GMS	Total	
March (M12) 22/23	**4,443.5**	**7,983.6**	**686.0**	**8,669.6**	**13,113.1**
Movement M1-7 of 2023/24	70.9	20.4	28.2	48.6	**119.5**
October (M7) 23/24	**4,514.4**	**8,004.0**	**714.2**	**8,718.2**	**13,232.6**
Movement M8-12 of 2023/24	74.0	299.9	46.7	346.6	**420.6**
March (M12) 23/24	**4,588.5**	**8,303.9**	**760.9**	**9,064.8**	**13,653.2**
October (M7) 24/25	**4,647.6**	**8,209.6**	**782.3**	**8,991.9**	**13,639.5**

System monitoring on workforce is developing and is focussed on both the budgeted and worked position. The NHS England focus is on worked whole time equivalent (WTE). Worked WTE figures will be subject to greater fluctuation on a month-to-month basis as they reflect vacancies, sickness, use of bank and agency as well as substantive staff.

The position at month 7 reflects an overall increase in worked WTE since reporting in October 2023, but a reduction since March 2024.

Trend analysis remains under development for future months.

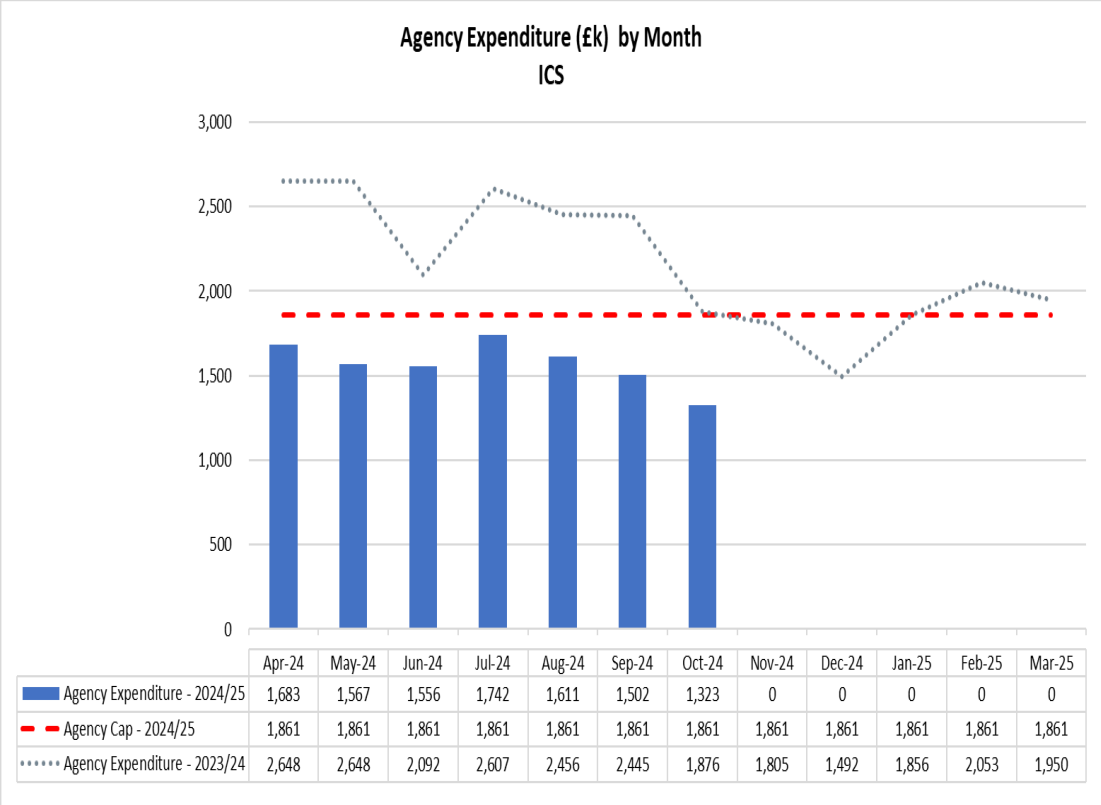
Overall, the GHFT position includes some longer-term increases due to specific investments increasing WTE usage.

In respect of the nursing aspects of the 2024/25 reduction, this is as a result of two key factors:

- Robust & on-going reviews of roster v funded establishment.
- Improved monitoring system in management of roster and bank/agency usage.

Finance and Use of Resources

System Workforce: Agency Spend vs Cap



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency Expenditure - 2024/25	1,683	1,567	1,556	1,742	1,611	1,502	1,323	0	0	0	0	0
Agency Cap - 2024/25	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861
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

GHC
Agency spend of £2.902m for GHC remains below the 3.2% national cap at 2.06% of total pay costs.

Off framework shifts for October totalled 66.

The Trust has a strong process in place to ensure that all requests for agency go through appropriate governance, in particular the use of off framework agencies.

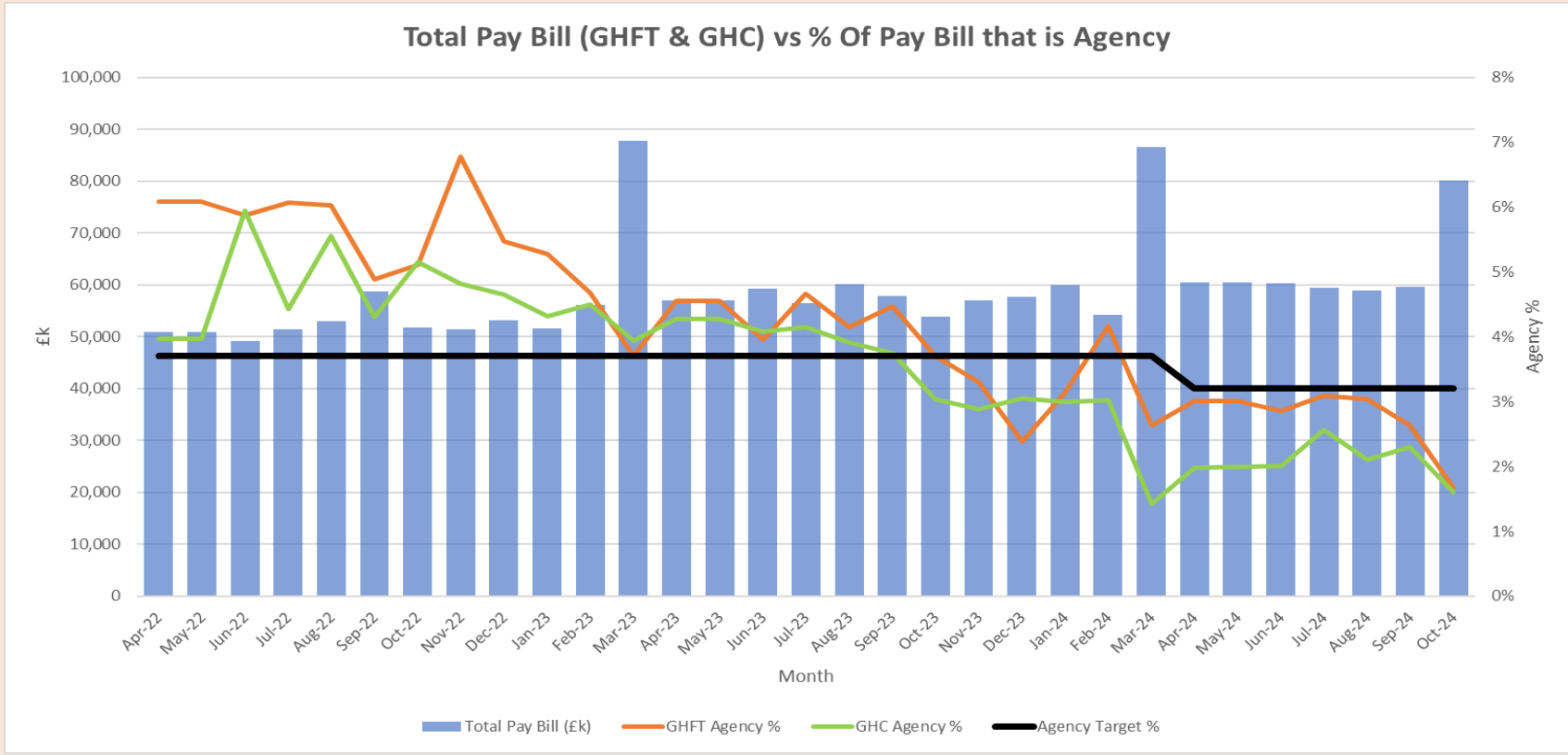
GHFT
In month shifts filled by agency are split across admin and clerical (including capital), medical, nursing and other/scientific.

GHFT booked 10 off-framework shifts in month 7 - 7 Midwives, 1 Theatre Nurse, 1 ODP and 1 RMN.

The Trust has processes in place to ensure agency requests are approved alongside wider workforce controls overseen by the Workforce Impact Group.

Finance and Use of Resources

System Workforce: Agency Spend



	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	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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	£ 1,306	£ 1,179	£ 1,171	£ 1,252	1208	1043	921
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	£ 377	£ 388	£ 385	£ 490	403	459	402
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	£ 1,683	£ 1,567	£ 1,556	£ 1,742	£ 1,611	£ 1,502	£ 1,323

One Gloucestershire
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NHS

ICB Finance Report

Month 7 2024/25 – October 2024

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Finance and Use of Resources

Financial Overview & Key Risks

- The ICB month 7 position is a forecast outturn position of breakeven as per plan. However, the position contains a significant amount of risk as it is predicated on delivery of a high level of savings and we have an emerging issue within the CHC and placements budget, there is work underway to identify areas of mitigation to offset.
- The prescribing forecast is breakeven, based on Month 5 data. The expected price reductions of generic rivaroxaban is expected to offset growth and current NCSO Pressures. The YTD growth is currently 3.1% increase compared to same period last year.
- Elective Recovery Funding - the Gloucestershire target is 107% with the system operational plan value set at 118% value weighted activity of 19/20. Based on Month 6 flex (interim) data the system is on track to deliver the planned overperformance.
- Continuing Health Care & Placements - The forecast is £2.7m overspend, however further risks have been identified that are expected to increase this to £4.7m overspend in M8. 13 high cost packages are driving the majority of the overspend as they have generated a £5m cost pressure in 24/25. There is also an increasing trend in domicillary care packages. The ICB is looking to provide some additional support to the team over the coming months to help manage the position.
- Independent Sector Providers is forecasting £1.4m overspend. The activity for Winfield Hospital has increased significantly in the latest data submitted which is likely to be sustained; this will contribute to a reduction in waiting lists.
- Other emerging pressures being managed in the position include ADHD assessments from private providers (forecast overspend £0.26m) which has seen an increase in activity over the last 3 years and patient transport (forecast overspend £0.21m).
- The Mental Health Investment Standard (MHIS) for 24/25 is £114.327m and is forecast to be delivered.

Finance and Use of Resources

Financial Key Risks and Issues

Key Financial Risks & Issues	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position. The working as One programme savings are now forecast to slip by c£6m.	Savings monitored monthly through the Programme Delivery Group and Strategic Executive meetings as well as internal governance routes, monitoring being strengthened. Working as One Programme Board focus on the delivery of cashable savings and implementation plan. The identification of further non recurrent savings in progress to mitigate risk of part year impact of recurrent savings delivery.
The ICB & Systems plan are dependent on delivery of the elective activity as per the plan; the Elective Recovery plan is 118%, the overall value above the baseline value is c£18.5m. The plan is currently on trajectory; however, escalation pressures could impact on delivery. The risk range c£4m-£5m.	Elective plan recovery is monitored at the Planned Care Programme Board (System) and mitigating actions are discussed and agreed, in addition, Resources Steering Group also monitor to look at the overall financial impact.
Significant NICE TAs are in progress which if issued will lead to high costs for all ICBs both in terms of drug and service costs. The risk of impact in this financial year is reducing with more significant impact potentially in 2025/26.	Potential impact on services and costs is being reviewed based on available information, the ICB is responding to consultations as they are issued.
Increasing high-cost placements, particularly children's and learning disabilities are a key financial issue and growing risk for the ICB. The current forecast is £2.7m (M7) with a further risk of £1.9m-£2.5m	Regular monitoring in place. Review to identify additional support for the team in progress.
Primary Care: high risk of contract hand back due to growing operational & financial pressures. Indicative direct costs £0.6m -c£1m per practice	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices
ICB delegated POD (Pharmacy, general Ophthalmic, and Dental) budget activity flagging a potential overspend risk, c£800k on pharmacy	Activity being validated with delegated host organisation.
24/25 Pay Award national funding not covering full cost of impact on system pay expenditure.	Organisations are calculating the forecast impact of the pay award on staffing expenditure; this will be collated and compared to the system allocation.

Finance and Use of Resources

ICB Allocation: M07

Description	Recurrent £'000	Non-Recurrent £'000	Total Allocation £'000
BALANCE BROUGHT FORWARD M06	**1,322,067**	**58,622**	**1,380,689**
AHP Workforce Funding		79	79
CDC Activity Central Costs		1,795	1,795
Digital Tools PCARP		80	80
Enhance Project		100	100
GP Wellbeing in Appraisals / Workforce / Social Prescribing		26	26
NHS InSites 24/25		200	200
Pay Award	26,693	3,125	29,818
Programme Reimbursement Scheme		3,642	3,642
PCT – Pharmacy First		322	322
PCT Additional Roles and Reimbursement Scheme		2,664	2,664
Pharmacy Integration Fund		1	1
Running cost Reimbursement Scheme	352		352
TOTAL IN-YEAR ALLOCATION 24/25 @ M07	**1,349,112**	**70,656**	**1,419,768**

Finance and Use of Resources

ICB Statement of Comprehensive Income

Statement of Comprehensive Income (£'000)							
Month 7 2024/25 - October	M7 Plan	M7 Actual Position	Year End Variance to Plan Favourable / (Adverse)		Full-Year Plan	Forecast Outturn Actual Position	Forecast Outturn Variance to Plan Favourable / (Adverse)
Acute Services	399,207	399,644	(437)		677,387	679,179	(1,792)
Mental Health Services	79,342	76,793	2,549		136,393	136,438	(45)
Community Health Services	76,291	74,630	1,661		132,891	132,112	779
Continuing Care Services	50,780	52,994	(2,214)		87,934	90,652	(2,719)
Primary Care Services	113,776	111,819	1,957		194,677	194,699	(23)
Delegated Primary Care Commissioning	77,151	77,033	118		131,489	131,489	0
Other Commissioned Services	22,838	22,441	397		38,281	38,703	(421)
Programme Reserve & Contingency	2,612	6,572	(3,961)		9,585	5,334	4,251
Other Programme Services	368	439	(71)		631	661	(31)
Total Commissioning Services	**822,365**	**822,365**	**(0)**		**1,409,268**	**1,409,268**	**(0)**
Running Costs	6,125	6,125	0		10,500	10,500	0
TOTAL NET EXPENDITURE	**828,490**	**828,490**	**(0)**		**1,419,768**	**1,419,768**	**(0)**
ALLOCATION	**828,490**	**828,490**	**0**		**1,419,768**	**1,419,768**	**0**
Outside of Envelope	**0**	**0**	**0**		**0**	**0**	**0**
Underspend / (Deficit)	**0**	**(0)**	**(0)**		**0**	**0**	**(0)**

Finance and Use of Resources

ICB Savings and Efficiencies Overview

Gloucestershire Integrated Care Board (GICB) has a savings programme amounting to £29.577m for the 2024/25 financial year.

- **Working as One** - £8.2m savings requirement within the system of which £6.2m is within the ICB savings plan. Currently slippage against this programme is £6m, c0.5m of the savings may be delivered. Non recurrent mitigations to this slippage are actively being identified within the ICB and system organisations.

- **Medicines savings** - forecast savings at month 7 include £1.5m in respect of national price changes for Rivaroxaban. These price changes commence from September. Overall, oral Anticoagulation drugs show a trend of reduced costs alongside increased rate per 1,000 items. Focus on new 2024/25 and 2025/26 schemes is taking.

- **CHC / Placements** - savings delivery to date are from Electronic Call monitoring and CHC LD reviews. There are still shortfalls in capacity, both within the ICB and GCC to carry out additional adult CHC reviews and re-assessments, this presents an ongoing financial risk.

- **ERF** - Elective Recovery - £20.8m overall additional allocation contributing to resources (£8.8m allocation within the ICB savings plan) and this is dependent on successful elective recovery. Activity to Month 6 indicates significant Elective Recovery, though current trajectory indicates a £2m-£3m shortfall risk.

- **£15m recovery plan** - At month 7, all of the £15m recovery plan is now identified.

Finance and Use of Resources

ICB Savings Summary: Month 7

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	Primary Care Medicines Optimisation	2,915	1,730	(1,185)	5,000	5,000	0	100.00%	Amber - Medium risk
	Home Oxygen	90	90	0	150	150	0	100.00%	GREEN - Low Risk
	PRIMARY CARE MEDICATION OPTIMISATION - TOTALS	3,005	1,820	(1,185)	5,150	5,150	0	100.00%	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Individual Personal Commissioning - Continuing Healthcare (CHC) / Joint Placements	933	933	0	1,600	1,600	0	100.00%	Amber - Medium risk
	CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS	933	933	0	1,600	1,600	0	100.00%	
OTHER - RECURRENT	1) ICB Other Recurrent Efficiencies (E.g. Out of County Contracts, Independent Sector Providers, Non Contracted Activity (NCAs), Etc.)	4,050	4,050	0	6,944	6,944	0	100.00%	GREEN - Low Risk
	OTHER RECURRENT EFFICIENCIES - TOTALS	4,050	4,050	0	6,944	6,944	0	100.00%	
OTHER - NON-RECURRENT	ICB Non-Recurrent Efficiencies	9,266	9,266	0	15,884	15,884	0	100.00%	Amber - Medium risk
	OTHER NON-RECURRENT EFFICIENCIES - TOTALS	9,266	9,266	0	15,884	15,884	0	100.00%	
	2024/25 ICB SAVINGS PROGRAMME - TOTALS	17,254	16,069	(1,185)	29,578	29,578	0	100.00%	Amber - Medium risk

Finance and Use of Resources

System-Held Savings Summary: Month 7

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD - SYSTEM HELD EFFICIENCIES 2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 7									
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
URGENT EMERGENCY CARE	UEC transformation savings	3,019	-	(3,019)	5,175	5,175	0	100.00%	RED - High Risk
URGENT EMERGENCY CARE SAVINGS - TOTALS		3,019	-	(3,019)	5,175	5,175	0	100.00%	
DISCHARGE	P2 Bed savings (System)	582	582	0	1,000	1,000	0	100.00%	Amber - Medium risk
DISCHARGE SAVINGS - TOTALS		582	582	0	1,000	1,000	0	100.00%	
ELECTIVE	ERF Productivity	1,750	981	(769)	3,000	3,000	0	100.00%	Amber - Medium risk
ELECTIVE SAVINGS - TOTALS		1,750	981	(769)	3,000	3,000	0	100.00%	
OTHER	Non-Recurrent slippage	1,279	1,969	690	2,194	2,194	0	100.00%	Amber - Medium risk
	Unidentiied Savings - Non-recurrent	1,123	1,924	801	1,924	1,924	0	100.00%	GREEN - Low Risk
OTHER & UNIDENTIFIED SAVINGS - TOTALS		2,402	3,893	1,491	4,118	4,118	0	100.00%	
2024/25 ICB SAVINGS PROGRAMME - TOTALS		7,753	5,456	(2,297)	13,293	13,293	0	100.00%	RED - High Risk

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Delivery Plan for Recovering Access to Primary Care – Update**
Purpose (X)	**For Information** X / **For Discussion** / **For Decision**
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:

ICB Internal	Date	System Partner	Date
ICB Operational Executives	05/11/2024	Strategic Executive	21/11/2024

Executive Summary	In November 2023 the System Delivery Plan for Recovering Access to Primary Care was presented to ICB Board, outlining how Gloucestershire ICB was taking forward the actions outlined in the national Delivery Plan (published by NHSE in May 2023). A further update was presented in March 2024 and NHSE have since requested ICBs present further updates in November 2024. This report provides an update on progress since March 2024.
Key Issues to note	There are several challenges faced by GP practices in the current climate which need to be considered alongside this programme of work, which include (but are not limited to), financial pressures, workforce pressures, patient demand and expectation. We are reviewing these and working with practices and PCNs to understand the issues.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	This piece of work requires intensive resources in practices, PCNs and the ICB. The ICB are working with several practices to support their ongoing resilience and sustainability. There is a risk that public and patient expectations around access could be set unrealistically given the number of factors at play.
Management of Conflicts of Interest	Any conflict of interest on the Recovering Access in Primary Care Project Group and wider system colleagues has been raised prior/during the meetings.

Resource Impact (X)	**Financial**	**X**	**Information Management & Technology**	**X**
	Human Resource	**X**	**Buildings**	**X**
Financial Impact	Small financial impact – funding is provided by NHSE.			
Regulatory and Legal Issues (including NHS Constitution)	N/A			
Impact on Health Inequalities	Health inequalities for recovering access in Primary Care are being addressed through various Primary Care workstreams including Core20plus5 areas.			
Impact on Equality and Diversity	PCN Capacity and Access Improvement Plans (CAIPs) consider the impact on equality and diversity on their patient population.			
Impact on Sustainable Development	The System Delivery Plan aims to support practices and PCNs to be sustainable and manage patient demand and capacity.			
Patient and Public Involvement	The ICB Patient Engagement Team have shared supportive information with practices/PCNs to help with the development of PPGs and local surveys.			
Recommendation	The Board is requested to: • Note the information provided.			
Author	Jo White	**Role Title**	Deputy Director of Primary Care & Place	
Sponsoring Director (if not author)	Helen Goodey, Director of Primary Care & Place			

Abbreviation	Explanation or clarification of abbreviations used in the paper
ARR	Additional Role Reimbursement
CAIP	Capacity and Access Improvement Plans
CPCF	Community Pharmacy Contractual Framework
CPD	Continuous Personal Development
DES	Direct Enhanced Service
DHSC	Department of Health and Social Care
DoS	Directory of Service
DPF	Digital Pathway Framework
EIA	Equality Impact Assessment
FFT	Friends and Family Test
FTE	Full Time Equivalent
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GPAD	GP Appointment Data
GPIP	GP Improvement Programme
GPPS	GP Patient Survey
HCA	Health Care Assistant

ICB	Integrated Care Board
ICES	Integrated Community Equipment Service
ICS	Integrated Care System
ICT	Integrated Community Team
IIF	Impact and Investment Fund
LMC	Local Medical Committee
MHP	Mental Health Practitioner
NHSE	NHS England
NWRS	National Workforce Reporting Service
PCARP	Primary Care Access Recovery Plan
PCN	Primary Care Network
PCTH	Primary Care Training Hub
POMI	Patient Online Management Information
PPG	Patient Participation Group
SDF	System Development Funding
SLF	Support Level Framework

Agenda Item 11

NHS Gloucestershire ICB Board Public Meeting

Wednesday 27 November 2024

1. Introduction

1.1. In November 2023 the System Delivery Plan for Recovering Access to Primary Care was presented to ICB Board, outlining how Gloucestershire ICB was taking forward the actions outlined in the National Delivery Plan (published by NHSE in May 2023).

1.2. ICBs were required to update to their public board in October/November 2023 and in February/March 2024. A further requirement by NHSE for ICBs to update on Progress in Oct/Nov 2024.

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

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

1.4. The National Delivery Plan has two central ambitions:

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

2. The System Delivery Plan

2.1. An update to the progress on Gloucestershire System Delivery Plan has been produced detailed in Appendix A.

2.2. A working group to support the development of the System Delivery Plan for Gloucestershire continues to meet and progress is reported through the Primary Care Operational Group and the Primary Care and Direct Commissioning Committee.

2.3. Following analysis against the nationally published checklist the key Gloucestershire priorities for the System Delivery Plan were identified as follows:

- Support practices to improve their 2-week and 4-week appointment wait data;

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

3. Recommendations

3.1. The Board is asked to:

- Note the contents of this report regarding an update on progress on the Recovering Access in Primary Care System Delivery Plan.

Appendix A

Slides attached

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Primary Care Access Recovery Plan (PCARP)

Progress Update

November 2024

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Introduction

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

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

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

The National Delivery Plan has two central ambitions:

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

Empower Patients

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

Implement Modern General Practice Access

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

Build Capacity

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

Cut Bureaucracy

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

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Empowering Patients

The **national ambition** is to empower patients by rolling out tools they can use to manage their own health, and expand services offered by community pharmacy. Helping the public do more for themselves, making information and easy-to-use tools available by:

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

2024/25 Action: Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.

Increase use of prospective medical records

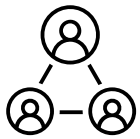
100% of practices have **configured their system** to allow patients access to their record

73% practices have **less than 10% of patients withheld access** due to need for enhanced review (104 code)

92% practices have enabled **automatic prospective record access** for new patients

75% practices have **enabled prospective access for over 90% of their patients with an online account.**

NHSED are actively looking for ambassadors to get involved with the NHS App and promote the benefits to both patients and colleagues. The NHSE aim is to have an NHS APP ambassador in every practice or within a PCN as a minimum.



Gloucestershire currently **have 7 NHS App ambassadors**;

- 1 at the ICB
- 6 based at practices

(POMI data June 2024)

patients who have an online account. This is an increase of 3.3% since March

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

- **Gloucestershire: 54.1%** (3.3% increase since March 24)
- South West: 52.8%
- Nationally: 52.1%

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

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Empowering Patients: Self-referrals

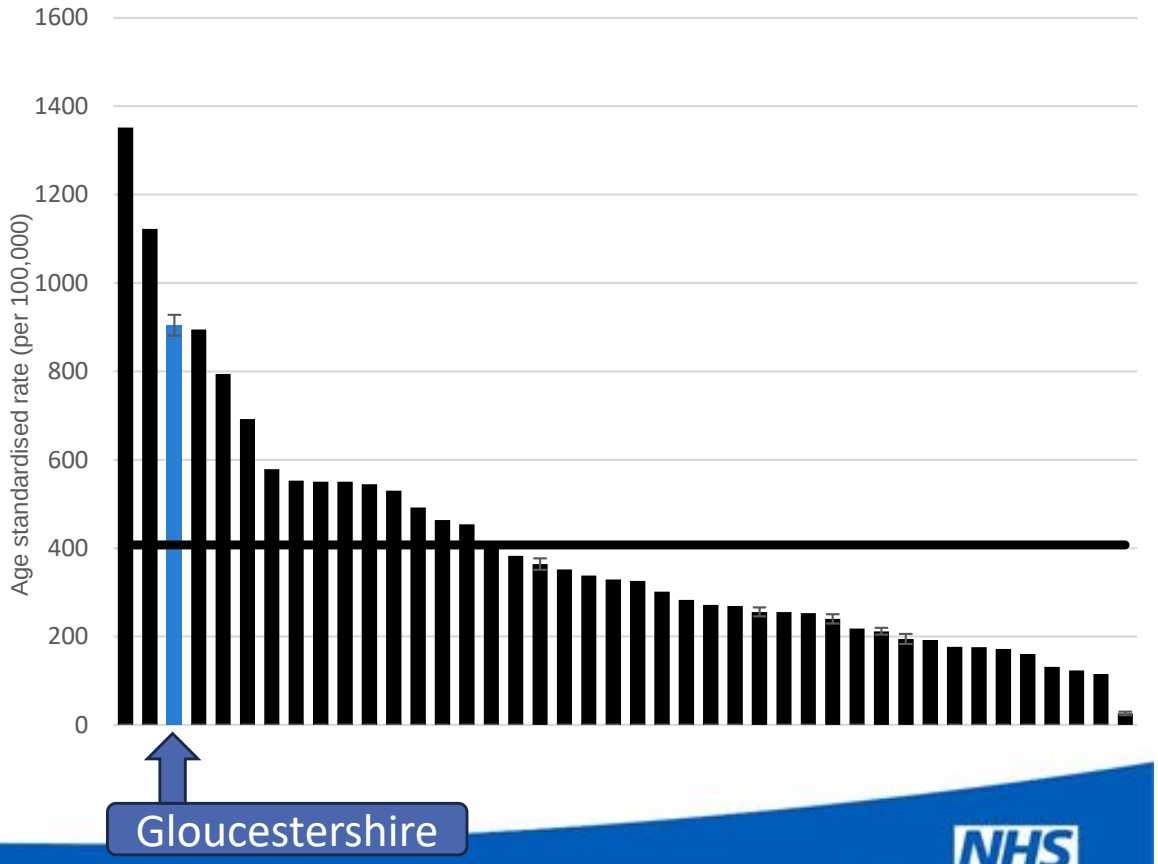
Continue to expand Self-Referrals to appropriate services. Increase number of self-referrals across appropriate pathways by a further 15,000 per month by March 2025 (National). *The self-referral target applies to community service that report data to the Community Services Data Set (CSDS), such as physiotherapy and podiatry.*

NHSE analysis of CDCS demonstrates **that Gloucestershire currently has the highest age standardised rate of self-referrals per 100,000 population in the South West, and the third highest rate nationally in June 2024 (see graph).**

According to NHSE monitoring data, **70% of self-referrals in Gloucestershire are made to District Nursing, physiotherapy, and podiatry services**

Audiology (one of the 7 original PCARP Self-referral routes) is still currently not accessible via self-referral routes. It is anticipated that this will not be reviewed by the service again until 25/26.

Work is underway to review NHSE benchmarking data to identify potential opportunities to increase self-referrals. However, the opportunities may be limited as Gloucestershire is already performing high both nationally and regionally.



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Expanding Community Pharmacy Services

- Increase PF pathways consultations per month by at least 320,000 by March 2025 (National Target).
- Increase oral contraception prescriptions coming directly from a Community Pharmacy by at least 25,800 by March 2025 (National Target).
- Increase Community Pharmacy Blood Pressure check appointments by at least 71,000 per month by March 2025 as part of our ambition to deliver a further 2.5 million blood pressure checks in community pharmacy (National Target).

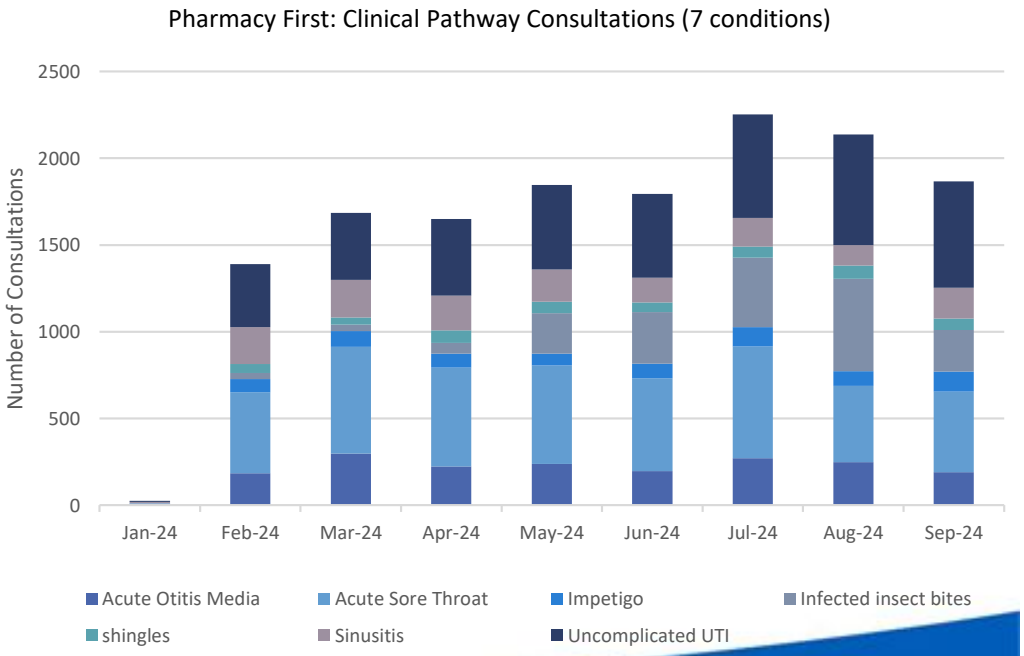
Pharmacy First Service Launched 31st January 2024; reducing pressures on General Practice and increasing patient access to assessment, advice and appropriate treatments by making pharmacies first contact for minor illness

8,165 patients in Gloucestershire presenting at pharmacies as first point of call – indicating acceptance of the service from patients

Pharmacy First, BP Check and Contraception clinical services introduced at pace have shown pharmacy teams ability and appetite to pivot and develop clinical services in response to NHS commissioning

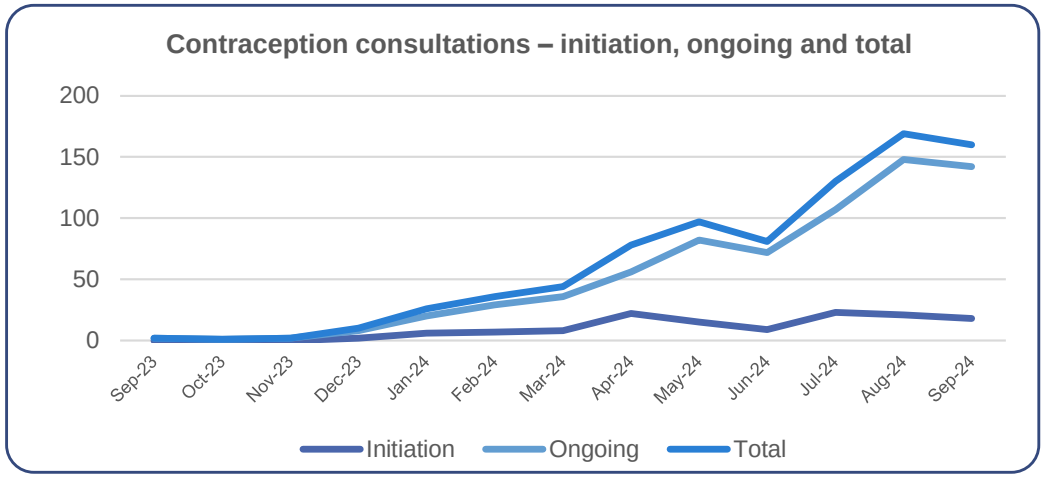
Community Pharmacy PCN Leads have been agreed

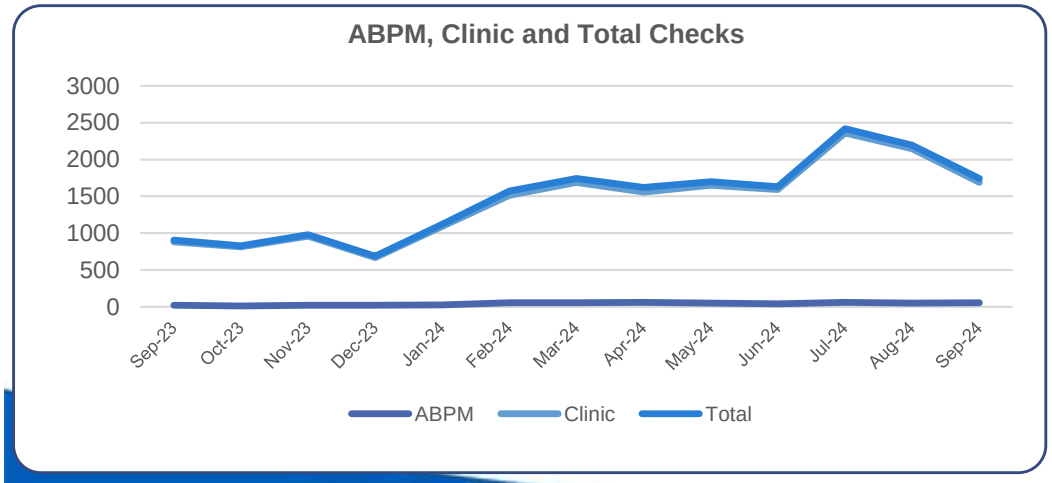
Contraception initiation and ongoing supply is the next significant opportunity to increase patient access to oral contraception and reduce pressure on GP teams working with our next iteration of Community Pharmacy PCN Leads.

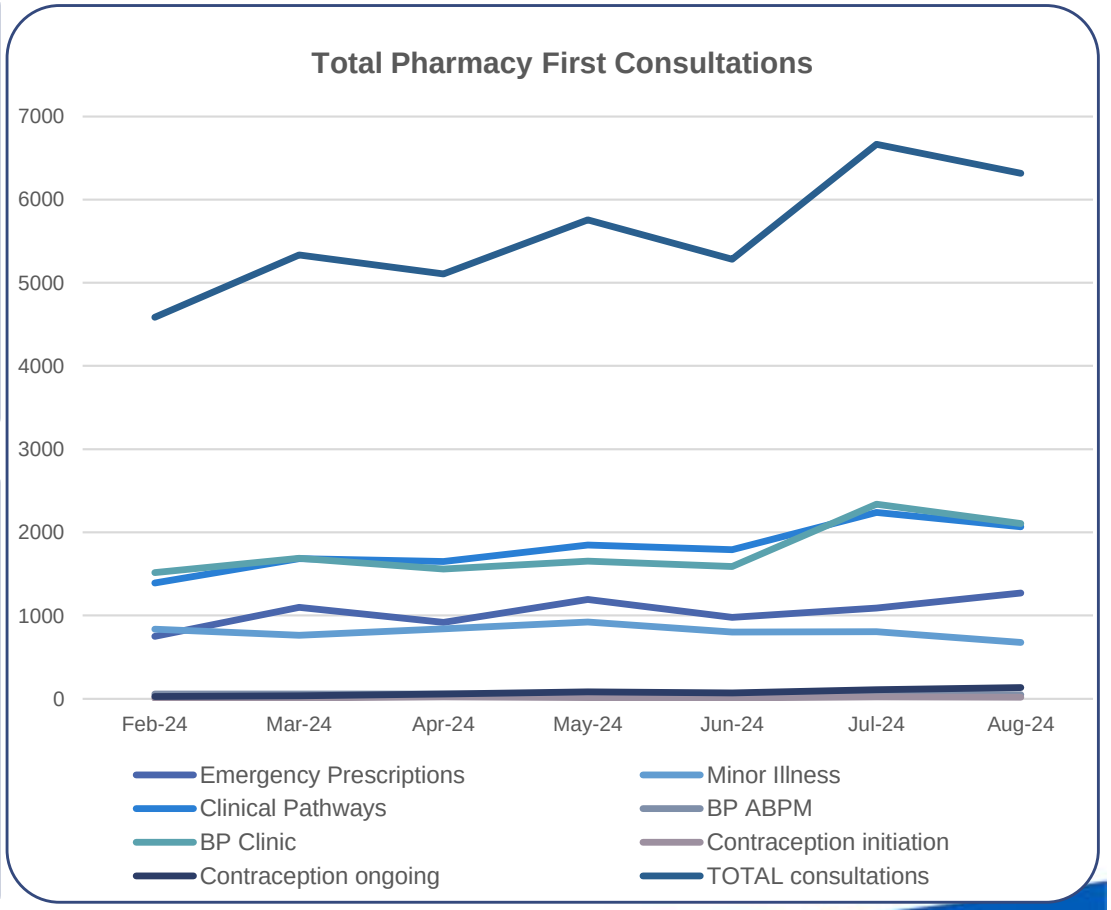


Workforce challenges remain and financial pressures have seen an increase in unregistered pharmacy staff, meeting increased patient and prescription volume and a reduction in registered pharmacists and pharmacy technicians to maintain financial sustainability.

Expanding Community Pharmacy Services







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General Practice Improvement Programme

The ICB Primary Care Team have continued to promote the NHSE **GPIP support offers** available to GP practices. 2024/25 is the final year that the Practice Support Offer is available via NHSE and Uptake in 24/25 has been lower than anticipated. This may be due to a high number of practices having already taken part in previous iterations of the programme

51 practices
practices accessed GPIP (all Offers) since April 2023

22 practices
Total taken part in Support Offer since April 23

3 PCNS (19 practices)
PCN Level Support Offer

34% of practices have taken part in the previous iterations of the GPIP programme (Productive General Practice and Accelerate)

No. of PCNs with at least 1 person taking part in the Digital & Transformation Lead training

Support Level Framework (SLF)

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

20 practices (5 PCNs) — PCN Led SLF

36 practices — NHSE Led SLF (via GPIP)

The remaining few practices that haven't engaged to date are being contacted to have a conversation around the SLF and their achievement/plans against the indicators to move towards a modern general practice model.

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Modern General Practice Access – 3 themes

A. Better Digital Telephony

33% PCNs declared Domain 1

PCNs have declared Domain 1, Better Digital Telephony, of the Capacity Access Improvement Payment (CAIP) add domains this covers and dates of declarations

CAIP DOMAIN 1:

- Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England.*
- Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.*

13 **Phase 1**

16 **Phase 2 'cohort a'**

All practices within cohort 1 (analogue to digital) and cohort 2a (digital full functionality) have moved or are in the process of moving to a Digital Telephony solution – the ICB are working with last few practices to finalise this.

The ICB primary care team are planning to carry out an audit with Practices to understand their progress towards functionality to support the modern general practice model.

B. Simpler Online Requests

13% PCNs declared Domain 2

As part of collective action, the BMA recommended that PCNs defer signing this domain until further GPC Guidance is released, to date 13% of PCNs have declared as part of the CAIP Payment.

CAIP DOMAIN 2:

- Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours.
- Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.

- Silicon Footfall websites & Accurx for online patient facing services and Ardens for data quality, have been offered to all practices and they have the choice to adopt the products procured by the ICB.
- A review of Digital Tools is underway with practices/PCNs to help inform an ICB approach for 2025/26.

Practice Websites: 60 practices in Gloucestershire have Silicon Footfall as their website solution. All Footfall sites have now booked an upgrade to the Foundation version which adheres to NHSE Standards.

46 Practices are now live with Foundation Footfall

C. Faster navigation, assessment, & response

33% PCNs declared Domain 3

PCNs have declared domain 3, **faster care navigation, assessment, and response.** of the CAIP Payment

CAIP DOMAIN 3:

- Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.
- Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

Workforce training has been provided to Practices to support total triage.

Register with a GP Surgery Online

94%

of practices in Gloucestershire enrolled for register with a GP Surgery Online Service (as at 23 Oct 24)

- This is a 41% increase from 32 (48.4%) in March 2024 to 58 (90%) in August 2024.
- The ICB Digital Team are in discussion regarding implementation with the remaining practices to ensure sign up by the 31st October 2024.

The ICB Digital and Primary Care team are continuing to support practices with any issues relating to all the digital elements of PCARP.

Primary-Secondary Care Interface

Led by CMO

NATIONAL PCARP ACTION: Make further progress on implementation of the four Primary Care Secondary Care Interface AoMRC recommendations.

This programme of work aims to reduce unnecessary additional work for practices and secondary care.
The Gloucestershire LMC are involved in the work programme.

Work is underway to establish a **primary care liaison service** within GHFT to provide a single point of contact for GPs and consultants to raise interface related issues for resolution.

- Interface working group is being established
- Clinical leads from secondary care in place
- Process in place for expediating appointments through the Elective Care Hub

The **interface principles document** has been published and circulated to primary and secondary care providers and will be held on G-Care.

- Implementation of inpatient eFIT notes in place since October 2024.
- Working on ensuring availability of paper fit notes in outpatients and associated communications to clinicians.
- Guidance has been developed for consultants on the duration of fit notes for common conditions.

GP and Consultant Networking event held in July 2024 brought clinician's together to discuss issues at the interface and build relationships. Feedback from the event is being used to inform the interface workplan priorities. Also introducing a series of GP show and listen events to continue discussions

- Project focused on Advice and Guidance optimisation progressing as part of the NHS Confederation Interface Improvement Collaborative.

- Follow up of the NHSE assessment of progress against the 4 national priorities has been submitted to NHSE at the end of September. This showed some progress from the baseline assessment.

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Communications

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

National resources (poster, video, social media posts and website copy) were shared with practices in December 2023.

The NHS App is being promoted to patients via social media.

The ICB are promoting Pharmacy First via social media and issued a media release in February 2024 when the service launched Pharmacy First will be an integral part of the 2024/25 Winter Campaign, featuring videos for each of the seven conditions

In May 2024 the ICB issued a media release about GP appointments.

In July 2024, the ICB issued a media release and stakeholder briefing following the publication of the GP Patient Survey results

The Be A GP in Gloucestershire campaign is being developed to support recruitment to general practices and promote Gloucestershire as a place to live and work.

Workforce

- Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP).

Primary Care Training Hub/Workforce team meeting with NHSE to outline plans as part of LTWP Optioneering exercise (planned for October 2024) for General Practice.

- Optioneering is a methodology that supports systems/organisations to evaluate the population growth and demographics and the resulting workforce needs, encompassing training numbers required to meet these needs

Ongoing focus on the 3 key areas of Train, Retain and Reform.

Further work required to understand Estates implications and funding as part of the LTWP objectives.

The LTWP outlined a significant increase in GP training numbers.
Regional and now system level expansion numbers have been received (over the coming years this will expand to approx. 15 additional GP trainees per year).
ICB/PCTH meeting planned with Glos GP training scheme to consider implementation of expansion numbers.

Risks to Delivery

Risk Area	Risk Description	Score (Lik.*Imp.)	Mitigations
Expanding Community Pharmacy Services	Increasing demand on Community Pharmacy affecting sustainability - also linked to extended wait times for finance (increasing costs, outcome of core contract negotiations and financial risk), workforce, new technological investment, further pharmacy closures and the wider effects of GP Collective Action across primary care sectors Risk to ability of Community Pharmacy to deliver core services and other clinical services (17% of NHS income) including Pharmacy First, Blood Pressure Monitoring, Contraception etc.	20(4*5) *On corporate risk register*	1) Development and implantation of an ICB Communication and Engagement Plan including hosting the first Community Pharmacy Engagement event in October 2024; 2) Successful deployment and effective utilisation of Community Pharmacy PCN Engagement Leads;
Primary Care / Secondary Care Interface	**Interface principles**: In large organisations, there may be ingrained behaviours and resistance to change. If there is in-sufficient buy-in from primary and secondary care, this could lead to inconsistent implementation and the interface principles may fail.	16(4*4) *On corporate risk register*	Considerable engagement between primary and secondary care has been undertaken to support the principles being achievable to be adopted
GP Collective Action	The 10 suggested actions by the BMA could risk delivery of the PCARP programme	20 (4*5) *On corporate risk register*	Ongoing conversations with practices/PCNs
Continuation of Digital Tools	No long term funding secured, year on year allocations makes planning difficult and digital advancements are at risk.	9(3*3)	Extending current contracts and prolonging the interim stage

Finance

National Funding Stream	Gloucestershire allocation	Anticipated spend by 31st March 25	Comments
IIF National Capacity and Access **Support** Payment (CASP) 24/25	£2.187m	£2.187m	Paid to PCNs, proportionally to their Adjusted Population, in 12 equal payments over the 24/25 financial year. This is 'unconditional' funding. For the period 1 April 24 to 31 March 25 this is calculated as £3.248 *PCN's Adjusted Population as of 1 January 2024.
IIF Local Capacity and Access **Improvement** Payment (CAIP) 24/25	£937k	£937k	PCN Clinical Director required to declare PCN has achieved each domain (3 domains). Once declared payment for domains declared to be made to PCN pro rata.
Transition Cover & Transformation Funding 24/25 ~Average £13,500 per practice in 23/24 and 24/25	£357k received to date (75% of £476k)	£476k	
Primary Care Service/System Development Funding (SDF)	**PC Transformation**: £1.375m *(this covers numerous programmes of work)* **GPIT**: £141k	**PC Transformation**: £1.375m **GPIT**: £141k	SDF funding, covers numerous programmes of work and has all been committed and planned to be spent by the end of the financial year.
Online consultation, messaging and appointment booking tools 24/25	£516k	£437k	Used to fund Silicon footfall Website & Accurx – fixed costs

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Intensive and Assertive Community Mental Health Care Review**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting						
	ICB Internal	**Date**	**System Partner**	**Date**		
	ICB Operational Executive	12/11/24	GHC Executive Meeting	19/11/24		
Executive Summary	ICBs are required by NHS England (NHSE) to '*review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge*.' The ICB and GHC are working together and have completed a self-assessment using the ICB Maturity Index Self-Assessment Tool. Key priorities and areas of focus have then been summarised in the ICB Intensive & Assertive Community Mental Health Treatment Review which was submitted to NHSE in September 24. The review has been an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, highlighting the strengths of our current community mental health service offer, but also the opportunities to make improvements via the development of a coproduced action plan for focused development in 2025/26.					
Key Issues to note	Safety is a key consideration in completing the review. The system has confirmed that DNAs (did not attends) are never exclusively used as a reason for discharge from care for this vulnerable patient group. As per national guidance the ICB has rapidly checked that existing service polices, and practice are clear on this issue and confirmed this to NHS England regional mental health team. The system must now produce a comprehensive action plan that addresses any areas identified as areas for improvement in addition the final discharge process.					
Key Risks:	***There is insufficient robustness in our psychosis care pathway to prevent future serious incidents involving this client group:*** 12 **Mitigation:** Assessment of the current pathway and its interfaces provided assurance of safety, quality and that adequate policies were embedded and adhered to. Development of the action plan will identify actions and/or initiatives					

<table>
<tr><td>Original Risk (CxL)
Residual Risk (CxL)</td><td>that can enhance the robustness of the pathway, support staff and interfaces across pathways and improve experience. This includes work to review the internal interfaces between GHC services i.e. Recovery and AOT and also exploring opportunities with VCSE partners. This is a significant issue, as service users move across services as clinical presentation changes. Residual Risk: 9

There is insufficient workforce to deliver the intensity and expertise required to safely manage people with psychosis who do not wish to engage with services: 12

The review and supporting guidance from NHSE identified steps that will need to be considered that could result in additional staffing being required within the community mental health workforce. The system will explore how current workforce and roles could be utilised differently and/or how training could support new ways of working and this work will need to be scoped further to mitigate the risk beyond its current score. Residual Risk: 12

The Dartmouth Fidelity Scale and ICB Maturity Index Self-Assessment Tool are based on 1990’s frameworks and will not provide sufficient improvement detail for a Transformed CMHT service: 12

GHC clinical and operational leads are reviewing the Dartmouth Fidelity Scale tool and have completed the ICB Maturity Matrix. The Dartmouth Tool is specific to AOT, and not to other teams treating psychosis. Locally we have developed a localised template that enables the tool to be utilised for a local clinical review, removing ambiguity, whilst ensuring a comprehensive review against the core principles of the tool/protocols. Residual Risk: 9</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>There have been no conflicts of interest in producing this review. If there are conflicts of interest identified, they should be managed in line with the Standards of Business Conduct Policy.</td></tr>
<tr><td>Resource Impact (X)</td><td><table>
<tr><td>Financial</td><td>x</td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>x</td><td>Buildings</td><td></td></tr>
</table></td></tr>
<tr><td>Financial Impact</td><td>The paper outlines the next steps to develop an action plan in response to the priority areas identified from the review. The system will prioritise mitigations, actions and assess financial impact, considering the potential additional resource i.e., workforce and investment in training that will be likely identified. NHSE have noted that additional investment has not currently been identified by the national team, but systems should share resource requirements with their regional team as the action plan is developed. Noting the key risks associated with the Maturity and Dartmouth tools, we may need a more suitable review methodology for modernised services.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td>None identified. Review via ICB Maturity Matrix aligned to core values of NHS Constitution.</td></tr>
</table>

Impact on Health Inequalities	At a national level, it is noted there is a risk that those with serious mental illness such as Schizophrenia (particularly with predominately negative symptoms) can be less visible to services and therefore often suffer poorer health outcomes. It is acknowledged that it is not possible to report true counts of psychosis for individuals in England. However, the 'Adult Psychiatry Morbidity Survey 2014' estimated a prevalence of psychotic disorders in the year prior of 0.7% in adults aged 16 and over. The 'Psychosis Data Report' (2017) outlines data that individuals from ethnic minority groups are statistically more likely to be diagnosed with psychosis. 14% of individuals newly diagnosed with psychosis will require rehabilitation services (Craig et al. 2004). The review highlights the need to ensure whole population data is available to support the self-assessment tool. The review also links to the Community Mental Health Transformation Programme and the work that has been undertaken with system partners to coproduce engagement and embed lived experience within codesign and decision making.		
Impact on Equality and Diversity	The review highlights the need to ensure whole population data is available to support the self-assessment tool. We are aware that our current caseload ethnicity profile is not in keeping with our community population profile. Initial work has been started within the Community Mental Health Team Transformation team and will require funding from April 2025 to continue. Assertive outreach teams are often tasked with minimising potential harms including harms to the individual and to others within the local community. Clinical decision making requires balancing each of these to find an optimal solution. Development of the action plan will therefore consider the impacts of our psychosis pathway, service delivery and balancing safety, with a person's Human Rights.		
Impact on Sustainable Development	None identified		
Patient and Public Involvement	The paper outlines the next steps to engaging with those with lived experience and the wider public. The system aims to coproduce an action plan with system partners and those with lived experience of serious and/or enduring mental illness.		
Recommendation	**The ICB Board is asked to:** • **Note the initial key findings of the completion of the ICB Maturity Matrix Tool, led by the Intensive & Assertive Task & Finish Group.** • **Support and recommend resources the next steps outlined to develop an Intensive & Assertive Community Mental Health Action Plan.**		
Author	**Sadie Trout** **Andrew Telford**	**Role Title**	Senior Programme Lead – Adult MH (ICB) Deputy Service Director – Community MH Services (GHC)

Sponsoring Director (if not author)	Benedict Leigh	Role Title	Director of Integrated Commissioning

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

1.0 Background

NHSE requires all ICB's to review their community services by Q2 2024/25 to ensure that they have clear policies, practice, and right care provision in place for patients with serious mental illness, who require intensive community treatment and follow-up particularly where engagement is a challenge. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want, or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

The collaborative approach by a multi-disciplinary task and finish group, including a range of system colleagues from across commissioning, community mental health teams, specialist services and including clinical and operational leaders, has provided a broad, honest, and open review of intensive and assertive mental health community provision provided by GHC across the county. Whilst it provides assurance to the ICB and NHSE regarding the comprehensive and safe service offered, it does highlight areas of improvement and opportunity that should be prioritised both in the short and longer term.

2.0 Key Themes from Task & Finish Review

The Intensive & Assertive Task and Finish Group completed the self-assessment over several workshops during September 24. Some of the sections are specific to Assertive Outreach Team(s) and other sections are applicable to all GHC services that treat people with psychosis (Recovery, GRIP, Specialist Community Forensic Team, Specialist Rehab and MHICT.) Overall, the initial self-assessment provided assurance that the cohort (outlined above) were well managed and able to support the complexities of treating people with severe and enduring mental illness, with no concerns or significant issues identified with regards to safety or quality of care.

2.1 Identified Strengths

• *Dedicated AOT*	• *Community Rehabilitation Offer*	• *Relevant Criteria in Place in Policy & Pathways*
• *Assessment Risk Assessment & Care Planning*	• *Improving Recruitment Picture*	

Unlike other systems, Gloucestershire benefits from a dedicated Assertive Outreach Team(s) delivered by GHC, that provides a recovery focussed, personalised approach. Operating across the county in 3 teams (North, South & West), the teams work with people with SMI, who require more regular professional help than mainstream mental health services, to help improve health and social function and achieve the best quality of life possible.

The system also benefits from a broad community rehabilitation offer, including a Specialist Treatment and Rehabilitation (STAR) Team, Supported Accommodation Service (SAS) and Specialist Community Forensic Team. Where our AOT Teams provide an 'assertive' function, the Community Rehabilitation Team offers the opportunity to work 'intensively' with individuals.

The clinical and operational review also identified that the relevant criteria in policy and pathways for the assertive outreach / intensive case management function in community service provision were in place across key patient pathways i.e., significant risk of persistent self-harm or neglect, high use of inpatient or intensive home-based care, difficulty in maintaining lasting and consenting contact with services.

Team awareness, knowledge, approach and delivery of assessment, care planning, risk assessment and safety planning were also considered a strength. The review particularly highlighted the positive impact of the roll out of My Care Plan to community services, further embedding coproduction with the individual and where possible their friends and family.

The review also noted, that although community mental health services continued to face clinical workforce recruitment and retention challenges, recruitment was improving, and vacancies were attracting good levels of interest from suitable candidates.

2.2 Areas of Opportunity

• *Improving Interfaces across pathways and between services*	• *Intervene more quickly and prevent relapse*	• *Discharge Processes*
• *Local Community Demographics*	• *Diversity Profile*	• *Embedding Lived Experience*

Interfaces within GHC services and across our pathways i.e., Learning Disabilities & Autism, Drugs & Alcohol is an area of opportunity that will be prioritised. Whilst the review identified clear pathways and processes within services, staff identified areas that could improve with sharing of information and clinical and/or operational practice. The review also highlighted the need to strengthen the interface with wider system partners i.e., VCSE, which will be supported by the roll out of community mental health neighbourhood teams but would benefit from a focus within the action plan.

The review also noted that there is opportunity to intervene quicker and prevent relapse. Strengthening interfaces, could go some way to support this, but revisiting our current team functions and dedicated service offers may identify solutions to assess and intervene more quickly and aim to reduce the length of time an intervention may be needed e.g., building on the strength of our community rehabilitation offer. There are

opportunities to extend the psychological intervention offer by upskilling of workforce in Family Intervention, Motivational Interviewing etc.

Discharge (both step up and step down) was highlighted as an area of focus and is supported by the Community Mental Health Framework and the CQC recommendations following the Nottingham report. We have assured the system and NHSE that DNA should never be used as a reason for discharge, but we can improve our policies by strengthening trust internal assurance processes, data sharing and building on the opportunities of embedding My Care Plan, ensuring discharge plan is also coproduced and information shared appropriately.

The review identified the need to develop plans that would provide further insight to our diversity pattern and local community demographics. As noted, developing a profile of people with psychosis where engagement is a challenge, is complex, but the action plan should explore opportunities with population health analytics and current caseload profiles, that could help staff to consider someone's history of using mental health services alongside changes in a range of factors around potential and additional support and drives decision making for people in need of intensive support.

The review acknowledged how lived experience was welcomed and pivotal to the codesign of pathways and services, but also was an opportunity in supporting how our services are delivered. It was suggested that the role of Peer Support Workers, those who have recovered from psychosis, could be key in developing our approach and management to those individuals who engagement is a challenge.

3.0 Next Steps

Following clinical review and in line with national guidance, the next step for the system will to be complete a detailed action plan that responds to the areas of opportunity outlined above. Coproduction of the action plan is key, to maintain a person-centred perspective and system ownership. The current Intensive & Assertive Task & Finish Group is currently developing an engagement plan that will ensure wider system partner representation, both lived experience and extended professional representation, to ensure the action plan is developed during Q4 24/25.

To further support the review and provide a comprehensive clinical review, staff from the Assertive Outreach Team will also engage with completion of the Dartmouth Assertive Community Treatment Scale (DACTS Fidelity Scale) which supports organisations to develop assertive community treatment through evidence-based review and improve outcomes for people with severe mental illness who are most vulnerable within our local communities. Completion of the DACTS Fidelity Scale will be undertaken concurrently across AO Teams within the county (North, South & West) during November/December 24.

The Intensive and Assertive Review remains a national priority and systems continue to report progress via their regional NHSE Team. The work programme will continue to report as per the ICB and GHC trust governance structures but will report directly to the ICS System Quality Committee for oversight and assurance.

3.1 Timeline

The high-level timeline below identifies the proposed next steps to developing a system Intensive & Assertive Community Mental Health Action Plan:

Completion of Dartmouth Assertive Community Treatment Scale (DACTS Fidelity Scale) across Assertive Outreach Teams.	October – December 2024
Intensive & Assertive Task & Finish Group Engagement Workshops	November – January 2024
Appoint dedicated clinical leadership resource for the GHC psychosis clinical pathway	December 2024
Implement Diversity and Inclusion Task and Finish group for psychosis within our communities	January 2025
Specify business intelligence requirements to identify those at risk of relapse or incident according to our clinical systems profile	February 2025
Intensive & Assertive Community Mental Health Action Plan developed and shared with system partners.	March 2025
I & A Community Mental Health Action Plan operational.	Expected delivery through Q1-2 2025/26.

Agenda Item 13

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Urgent and Emergency Care (UEC) Winter Plan**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X						
Route to this meeting	*Describe the prior engagement pathways this paper has been through, including outcomes/decisions:*						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Tactical Escalation Group & Strategic Escalation Group	18/11/24	Strategic Executive	19/11/24			
Executive Summary	The purpose of this paper is to present Public Facing Winter Plan 24/25 (see **Appendix A**). The plan has been developed collaboratively with system partners and co-produced with the UEC People and Communities Reference Group. The audience for the plan is the general population of Gloucestershire, however there will be bespoke communications for specific groups and communities which are being developed as part of the planned communications campaigns this winter including an Easy Read version of the Winter Top Tips. The focus of the plan is prevention and early intervention, supporting the public to avoid the need to attend Emergency Departments where possible. Accessing the right support, at the right time, in the right place, closer to people's homes and communities.						
Key Issues to note	The plan follows a similar model to last year's winter plan, however new additions include: - • Top tips for this winter. • Focus on prevention and staying well. • New section on support for unpaid carers. • An enhanced NHS 111 to access urgent support for both physical and mental health issues. • Highlighting innovations such as extended virtual wards, pharmacy first and support for vulnerable children in hospital delivered by Young Gloucestershire. • "Did you know?" feature with data to support prevention and early intervention. There has been extensive engagement both within the ICB and with system partners to develop the content. In addition, the UEC People and Communities Reference Group have played a key role in helping to shape this report.						

Key Risks:	The plan is low risk, however promoting access to community services may lead to an increase in use.			
Management of Conflicts of Interest	No conflicts of interest declared.			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	No financial impact as the plan highlights existing services.			
Regulatory and Legal Issues (including NHS Constitution)	The plan supports existing NHS Gloucestershire ICP KPIs and both national and local drivers.			
Impact on Health Inequalities	Significant engagement with different groups and communities will help to address health inequalities through bespoke communications.			
Impact on Equality and Diversity	Positive impact, due to the work with groups and communities to communicate key messages, this includes: - • Cheltenham, Sahara Saheli Women's Group – group of up to 20 women from lots of different countries, many of them are Muslim • Women's Group, Friendship Café – all the women are Muslim • Ebony Carers – around 60-80 Black Elders • Gloucestershire City Misson, those facing homelessness • Traveller community • 5 Partnership Boards – Learning Disability, Physical Disability and Sensory Impairment, Autism, Mental Health and Wellbeing, Carers. A separate Easy Read version of the Winter Top Tips has been commissioned via Inclusion Gloucestershire.			
Impact on Sustainable Development	No impact anticipated			
Patient and Public Involvement	The Winter Plan 24/25 has been co-produced with the UEC People and Communities Reference Group (PCRG), chaired by Albert Weager and the UEC Clinical Programme Group (CPG).			
Recommendation	**The Board is requested to:** ⇒ **Note the contents of the public facing Winter Plan 2024/25.**			
Author	**Eve Olivant**	**Role Title**	**Director of System Flow**	
Sponsoring Director (if not author)	**Ellen Rule, Deputy CEO / Director of Strategy and Transformation**			

Appendix A: Winter Plan 2024/25

One Gloucestershire
Transforming Care, Transforming Communities

Working as One
Prevention | Support | Redesign

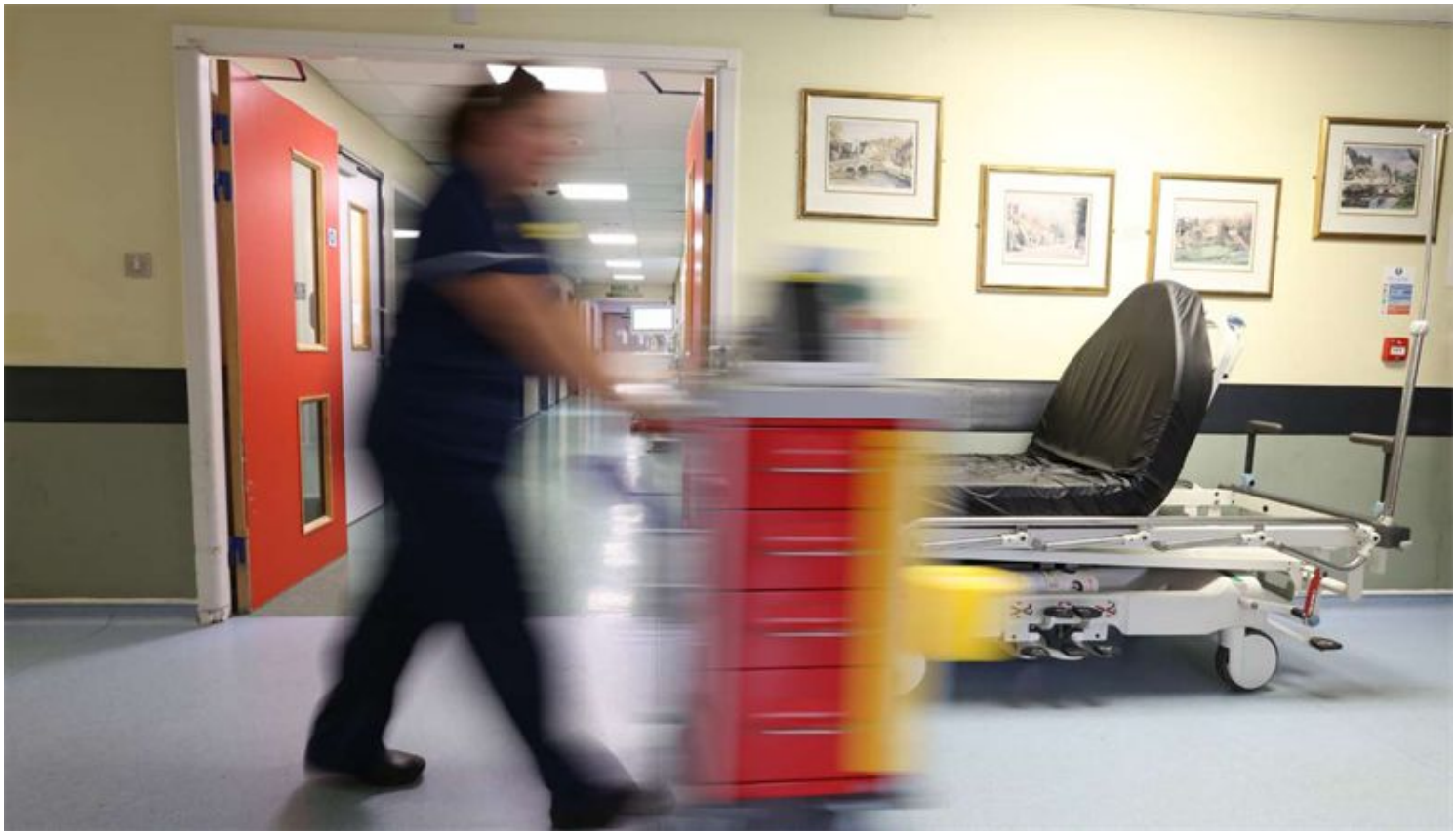
One Gloucestershire
Winter Pledge

One Gloucestershire
Integrated Care System (ICS)

Winter Plan

2024/25

Contents



Forewords

Albert Weager
Chair of the Urgent and Emergency Care People and Communities Reference Group

As chair of the UEC People and Communities Group it is my great pleasure to share the Winter Plan for 2024-25.

Continuing good health and wellbeing is most welcome for us all as our healthcare providers face challenging times in their quest to offer us all safe, high quality, care, as needs arise this coming winter.

What can we all do for ourselves and with others to sustain or acquire good health and wellbeing, to prevent or reduce healthcare needs happening? It's very much about us, our lifestyle choices and opportunities and making the ones which will be best for ourselves and our loved ones. Loneliness is as bad for our health as smoking up to 15 cigarettes a day*. Why not have a cup of tea with your neighbour or see what's on in your local community. In our communities there are isolated, lonely people, for whom social interactions are very important for their health and wellbeing.

The focus of the plan is on prevention and staying well, the plan offers up-to-date information on how to keep healthy and well this winter and offers "top tips". The intent is to provide the right care, at the right time, in the right place as close to home as possible.

I am reminded of a quote by Helen Keller a US author and human rights activist who said, "Alone we can do so little; together we can do so much." I'd like to challenge you to think about what you can do to support your family, friends, and neighbours to stay healthy and well this winter.

*https://www.who.int/groups/commission-on-social-connection

Dr Ananthakrishnan Raghuram
Chief Medical Officer

Dr Helen Mansfield
Urgent and Emergency Care Clinical Lead

We are delighted to share Gloucestershire's Winter Plan for 2024-25 and are proud of the collaborative work between people, places and wider integrated health and care system in Gloucestershire.

This plan gives you a fantastic overview of local services to support you during the winter months and will provide guidance on how to access the right services in the right place.

We know from our work both in the hospital and in the community that many services are over stretched, but by following our 'Winter Top Tips' you can access support, where possible, closer to home.

Try to encourage your friends and family to stay up to date with seasonal vaccinations, look out for the new Pharmacy First service which is an innovative healthcare service designed to provide immediate access to essential clinical treatments without the need for a GP appointment.

Did you know?

By focusing on education and exercise, people with respiratory illnesses can often feel much better. Find local activities in your local area here: **www.nhsglos.nhs.uk/your-health-services/healthy-communities/live-well**

Top tips for this winter

Unless it's an emergency we recommend that you access the Gloucestershire ASAP website (www.asapglos.nhs.uk). ASAP can help you to search by both adult and child conditions, or by service.
We want you to get the right support in the right time at the right place.

1. **Stay Well This Winter** - Whether it's advice and support to boost your immunity, keep warm, prioritise your mental health, eat well, stay active or look out for vulnerable family, friends and neighbours, Stay Well This Winter provides a link to top tips and a wealth of information and resources www.onegloucestershire.net/campaigns/winter/

2. **Carers Support** - If you help to look after a family member or friend you are a carer and can access support call 0300 111 9000 Monday, Wednesday and Friday 9.00am – 5.00pm, Tuesday and Thursday 8.00am – 8.00pm or visit www.gloucestershirecarershub.co.uk

3. **Mental Health Support** - If you or someone you know needs help in a mental health crisis, call NHS 111. If you have a hearing impairment, please text 07775 510 693 (7.00am to 9.30pm) or 07768776863 (9.30pm to 7.00am).

4. **Find Local support - Pharmacy First** - Did you know that you can ask your local pharmacy for help? They offer confidential consultations for many common illnesses and can provide information about the medicines. Your local pharmacy will also be able to give you specialist advice and help to signpost you to the right services. www.nhs.uk/service-search/pharmacy/find-a-pharmacy

5. **GP Surgeries** can support with a whole range of physical and mental health needs, as well as social prescribing, personalised care, medicines management etc. We recognise that GP services are stretched so, where possible, try to use other services first.

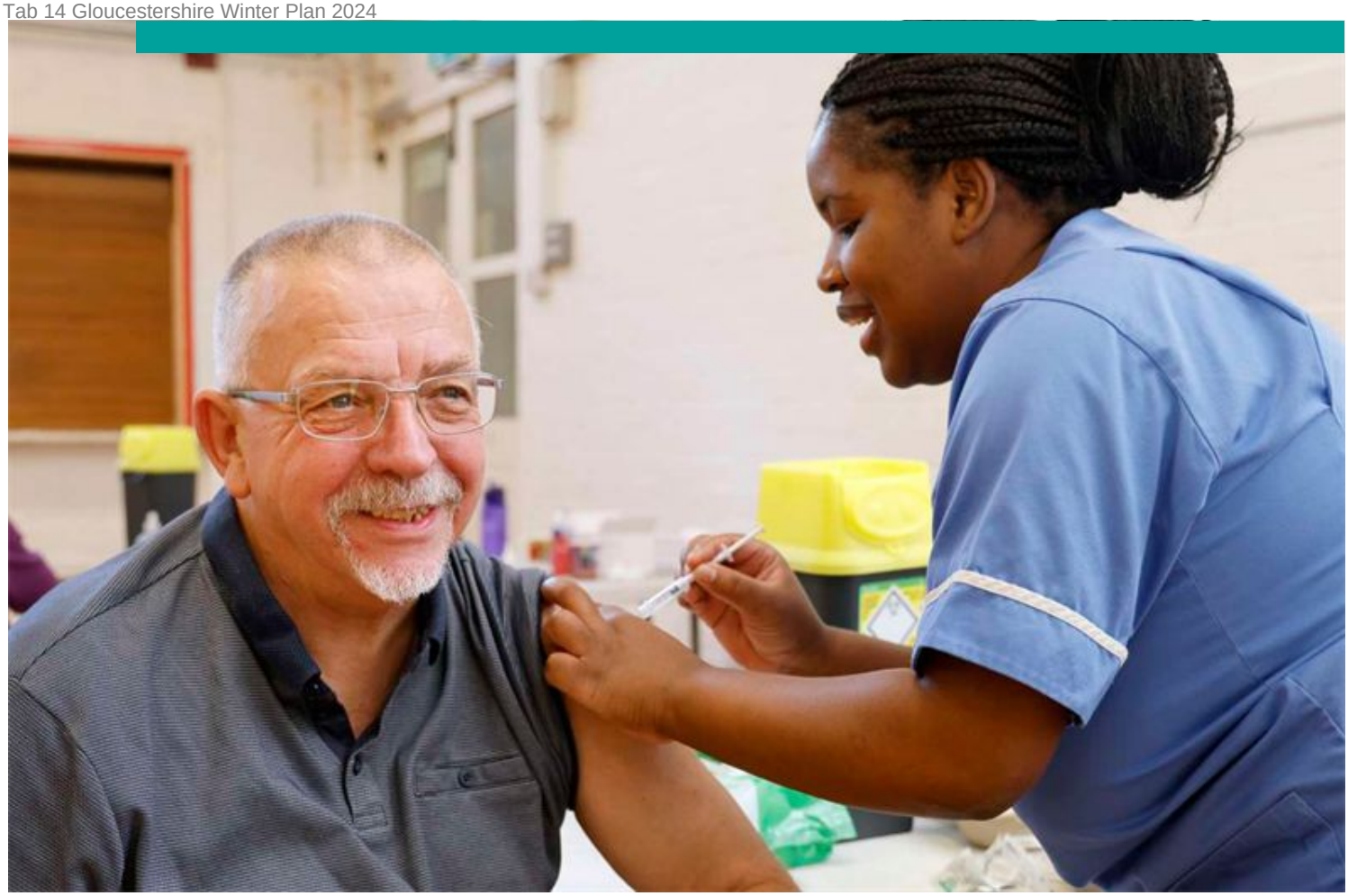
6. **NHS 111** - Use 111 by telephone or online when you need medical help quickly but it's not a life-threatening emergency they will refer or book you into the most appropriate services.

7. **999** - Only dial 999 if you really need to. There are lots of alternatives to a 999 call for situations that, while urgent and important, can be helped quickly by one of our other services. Please see Section 3 of the plan for when to use 999.

8. **Emergency Departments (A&E)** - These are for patients with serious injuries and illnesses. Using other services before considering visiting one of the emergency departments helps us to prioritise the most unwell patients. Patients with less serious needs can be supported well by the services above.

What is in this winter plan?

One Gloucestershire Winter Pledge



Prevention - Keeping you healthy and well

Staying healthy and well

Store some home remedies in your medicine cabinet e.g., paracetamol, stomach treatments, throat lozenges, etc. Keep warm and hydrated and try to avoid travelling in bad weather. Please see government advice advice: www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather/top-tips-for-keeping-warm-and-well-this-winter

Vaccinations

It is really important to stay up to date with your vaccinations this winter. The flu viruses can change from one winter to the next. If you want the latest information on vaccinations please visit: https://www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/vaccination/

Did you know?

To protect yourself from respiratory viruses (coughs, colds and flu): -

- Get vaccinated.
- Let in fresh air if you are meeting people indoors.
- Wash your hands.
- Cover your coughs and sneezes.
- Clean your surroundings.

Colds, coughs and ear infections in children

Please see this helpful advice about how to treat colds, coughs and ear infections in children: https://www.nhs.uk/conditions/baby/health/colds-coughs-and-ear-infections-in-children/

Community blood pressure and health checks

The Check Your Blood Pressure campaign urges everyone, particularly those aged 40 and over, to get a blood pressure (BP) check to find out their numbers and start making healthy lifestyle changes or taking medicines if needed to help bring their blood pressure down.

There are several ways for people to access a blood pressure check, including at a local pharmacy, at a community drop-in event, or at their GP surgery. Some people may also wish to check their BP at home with a home blood pressure monitor. To find out more information please see: https://www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/cardiovascular/blood-pressure-know-your-numbers/

Keep your care plans up to date

If you have a long-term condition or a disability, it's important to keep your care plans up to date. For example, hospital passports are an easy read communication tool which can help healthcare professionals to understand people with disabilities needs. www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/learning-disability/annual-health-checks

Annual health checks

If you are over 75, have specific long-term conditions (https://www.nhs.uk/conditions/nhs-health-check) or are registered as having a Learning Disability (https://www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/learning-disability/annual-health-checks), Autism or a Serious Mental Illness, you are entitled to have a physical health check at your GP Practice every year.

Having an annual physical health check means that there is a better chance of a spotting physical health problems early, when they are simpler and easier to treat.

Advanced care planning

Advance Care Planning is an umbrella term covering personal, legal, clinical, and financial planning. It enables a person to think about what matters to them and plan for their future. www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/palliative-and-end-of-life-care/planning-ahead

COMMUNITY PHARMACY GLOUCESTERSHIRE

Primary Care

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

Community Pharmacies

Community pharmacies can provide services to support and treat minor illnesses, including both ongoing and emergency hormonal contraception, advice on medicines, and blood pressure checks.

Pharmacy First

Pharmacy First is a service that enables community pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions without the need to visit a GP. The seven conditions are:

- Sinusitis (adults and children aged 12 and over)
- Sore throat (adults and children aged over 5 years)
- Earache (anyone aged between 1 – 17 years)
- Infected insect bite (anyone aged 1 year and over)
- Impetigo - a bacterial skin infection (anyone aged 1 to 17 years)
- Shingles (adults aged 18 and over)
- Uncomplicated urinary tract infections in women (females aged 16 – 64 years)

You can get treatment for these conditions by walking into a pharmacy, via a formal electronic referral from your GP surgery team or via NHS111.

Many pharmacies have extended hours, and no appointment is needed. They can also advise if another local NHS service is needed.

Click nhs.uk or the ASAP Glos NHS website or app for locations and opening hours.

Did you know?

We have 105 pharmacies in Gloucestershire, and all of them have a consultation room for you to have a 1:1 private conversation with a member of our pharmacy team. To find your nearest pharmacy please see https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy

GP Surgeries

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

NHS Dentistry

It's important to look after your teeth and the people you care for. To find out how to register with a NHS dentist, you can visit www.nhs.uk

There are now urgent care appointments available each week at clinics across the county, including weeknight and weekend clinics. Patients can access these appointments by contacting NHS 111.

Last year, we invited dental practices to provide additional appointments for patients not registered with a dental practice to help them avoid the need for frequent urgent support. Over 200 additional appointments, which may include follow-up appointments, are now provided each week.

Urgent Eye Appointments

Did you know that you can get access the Urgent Eye Care Service if you have one of the following symptoms:

- Red or painful eye or eyelids
- Recently occurring flashes or floaters
- Recent and sudden loss of vision
- Foreign body in the eye.

For a full list of optical practices please visit: www.primaryeyecare.co.uk/find-a-practice

Did you know?

A 2023/24 report showed that only 29.5% of adults and 50.7% of children in Gloucestershire had been seen by an NHS dentist in the last 1-2 years.

Primary Care Pledges

One Gloucestershire Winter Pledge

Pharmacies:

- We will continue to work with our community pharmacies to provide as mu pharmacy-based care as possible appropriate to people's needs, including usi g the Pharmacy First for many common conditions.
- We will provide services to support and treat minor illnesses, including ongoing and emergency hormonal contraception, advice on medicines, and blood pressure checks.

GP Practices:

- We will continue to work with our general practices to provide free vaccinations at the heart of our local communities to those who are eligible, such as people with 'at risk' clinical conditions, and people in areas of known health inequalities.
- We will further support people where possible with their medicines.
- GP surgeries will work together to offer additional appointments on weekday evenings and Saturdays.

Dental:

- We will continue to increase the number of urgent appointments and follow up courses of treatment available each week in locations across the county.
- We will continue to work with existing dental practices to improve access to NHS dentistry making sure more appointments are available starting in areas of known health inequality.

First Response Services

Integrated Urgent Care Service - NHS 111

From November, a new enhanced 111 service will bring together NHS 111 with a new Clinical Assessment Service (CAS) and GP out-of-hours services in Gloucestershire. This service will play a key role in providing urgent care advice and support across the county and can be accessed 24/7 by calling 111, contacting NHS 111 online – www.111.nhs.uk or using the NHS App. The Clinical Assessment Service (CAS) will provide clinical telephone and video consultations for patients and support to healthcare professionals in the community

The service provides advice, signposting and booking into the most appropriate service if required. This may include:

- Pharmacy
- GP surgery
- Community Minor Injury and Illness Units
- Other services such as urgent dental services, mental health practitioners and community nursing
- Emergency Department (but please continue to dial 999 in an emergency)
- Home visits (where clinically appropriate)
- Voluntary sector organisations.

Did you know?

What is an emergency?

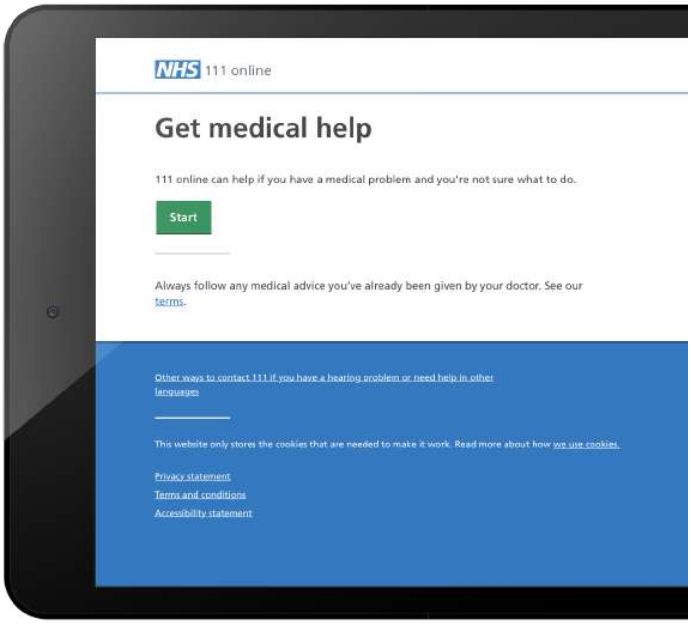
Phone 999 when you have:

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

Emergency Prescriptions

Did you know if you have run out of prescribed medicine and need some urgently, you can call NHS 111 or use NHS111 online (www.111.nhs.uk). If you get your medicine with a repeat prescription, you can use the 111 online emergency prescription service.

They will ask some questions, including where you are and when you are due to take your medicine so they can suggest the best way to get it. They may refer you to a pharmacy to get your medicine.



South West Ambulance Service NHS Foundation Trust (SWASFT)

The ambulance service provides paramedics and vehicles to accidents and emergencies, and much more besides.

As well as taking people to emergency departments if needed, the ambulance service carries out 'hear and treat' responses over the phone and provide 'see and treat' paramedic services in people's homes, avoiding taking people to hospital when it's not needed.

Paramedics are also able support patients, where appropriate directly to specialty assessment services including Same Day Emergency Care, Frailty Assessment Unit, Surgical Assessment Unit and Stroke services.

Only call 999 if you have an emergency or life-threatening situation and use the ASAP app or website (www.asapglos.nhs.uk) or call your GP Surgery, NHS 111 or visit one of our Minor Injury and Illness Units.

Community and mental health services

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

Minor Injury and Illness Units (MIIUS)

To support people's physical health, we have seven Minor Injuries and Illness Units (MIIUs), based in our community hospitals, open to walk-in patients or appointments can be booked through the NHS 111 service.

Minor Injury and Illness Units are open every day 8.00am to 8.00pm
(final appointment and walk-in at 7.30pm at the Community Hospitals)

- Cirencester Hospital
- Forest of Dean Hospital (Cinderford)
- North Cotswolds Hospital (Moreton in Marsh)
- Stroud General Hospital
- Tewkesbury Community Hospital
- Vale Community Hospital (Dursley)
- Tetbury Hospital
  (8am to 6pm – Monday to Friday)*
- Winchcombe Medical Centre
  (8am to 6.30pm, Monday to Friday)*

**Please note different opening times. Both services ask any patients to attend no later than 30 minutes before they are due to close.*

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

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

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

Mental Health Support

It is estimated that one in four adults and one in 10 children experience mental illness at any one time and many more of us know and care for people who do.

Mental health problems are common, and they affect thousands of people in the UK as well as friends, family, and work colleagues. Don't let perceptions of the social stigma attached to mental ill health stop you from coming forward and getting the help you need.

There are many ways the NHS, and the voluntary sector, work together to care for people with mental health concerns and crises:

Where to go for help for adults:

- Be Well Gloucestershire is a local campaign supported by the Gloucestershire system aimed at promoting health and wellbeing support. www.bewellglos.org.uk
- Mental Health Crisis team – call NHS 111 or use NHS111 online (www.111.nhs.uk) available 24 hours a day, 7 days a week. If you are hearing impaired, please TEXT: **07775 510 693** 7am – 9.30pm or **07768 776 863** 9.30pm – 7am
- Samaritans, if someone is experiencing feelings of distress or despair call **116 123**.
- The Stay Alive App (www.stayalive.app), packed full of useful information and tools to help you stay safe in crisis.
- Gloucestershire Connect and Offload Helpline (www.gloucestershirecando.org) - supports adults living in Gloucestershire who are experiencing mild to moderate wellbeing difficulties, such as anxiety, low mood or depression, including support for self-harm. They also provide support and information to friends, family, carers and professionals. Telephone: **0808 801 0606** Text: **07537 410 022**
- Shout – 24/7 text service for anyone in crisis – text **85258** (free on all major mobile networks)
- The Silver Line (supporting older people – **0800 470 8990** (free)
- Some GP surgeries work with dedicated primary care Mental Health workers.
- The Cavern (Gloucester) - mental health drop in (18+) and is open 6pm-10pm 365 days a year.

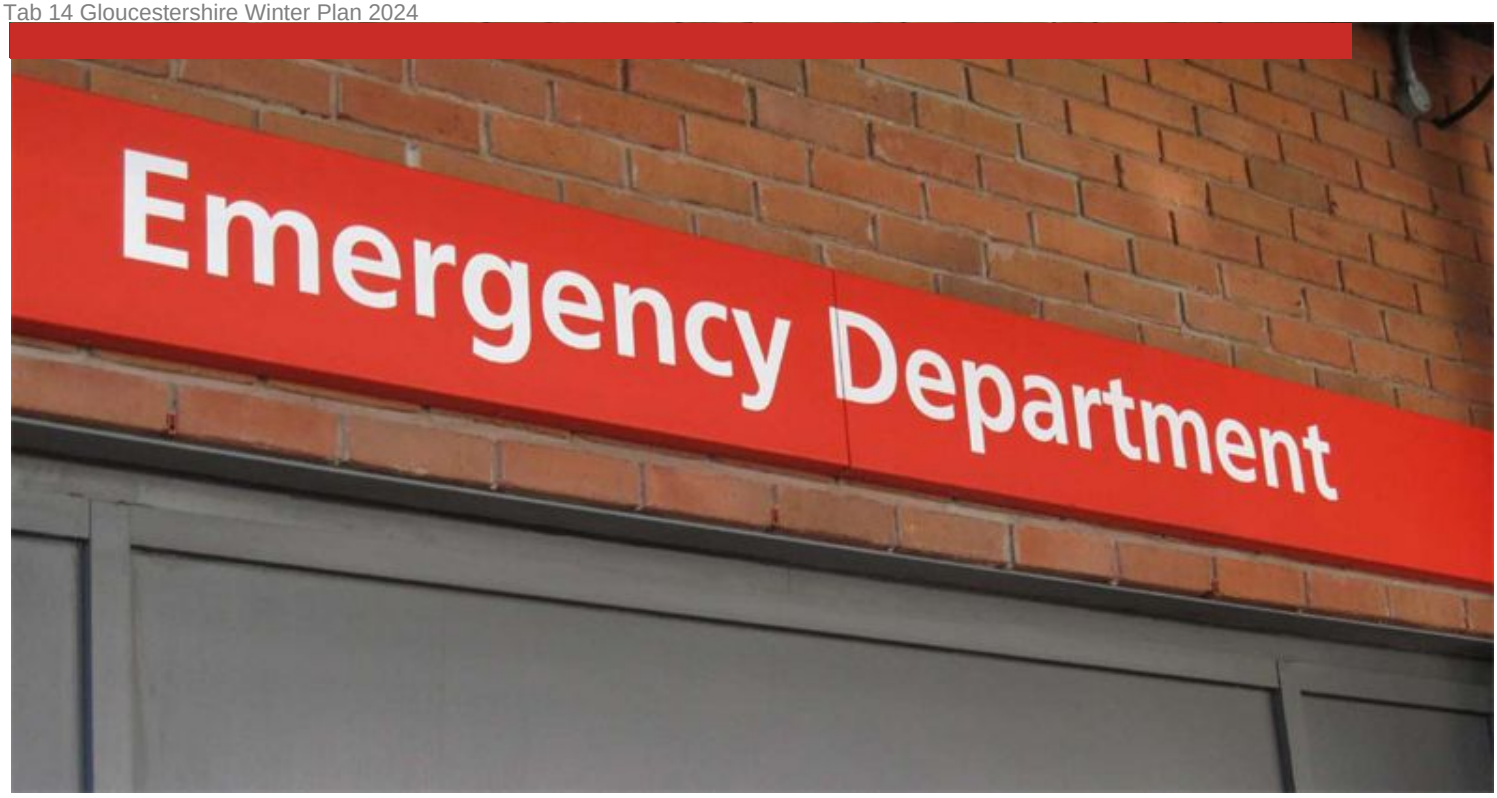
For children and young people:

- On Your Mind Glos - www.onyourmindglos.nhs.uk
- Childline – **0800 11 11** (free)
- Tic+ is a Gloucestershire-based charity which provides confidential counselling, support and care for young people and their families. For more information visit: www.ticplus.org.uk or call: **01594 372777**
- Tic+chat is an anonymous, safe, confidential 1-2-1 live message chat support service for young people aged 9-21 living in the county open Sunday – Thursday 5pm – 9pm at standard network local rate accessed via www.ticplus.org.uk or by calling: 0300 303 8080.
- Tic+ Parent and Carer Support including support groups, family counselling information and online chat service is available www.ticplus.org.uk or by calling: **0800 625675**
- The Cavern (Gloucester) – mental health drop in (under 18s) open 5pm-9pm, 365 days a year.

Mental Health services winter pledges

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

One Gloucestershire Winter Pledge



Cheltenham and Gloucester Emergency Departments (A&E)

We will do everything possible to keep the length of time people spend waiting in the Emergency Department (A&E) as short as possible and will also reduce the chance that someone will be admitted for an overnight stay when they don't need to.

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

We will work hard to prevent the spread of infections and only restrict visits to wards where it is unavoidable, if there are risks of infection, notably from flu, norovirus (vomiting bug) or other seasonal illnesses including COVID-19. These illnesses can make patients more ill and impact the health and availability of our staff.

Care in our hospitals

- People will have their conditions and care reviewed by the most appropriate experts, including doctors, nurses and therapists, every day of the week. We will ensure as much diagnostic testing is requested earlier in the day, to make timely decisions about the best place for people's ongoing care or whether they are ready to go home.
- We will work hand-in-hand with our colleagues in the community and social care to ensure people can go home or to a more appropriate place to finish their recovery.

Virtual Wards

For some people, being supported in a virtual ward at home is a better option than going into hospital. A virtual ward allows you to get the care you need at home, safely in familiar surroundings, whilst still receiving the support that you need to help you recover from an illness.

Being on a virtual ward means that you will have a care plan that will be designed specifically for you. You will receive a home monitoring kit and depending on your care plan, you may also receive regular phone calls, be visited in your home, or asked to visit a health care setting.

We now have virtual wards for:

- Respiratory
- Frailty
- Heart Failure
- Acute General Medical
- Oncology
- Surgery
- Rapid Response Shared Care.

Supporting Young People

Gloucestershire Royal Hospital now hosts youth workers from Young Gloucestershire on the children's ward.

These specialised professionals are equipped to offer essential support and guidance to young people aged 11-16 years who are admitted for their safety due to mental health concerns.

Hospital winter pledges

One Gloucestershire Winter Pledge

- We will use our range of Same Day Emergency Care (SDEC) services as much as possible every day of the week to reduce pressure on our Emergency Departments (A&E). This will also help how quickly we transfer people from ambulances into hospital to ensure they get the most appropriate care as soon as possible, and to help ambulances get to the next person that needs them.
- We will ensure people with specific conditions are cared for by the right people as quickly as possible. For example, by guiding people to facilities such as:
  - Anyone attending A&E with mental health concerns (regardless of physical health issues) will be able to access a specialist assessment within 45 minutes on average. This service, one of only three of its kind in England, is available 07.00 – 19.00 every day; during the winter we have an ambition to increase this towards a full 24/7 service.
  - 'Virtual Wards' (increased from 50 spaces last year to 223 by December), notably for people affected by frailty and respiratory conditions, and people who have had a stroke.
  - We will ensure children and pregnant people are directed to the most appropriate area if not the Emergency Department.
- We will focus on increasing our discharges across all seven days of the week and will prepare information and medication for you to go home, as early as possible in the day.

Adult Social Care

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

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

To find out more about adult social care in Gloucestershire visit www.gloucestershire.gov.uk/health-and-social-care/adults-and-older-people/finding-the-right-information-and-support/information-advice-and-services-to-manage-your-care-and-stay-independent/adult-social-care-helpdesk

Our key priorities this winter are:

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

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

Did you know?

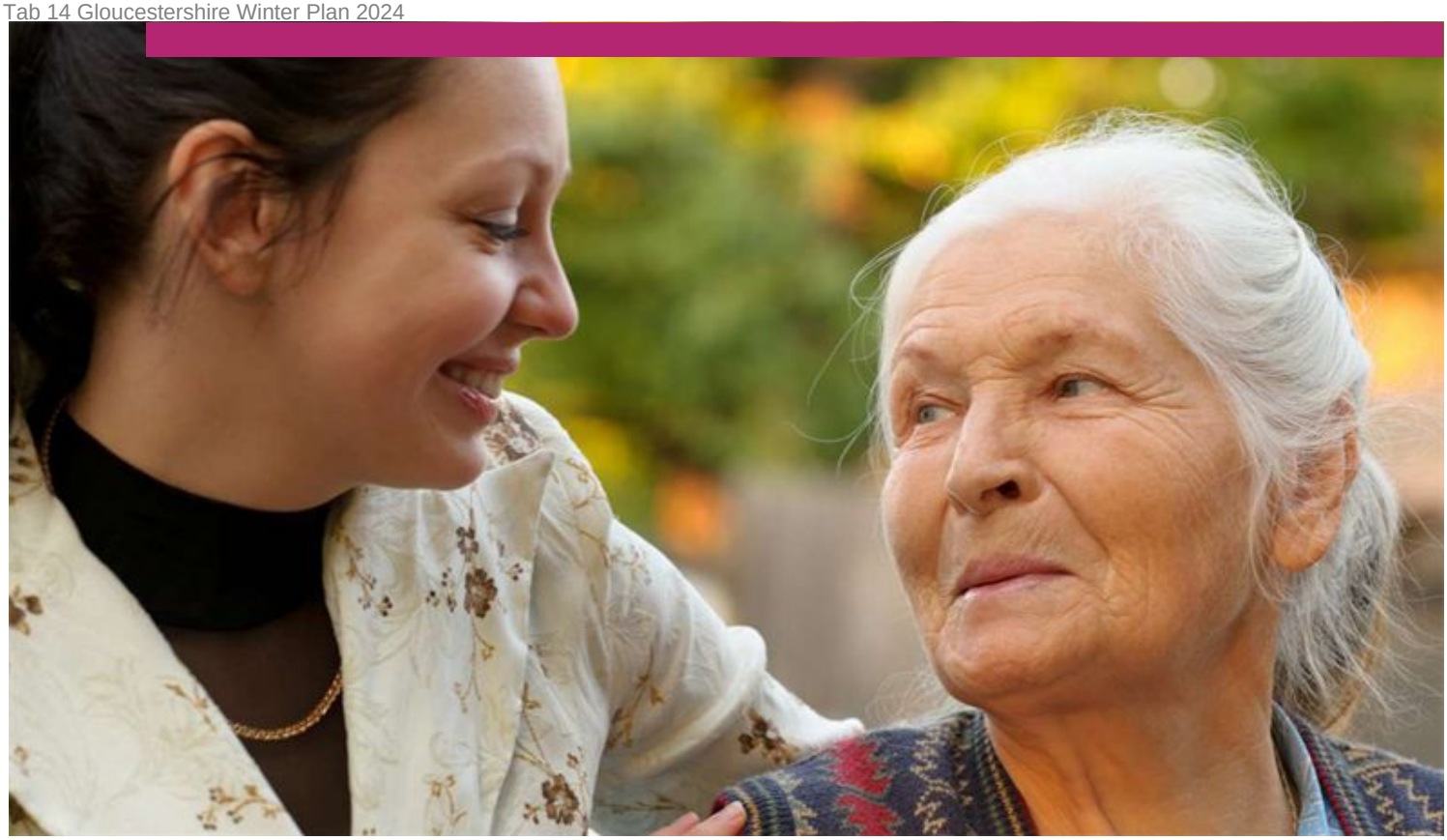
You can hand back unwanted equipment to the Gloucestershire Equipment Loans Service (GELS) who will clean and fully refurbished the equipment ready to loan it out to someone else. To find out more visit www.gloucestershire.gov.uk/gloucestershire-equipment-loan-service.

Social Care winter pledges

One Gloucestershire Winter Pledge

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

You can get independent advice about paying for care via the Care Advice Line for Gloucestershire by visiting www.thecareadviceline.org or calling 01452 222200



Support for Unpaid Carers

"An unpaid carer provides support or looks after a family member, partner or friend who needs help because of frailty, physical or mental illness, addiction, or disability." Unpaid carers are an essential part of our health and care system, they contribute an annual £162bn to the economy across England and Wales (Petrillo and Bennett, 2023).

In Gloucestershire, we have approximately 52,000 carers with 7,000 young carers.

The Gloucestershire Carers Hub offer support to unpaid carers, and you can request support at any time. Once you have registered you can have as little or as much contact you need. The Hub provides the following support:

- Information, Advice and Guidance
- Wellbeing support
- Signposting to other services
- Contingency Planning Support
- Benefits and financial advice
- Full Carers assessments, support planning and reviews Gloucestershire Carers Hub have the delegated responsibilities to do Care Act assessments on the behalf of Gloucestershire County Council
- Access to groups
- Training, social gatherings and activities
- Access to the Carer Aware Discount Scheme
- Professional counselling service
- Buddy Up
- Employment support.

Gloucestershire Carers Hub offer a safe space to talk about you and your caring role, we will work with you to identify how we can support you. We are here for you when you need us and can act as a listening ear when you need one. To find out more, call 0300 111 9000 Monday, Wednesday, and Friday 9.00am – 5.00pm, Tuesday & Thursday 8.00am – 8.00pm or visit www.gloucestershirecarershub.co.uk

"I am feeling more in control in a sense that I know who I can go to for help and support, and that is down to the Carer's Hub. I now know that I am entitled to support as a carer and that makes a big difference, knowing that I am allowed to ask for help and that it's OK to ask".
(Quote from an unpaid carer)

Young Carers

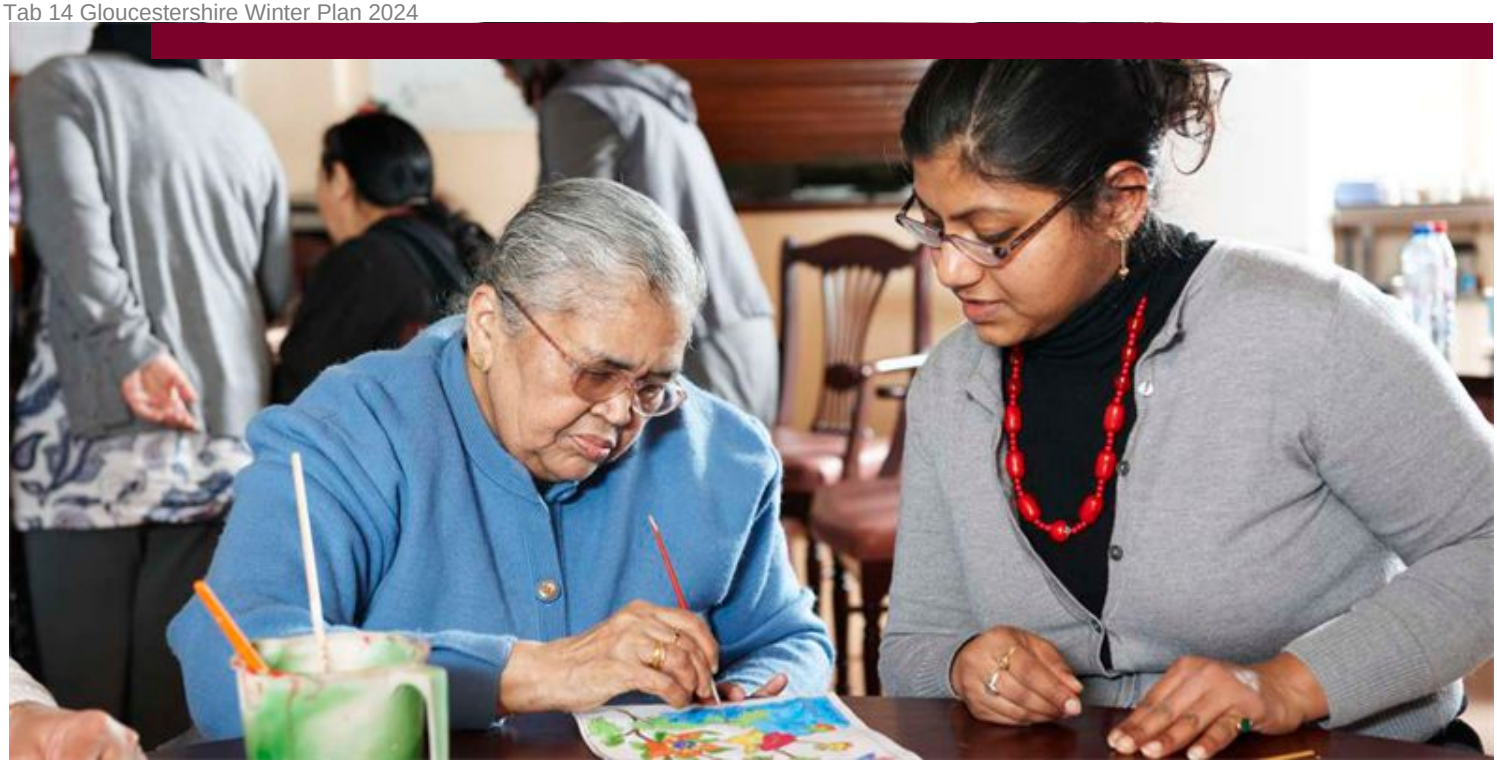
If you are a child or young person who helps to look after someone, Gloucestershire Young Carers can provide information and support. Please contact **01452 733060** or go to www.glosyoungcarers.org.uk/contact-us

Unpaid Carer winter pledges

Carers Partnership Board have developed 6 key priorities for us to help support carers in Gloucestershire, we want to ensure that unpaid carers can be:

- **Heard** – to identify, support and act on feedback.
- **Recognised** – to be carer aware.
- **Informed** – to have relevant information and advice.
- **Prepared** - to have plans in place for the unexpected.
- **Connected** - to help reduce loneliness and improve wellbeing.
- **Reached** – to provide the right methods of communication and help to access online support.

One Gloucestershire Winter Pledge



Support in your community

Social Prescribing

Support for non-medical needs that impact our health and wellbeing is sometimes referred to as Social Prescribing. In Gloucestershire, the health and care sector work closely with the voluntary sector to ensure we understand what is important to an individual and then make necessary connections so that the person can access the support they require.

We also know that engaging in meaningful activity in our community can support people in making connections and keeping well when they have health conditions. In Gloucestershire we have a range of creative health interventions that support people with a range of medical needs to build their self-management skills and develop a network of peer support in their community. You can find out details of how to self-refer through www.gloscreativehealth.org

Voluntary Community and Social Enterprise (VCSE)

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

Online Directory of Services

You can access lots of information about these services and support at www.yourcircle.org.uk, an online directory provided by Gloucestershire County Council. This website can help you find your way around care and support and connect with people, places, and activities in Gloucestershire.

Examples of just some of the services the VCSE provide include: -

- **Warm Spaces** - The Warm Welcome Campaign helps to connect people to welcoming community spaces. A Warm Welcome Space is a great place to share a cuppa, connect with others, and make new friends. https://www.warmwelcome.uk
- **The Cavern** - As an independent coffee shop, they provide great drinks, fresh food, and a lively environment. The Cavern is a space that facilitates mental health support in the evenings and provides valuable training to volunteers throughout the day. 56 Westgate Street, Gloucester, GL1 2NF (round the corner from the cathedral). Opening Hours: Monday to Saturday: 10am – 10pm. Sunday: 12 (midday) – 10pm (see Mental Health section for details on drop ins).
- **Age Concern** - Age UK Gloucestershire offers advice and support for older people, their families and carers please visit: www.ageuk.org.uk/gloucestershire

Community Support Winter Pledges

One Gloucestershire Winter Pledge

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

Glossary of Services

Organisation	What they provide	Where they provide it
GP surgeries	Broad diagnosis, treatment, and care of non-emergency illness. Support and decisions to refer patients to specialist services in other organisations. Long-term care and supporting self-care.	Through GP surgery premises across the county, and their branch sites. Via the Out of Hours service. More help available at: www.asapglos.nhs.uk
Gloucestershire Health and Care NHS Foundation Trust (GHC) www.ghc.nhs.uk	District nursing. Health services, clinics and therapies. Inpatient care, rehabilitation, Minor Injury and Illness Units. Mental Health assessment, treatment and care services.	In people's homes. At NHS clinic sites around the county. At community hospitals. At mental health specialist centres and hospitals.
Gloucestershire Hospitals NHS Foundation Trust (GHT) www.gloshospitals.nhs.uk	Specialist medical treatment and care, and diagnostics. Emergency departments for the most urgent and serious injury and illness.	At Cheltenham General Hospital and Gloucestershire Royal Hospital.
Gloucestershire County Council (GCC) www.gloucestershire.gov.uk/health-and-social-care/	Social care services. Domiciliary care visits. Carer assessments.	In people's homes. In the community. In care homes.
Community Pharmacies www.nhs.uk/service-search/pharmacy/find-a-pharmacy	Services to support and treat minor illnesses, including emergency and ongoing hormonal contraception, advice on medicines, and blood pressure checks.	In the community.
South West Ambulance NHS Foundation Trust (SWAST) www.swast.nhs.uk	999 call handling. Ambulance and paramedic prioritisation and despatch. Transfer of patient care appropriate for other services.	Ambulance main hub, local ambulance stations, a range of ambulance vehicles and in people's homes.
Voluntary, Community and Social Enterprise (VCSE) organisations www.glosvcsalliance.org.uk/	Ranges from small community-based groups/schemes through to larger registered Charities that operate locally, regionally & nationally.	Within communities and peoples' homes and health and social care facilities.
E-zec e-zec.co.uk/our-services/	Non-emergency patient transport services.	Non-emergency ambulance vehicles.
Gloucestershire Integrated Care Board (ICB) www.glosnhs.nhs.uk	Oversight and commissioning (purchasing) of all health and care services for Gloucestershire. Gloucestershire Integrated Brokerage.	

Terms and acronyms

These are some of terms you may hear if you use our Urgent and Emergency Care services this winter:

A&E	Accident & Emergency, operated from our acute hospital Emergency Department
ARRS	Additional Roles Reimbursement Scheme, expanding types of roles in primary care
ASC	Adult Social Care, a function of Gloucestershire County Council
CAS	Clinical Assessment Service
CATU	Community Assessment & Treatment Unit (Older Person)
CGH	Cheltenham General Hospital, one of our two acute hospitals
CPG	Clinical Programme Group
CYP	Children & Young People
D2A	Discharge to Assess
DTA	Decision To Admit (to hospital)
DoS	Directory of Services
EAC-I	Enabling Active Communities and Individuals – promoting healthy lifestyles
ED	Emergency Department, dealing with the most serious injuries and illness
EPR	Electronic Patient Record
FAU	Frailty Assessment Unit – a dedicated unit to assess underlying frailty
G-care	Online point of clinical reference for Gloucestershire clinicians
GP	General Practitioner
GRH	Gloucestershire Royal Hospital, one of our two acute hospitals
GELS	Gloucestershire Equipment Loan Service
HALO	Hospital Ambulance Liaison Officer – a dedicated function to enable flow
HAT	Homeward Assessment Team
HIU	High Intensity User – patients who have complex and frequent health issues
HOSC	Health Overview & Scrutiny Committee (GCC) holding organisations to account
IAPT	Adult Improving Access to Psychological Therapies, a key mental health service
ICS	Integrated Care System
IPC	Infection Prevention and Control
LA	Local Authority (Gloucestershire County Council)
LoS	Length of Stay, a key measure in hospital-based care
MDT	Multi-Disciplinary Team, an approach to care that looks after all a patient's needs
MH	Mental Health
MiDOS	My Directory of Service; electronic signposting to the most appropriate care
MIIU	Minor Injury & Illness Unit, based on community hospitals
NEPTS	NHS funded Non-Emergency Patient Transport Service
NHS 111	Free telephone and online service for patients to access urgent health care advice
NHSE	National Health Service England, the national body that oversees delivery of services
OOH	Out Of Hours (usually in reference to primary care services at night and weekends)
OPEL	Operational Pressures Escalation Levels (1, 2, 3, 4)
POC	Package of Care
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SDEC	Same Day Emergency Care
SHREWD	Single Health Resilience Early Warning Database
ToCB	Transfer of Care Bureau
UEC	Urgent & Emergency Care
VCSE	Voluntary, Community and Social Enterprise

One Gloucestershire
Transforming Care, Transforming Communities

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如需以其他格式接收此信息，请联系

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આ માહીતી બીજા ફોરમેટસમાં મળાવાની ચર્ચા કરવામાટે કૃપાકરી સંપર્ક કરો

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November 2024

Agenda Item 14

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Emergency Preparedness Resilience and Response (EPRR) Annual Assurance paper 2023/24**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting	The pathway undertaken for this paper was: • The annual NHS EPRR assurance process, • Submission of evidence and assurance rating from NHSE confirm and challenge meetings • Feedback from NHSE held between September and October 2024.					
Executive Summary	As part of the EPRR annual assurance process we are bound by NHSE to summit the feedback to the ICB Board, on the level of assurance that has been rated from evidence submitted and subsequent "confirm and challenge" meetings held for a number of providers including:- ▪ Gloucestershire Health and Care NHS Foundation Trust, (GHC) ▪ Gloucestershire Hospitals NHS Foundation Trust, (GHFT) Patient Plus Group (PPG) ▪ E-Med Patient Transport Services ▪ South West Ambulance Service NHS Foundation Trust (SWASFT) ▪ and the Integrated Care Board (ICB). The above organisations are provided with a similar number of EPRR Standards and asked to carry out a self-assessment against these. Standards are RAG rated with accompanying evidence submissions in support of their response. This is followed up by a face to face "Confirm and Challenge" meeting between the ICB Accountable Emergency Officer (AEO) and EPRR Lead, along with the organisation's AEO's and EPRR Leads. This informs the overall rating for all agencies concerned. We received a letter from NHSE on 11th November confirming our assurance rating and containing our system outcome summary. We are delighted to inform the Board that all but two of the Partners has achieved a submitted standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. A great deal of work has been undertaken to improve E-Med's score and they have moved to "Substantially Assured" from "Non Compliant" last year. Unfortunately, due to a variety of factors, as an ICB we have seen our overall rating remain static and again whilst a self-assessment of "fully compliant" was submitted, we have been rated as "partially assured" by NHSE.					

	We submit this report to the Board for acknowledgement of the standards attained and recognition of the potential risk faced within EPRR resilience for the ICB.
Key Issues to note	**<u>Common challenges/issues</u>:** **Improvements – Resilience:** We reported last year that there was a risk in terms of the Senior EPRR Manager retiring and change of AEO. The new Senior EPRR Manager for the ICB, Andy Bruce joined the organisation in October replacing Andy Ewens who retired in June 2024. In addition, Marie Crofts joined the organisation in Jan 2024, as the Chief Nursing Officer and designated AEO. EPRR resource was rated 'partially compliant' last year, however this will improve with the additional Band 4 EPRR Support Officer joining the team mid-November. This past year has seen extraordinarily busy work schedules with the impact of Industrial Action by Nurses, Junior Doctors, and Consultants. This has impacted EPRR colleagues across the Healthcare sector and been time consuming as these were not 'one off' events but often had prolonged and ongoing impact. This in some way drew focus away from "Business as Usual". In 2023 the ICB was rated as "partially compliant" regarding adverse weather, and we have demonstrated significant improvement in terms of managing alerts within the health system and engagement with partners across the system. Another area of significant improvement includes the provision of training on-call staff. NHSE referenced the time spent to maintain a detailed training needs analysis and internal training record aligned to compliance with Principles of Health Command training. We are "fully compliant" with this standard this year. **Testing & Exercise:** Whilst a great deal of training has been provided to on-call staff and other relevant departments across the organisation, it is noted that more needs to be done to structure the training and exercise offer and provide a 'forward plan' for the year. The EPRR team will work with training providers to produce an overarching ICB Training & Education strategy aligned to risk and a schedule of training aligned with the Local Resilience Forum (LRF) multi-agency offer and training needs analysis. We hope that this work and the additional resource in the team to support this work will bring us up to 'Fully Assured' status next year. **Business Continuity:** Last year we reported that significant work had taken place in this area with all ICB Directorates now having Business Impact Analysis (BIA) that meet the recognised standard internationally (ISO 22301). Whilst our Business Continuity (BC) scope and objectives are clear and BIAs are this year "fully compliant", monitoring and evaluation is still a concern and the ICB are not compliant against this standard. The EPRR Manager will be introducing a continuous improvement process to ensure BC plans are improved and that lessons are learnt from BC incidents which translate to improved planning and arrangements. The EPRR team need to clearly

	see that departmental plans are being tested and exercised at least annually and that improvements are being made on the back of such tests. **Final Comments:** It was acknowledged in the Confirm & Challenge meeting that the ICB have had a challenging year with the retirement of our EPRR Manager and period whilst recruiting when this post was vacant. In addition, it has taken some time for our new Band 4 Administrator to join the organisation, leaving only the Training and Exercise Coordinator to undertake all the EPRR duties and manage the assurance process. This workload should not be underestimated, and full credit should be given for our submissions alongside these challenges. The shortage of dedicated EPRR resource for the majority of the assurance year coupled with the increased workload (as outlined in last year's report) is likely to have led to our ICB "partially compliant" rating for the second year. **Next steps:** The new EPRR Manager is committed to introducing a new robust work plan for the ICB which is risk driven and encompasses all elements of the EPRR agenda. As identified through the assurance process, this should include priorities for the ICB and embed strengthening the tracking of lessons identified with a view to continual improvement. The EPRR team continue to support regional collaborative working including attendance at the Regional Health Resilience Partnership (RHRP) and the newly created SW EPRR Collaborative. This new group comes together bi-monthly with quarterly face to face meetings and is attended by SW EPRR Leads and NHSE to share best practice and escalate shared issues. Whilst the EPRR assurance report comes to the Board annually, moving forwards in order to improve EPRR visibility and track progress against the standards, it is proposed that further reporting takes place through quarterly reports to the System Quality Committee.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Resource resilience Significant increase in workload and additional demand on EPRR resource from LHRP, RHRP, SW Collaborative, LRF and ICB – Industrial action (this is listed on the Board Assurance Framework – BAF 9 and BAF 10)
Management of Conflicts of Interest	**N/A**
Resource Impact (X)	**Financial** X **Information Management & Technology** **Human Resource** x **Buildings**
Financial Impact	

Regulatory and Legal Issues (including NHS Constitution)	The ICB are submitting "Partial Compliance" therefore there are no Regulatory or Legal issues. Should that level decrease next year to "Non-Compliant" there would certainly be implications, and this is captured as a risk on the EPRR organisational risk register maintained by the team.		
Impact on Health Inequalities	This is about patients. How will this impact on health inequalities for people? **N/A**		
Impact on Equality and Diversity	An EIA should be completed for large scale projects and initiatives and the outcomes should be included here. **N/A**		
Impact on Sustainable Development	Will there be any impact on sustainability of programmes, places, or people. How does the proposal meet the ICB/ICS objectives for sustainable developments? **N/A**		
Patient and Public Involvement	Will the decision impact on patients, carers, families, or the public? If so, how have they been involved in the process? Will the report be published anywhere? **N/A**		
Recommendation	The Board is requested to: Note the content of this report and consider the implications.		
Author	Andy Bruce	**Role Title**	Senior EPRR Manager
Sponsoring Director (if not author)	Executive Lead, if not the author. AEO Marie Crofts, Chief Nursing Officer		

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

Agenda Item 14

NHS Gloucestershire ICB Public Board meeting

Wednesday 27th November 2024

1. Introduction

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

2. Purpose and Executive Summary

2.1. **EPRR Core Standard 2024 summary.**

2.2. This assurance summary has been completed by NHS Gloucestershire ICB in fulfilment of the NHSE National EPRR Core Standards assurance process. The diagram below shows the assurance ratings given in 2024.

2.3. It is noted that this year's assurance levels reflect a more in-depth approach and growing NHS challenges from the regional team. This year's deep dive theme was cyber resilience with significant work undertaken in this area to demonstrate assurance.

2.4. **NHS Feedback:** ICB outcome from the 2024 EPRR Core Standards review

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

Organisation	2022	2023	2024
NHS Gloucestershire ICB	Substantial CCG/ICB	Partial ICB	Partial ICB

Provider Assurance levels:

Organisation	2022	2023	2024
E-Med Patient Transport Services (PTS)	Fully Compliant	Non Compliant – assessed using different methodology this year, led by Cornwall and Isles of Scilly ICB	Substantial
Practice Plus Group (PPG) formerly Care UK	Substantial	Fully	Fully
Gloucester Hospitals NHS Foundation Trust	Substantial	Substantial	Partial
Gloucestershire Health and Care NHS Foundation Trust	Substantial	Substantial	Substantial

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

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

2.8. All organisations have recognised the increase in EPRR workload in the last two years and this is on a continuing trajectory. A lot has been learned through the Covid Inquiry report, Grenfell report and the Manchester Arena report. In addition, significant local incidents such as the recent Tewksbury cyber incident which we continue to learn from strengthen the case for well supported and funded EPRR teams.

2.9. Key identified ICB areas needing improvement are:

- Core Standard 4: EPRR Work Programme
- Core Standard 6: Continuous Improvement
- Core Standard 23: EPRR Exercising and Testing Programme
- Core Standard 48: The organisation has in place a procedure whereby testing and exercising of Business Continuity plans
- Core Standard 50: There is a process in place to assess the effectiveness of the Business Continuity Management System (BCMS)
- Core Standard 52: There is a system in place to demonstrate continuous improvement in the BCMS

These standards form the basis of the ICB EPRR work program for the next twelve months. The new EPRR Manager is committed to introducing a new robust work plan for the ICB which is risk driven and encompasses all elements of the EPRR agenda. As identified through the assurance process, this should include priorities for the ICB and embed strengthening the tracking of lessons identified with a view to continual improvement.

Work has already started in this area, and we continue to seek views from on-call officers, departmental leads, and others in the organisation with a role to play in supporting EPRR.

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

- GHFT: as with 2023's submission, it was noted the systematic nature in which Gloucestershire Hospitals has approached its EPRR over the last year whilst running alongside the impact of Industrial Action of Nurses, Junior Doctors and Consultants has led to a substantial commitment of EPRR resource to the mitigation of the risk presented. They are to be congratulated in keeping their head above water in this regard whilst supporting business as usual within the Trust.
- Gloucestershire Health and Care Trust:. We have been particularly impressed this year with the way that GHC have presented their evidence whilst continually dealing with Industrial Action.
- Good collaborative EPRR work.
- The flexibility of all staff to adapt to the ongoing impact of Industrial Action

2.11. **Common challenges/issues:**

- As reported last year, Business Continuity is still a challenge across the system. This absolutely critical with the risks that are faced by all sectors and departments within the ICB. It is a subject that has to be taken seriously by all organisations and resourced adequately.

- The common theme across all organisations was more emphasis needed on Business Continuity training and especially needing Business Impact Assessments (BIAs) in place for all key services. EPRR attendance for training and exercise needs further improvement /support. This was a key identifier in the Grenfell Inquiry report - 'too busy' is not an excuse for not ensuring high compliances levels with all aspects of EPRR training are maintained.

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

3. Considerations for EPRR improvement/ development activity:

3.1. Having supported the ICB with one full time resource for the EPRR subject, the agenda has increased exponentially. Improvement should be felt soon with the additional post of a Band 4 EPRR Support joining the organisation and we would hope to improve on the standards next year with a dedicated team of 3.

3.2. The ICB's assurance level has stood still, we have recognised the differences this year and whilst always wanting to achieve a higher level of assurance we accept matters identified. There is work to do and this has already started with the introduction of our workplan for 2024.

3.3. It should be noted that EPRR is a whole organisational endeavour and does not just fall to the EPRR team. There is still work to do to address some cultural challenges within the organisation and ensuring that we are clear of our obligations as a Cat 1 responder under the Civil Contingencies Act.

4. Recommendations

The Board is asked to:

4.1. Note the content of this report.

4.2. Pay due notice to the reduction in compliance rating over the past two years of the ICB Core standards and support EPRR initiatives to address the non-compliant areas e.g. Business Continuity.

4.3. Support regular updates on monitoring of the improvement areas over the year with quarterly reporting on progress to the System Quality Committee.

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

Organisational assurance rating

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

Organisational rating

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

Agenda Item 15

NHS Gloucestershire ICB Public Board Meeting

Wednesday 27th November 2024

Report Title	**Renewal by means of legal variation of the Section 75 Agreement relating to partnership arrangements between GCC and ICB in connection with the delivery of integrated health and social care services**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Operational Executive (verbal update)	21/10/2024	GCC Legal team	16/10/2024			
	Operational Executive (paper)	TBC	Joint Commissioning Partnership Executive (JCPE) (verbal update)	24/10/2024			
	Strategic Executive	21/11/2024	JCPE (paper)	TBC - 28/11/2024			
	ICB Legal advice	TBC	GCC Cabinet	29/01/2025			
	Previous ICB Board decision 25/01/2023 - Extension to existing Section 75 ▪ ICB-Public-Board-papers-25th-Jan-2023.pdf Previous GCC decisions for background: ▪ Cabinet Decision (25/01/2023): Extension of existing Section 75 (joint funding arrangements) between Gloucestershire County Council and NHS Gloucestershire to 31 March 2025. ▪ Officer Decision (22/03/2021): Section 75 Agreement with Gloucestershire Clinical Commissioning Group ▪ Cabinet Decision (11/03/2020): Section 75 Agreement with the Gloucestershire Clinical Commissioning Group for the commissioning of health and social care services						
Executive Summary	To seek approval to renew by way of variation for a further 3-year period (1/4/2025 to 31/3/2028) the term of the existing Section 75 Agreement between GCC and ICB (the successor body to NHS Gloucestershire Clinical Commissioning Group, with whom the Agreement was entered into originally) which relates to the						

	commissioning of health, public health, children's and adult social care services (in exercise of powers under Section 75 of the NHS Act 2006). The renewal is proposed by way of the ICB and GCC entering into a new legal "Deed of Variation" which seeks to amend the original expiry date of the Section 75 Agreement but in all other aspects, the Agreement will remain the same and in full force and effect.
Key Issues to note	A Section 75 Agreement is a requirement under the NHS Act 2006 and provides for designated Health and Social Care bodies to act on each other's behalf in the commissioning or delivery of services for people for whom there is a shared responsibility. Further, it is mandated to have an active Section 75 Agreement for the BCF and use of such Agreement is required under BCF funding guidance: the DHSC: Adult Social Care Discharge Fund funding announced on the 18th November 2022 and subsequent Addendum to the 2022/23 Better Care Fund policy framework and planning requirements. The term of the Section 75 Agreement expires on 31st March 2025. The renewal of its current term will allow the continuation of the partnership arrangement and delivery of health, public health, children's and adult social care services under it. The ICB and GCC are committed to the principles of shared work and joint approaches to delivery of services for the population of Gloucestershire which are embedded in our longstanding Section 75 Agreement and a range of annual, individual Section 76 and Section 256 Funding Transfer Agreements. At the time of the 2023 ICB Board decision to extend the Section 75 Agreement, it was intended that exploration of opportunities to consolidate certain health and social care services sitting under individual Section 76 and Section 256 Agreements into the Section 75 Agreement. This, unfortunately, did not happen. If the ICB Board approve this request to renewal by variation, the ICB and GCC are committed to undertake a full review of the existing Section 75 Agreement (including its financial arrangements and the individual scheme specifications thereunder) and exploration of inclusion of the Section 76 & 256 Agreements. The Deed of Variation will secure this commitment to review within the 3-year renewal term. The existing services that are commissioned under the Section 76 and Section 256 Agreements are outside of the scope of this decision. Any future inclusion of them within the Section 75 Agreement will be the subject of a separate decision process and paper.
Key Risks:	The risks are: 1. The main risk is that the existing Section 75 Agreement, its financial arrangement, joint working and the individual scheme specifications thereunder will expire on 31st March 2025. This would have significant

<table>
<tr><td>Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">consequences to the funding and therefore delivery of the services under the Agreement and through the BCF.
2. A key risk to the ICB relates to the delegation of statutory duties under the Care Act 2014 and the Mental Health Act 1983 (amended 2007) from GCC to the ICB. These duties are then discharged through the NHS Standard Contract with GHC for the delivery of the relevant services. These services include Mental Health Social Work, Approved Mental Health Professional and Occupational Therapy.
3. The ICB (and GCC) would be breaching legislation in the NHS Act 2006 and the mandated BCF requirement.

The original and residual risks are high.
Original risk: 5 x 5
Residual risk: 5 x 5</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">No conflicts of interest have arisen.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td>X</td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">The financial schedule within the Section 75 Agreement is reviewed annually, signed off by the Directors of Finance for the ICB and GCC and reported to JCPE. It is updated annually to reflect any funding changes for such factors as demographic growth, inflation and savings.

The final outturn 2023/24 position for the s75 (as reported to JCPE in February 2024) is:
➢ £228m under S75 – split as to £183m NHS and £45m for GCC
➢ This includes Continuing Health Care and Funded Nursing Care which is solely NHS at a value of £60m
➢ It also includes Adult and Children’s Mental Health services at £89m of which £79m relates to Adult Mental Health within NHS Gloucestershire
➢ It covers the Better Care Fund (BCF) and Carers at a combined value of £57m
➢ The remainder is Integrated Community Equipment Services, Occupational Therapy and Discharge Funds at a combined value of £22m</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">Regulatory and legal issues for both the ICB and GCC constitutions are covered within the existing Section 75 Agreement. The legal position of entering into the Deed of Variation has been advised and is supported by the ICB and GCC independently.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">The Section 75 Agreement is a mechanism for transferring funding to support contracts such as GHC and for services purchased on behalf of the ICB via GCC mechanisms such as Funded Nursing Care and Continuing Health Care.

These services are covered by the contracts (service specifications) which are funded via the Section 75 Agreement.</td></tr>
</table>

Impact on Equality and Diversity	No EIA is required. The individual services commissioned under the Section 75 Agreement will themselves be subject to individual equality impact assessments as and when appropriate. The arrangements between the NHS Standard Contract with GHC and managed via individual Schedule 2A Service Specifications enables the ICB to comply with its equality duties		
Impact on Sustainable Development	As above, this is not required for the overarching Section 75 Agreement as will be the responsibility of the individual services commissioned thereunder.		
Patient and Public Involvement	As above, this is not required for the overarching Section 75 Agreement as will be the responsibility of the individual services commissioned thereunder. This report will be published along with any accompanying papers on NHS ICB website. A similar GCC Cabinet report for Cabinet meeting on 29th January 2025 will be published on GCC website.		
Recommendation	The Board is requested to: **Approve** renewal of the term of the Section 75 Agreement (by way of a Deed of Variation between the ICB and GCC) for a further 3-year period (1/4/2025 to 31/3/2028) which relates to the commissioning of health, public health, children's and adult social care services (in exercise of powers under Section 75 of the National Health Service Act 2006) thereby ensuring continuation of the existing framework for ongoing joint partnership working and delivery of services and funding.		
Author	**Sally Jones**	**Role Title**	**Senior Commissioning Manager – Community Care**
Sponsoring Director (if not author)	**Benedict Leigh – Director of Integration**		

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
Section 75 Agreement	Section 75 Framework Partnership Agreement between GCC and ICB (formerly NHS Gloucestershire Clinical Commissioning Group) dated 25/03/2021
NHS Act 2006	National Health Service Act 2006

Dated_____2025

GLOUCESTERSHIRE COUNTY COUNCIL (1)

and

GLOUCESTERSHIRE INTEGRATED CARE BOARD (2)

Deed of Variation

Assistant Director of Legal Services
Gloucestershire County Council
Shire Hall, Westgate Street,
Gloucester
GL1 2TG

THIS DEED is made the_____day of_____2025

BETWEEN:

(1) **GLOUCESTERSHIRE COUNTY COUNCIL** of Shire Hall, Westgate Street, Gloucester GL1 2TG (the **"Council"**); and

(2) **GLOUCESTERSHIRE INTEGRATED CARE BOARD** of Shire Hall, Westgate Street, Gloucester GL1 2TG (**"GICB"**) which replaced NHS Gloucestershire Clinical Commissioning Group with effect from 1st July 2022 as a party under the Section 75 Agreement to which this this deed relates in accordance with the requirements of the Health and Care Act 2022.

BACKGROUND

(A) The Council and GICB are party to a framework partnership agreement dated 25th March 2021 relating to the commissioning of health and social care services in exercise of powers referred to in Section 75 of the National Health Service Act 2006 (the "**Section 75 Agreement"**).

(B) The Council and GICB have agreed to renew the Section 75 Agreement by means of this deed and to review and (if appropriate) amend the parties' data processing obligations and the agreed Individual Scheme Specifications thereunder no later than 31st March 2026.

(C) Consequently, the parties wish to amend the Section 75 Agreement as set out in this deed with effect from the date of this deed (the "**Variation Date"**).

NOW THIS DEED WITNESSES as follows:

1. Terms defined in the Section 75 Agreement

In this deed, expressions defined in the Section 75 Agreement and used in this deed have the meaning set out in the Section 75 Agreement. The rules of interpretation set out in the Section 75 Agreement apply to this deed.

2. Variation

2.1 With effect from the Variation Date the Parties agree the following amendments to the Section 75 Agreement:

a)	PART ONE - POLICY STATEMENT replaced:	The entire text of PART ONE - POLICY STATEMENT is deleted and replaced with the wording set out in the Schedule to this deed:
b)	Clause 2.3 amended:	This clause is amended to read as follows: *"2.3 Following the expiry of the Initial Term of this Agreement the Term shall be extended:* *2.3.1 by a period of 2 (two years) commencing on 1st April 2023; and* *2.3.2 by a further period of 3 (three) years commencing on 1st April 2025,* *unless the Partners agree in writing that the Term shall not be so extended."*
c)	Clause 2.4 deleted:	The entire text of Clause 2.4 is deleted and replaced with the words "*Not used*".
d)	Clause 2.6 added:	This clause is inserted into the Section 75 Agreement: *"2.6 The Partners agree that they shall review and (if appropriate) amend the agreed Individual Scheme Specifications no later than 31st March 2026 Provided that the Term of this Agreement is extended pursuant to Clause 2.3.2."*
e)	Clause 2.7 added:	This clause is inserted into the Section 75 Agreement: "2.7 *The Partners agree that they shall review and (if appropriate) amend the Partners' respective data processing obligations under this Agreement no later than 31st March 2026 Provided that the Term of this Agreement is extended pursuant to Clause 2.3.2"*

2.2 Each of the parties to this deed hereby acknowledges that the Section 75 Agreement shall remain in full force and effect, save as modified by the provisions of this deed.

3. Governing law

This deed and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

4. Jurisdiction

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this deed or its subject matter or formation (including non-contractual disputes or claims).

This Deed has been entered into on the date stated at the beginning of it.

SCHEDULE

"PART ONE - POLICY STATEMENT

We have a shared vision in Gloucestershire to make the county the healthiest place to live and work – championing equity in life chances the best health and care outcomes for all.

This is about supporting people to live independently for as long as possible – enabling every person in Gloucestershire to be able to live the life they want to lead.

We of course face challenges in achieving this:

- We expect to see an 8% increase in the Gloucestershire population from 2028-2043 with new planned housing developments adding to this.
- Population changes are expected to be most significant for those living over the age of 65 with a 52% growth between 2018 and 2043.
- Whilst the fact that people are living longer should be welcomed, we do expect to see more people living with long-term conditions such as dementia or CVD. This inevitably often leads to greater utilisation of health and care services.

As partners together we are prioritising prevention. This means enabling communities to live healthy lives, diagnosing long-term conditions early and supporting people with care and health needs to be able to live as independently as possible. We know that this can only be achieved by working together with partners and importantly with people and communities themselves.

In 2022 the Integrated Care Partnership for One Gloucestershire Integrated Care System (ICS) published the first Integrated Care Strategy. This strategy is a shared commitment across partners to work to improve population health outcomes of people in Gloucestershire.
This strategy is based on three pillars:

1). Making Gloucestershire a better place for the future
We are committed to working together to improve outcomes for local people in the longer-term. We are achieving this through focusing on existing priorities such as

improvement physical activity, supporting people to live healthy lifestyles and improving mental health and wellbeing.

2). Transforming what we do

Together we are improving the way that care is delivered so that it is more connected (where people do not need to tell their story more than once) and, where practical, provided closer to where people live. Our shared transformation programmes are supporting this delivery – demonstrating our commitment to take a community and locality approach and achieve health equity for people across the county.

3). Improving health and care today

We are also working hard as a system to address the challenges we are facing today – improving access to care, improving the way that people are supported through the health and care system and working to reduce waiting times for care and treatment.

Our focus is not on the structures of our organisations but rather on improving how we commission and deliver care to deliver better outcomes. This Section 75 agreement allows for the pooling of NHS and Local Authority resources and the delegation of certain NHS and Local Authority health related functions to each other and provides a strong legal framework to enable this work."

The Common Seal of
GLOUCESTERSHIRE COUNTY COUNCIL was hereunto affixed in the presence of:

Assistant Director of Legal Services

Executed as a deed by
GLOUCESTERSHIRE INTEGRATED CARE BOARD acting by and under the signature of:

……..

Authorised Signatory

Title:

Gloucestershire ICB Board			
Agenda item:	**16**	**Enclosure Number:**	
Date	27th November 2024		
Title	Proposal for the Reconfiguration of Gastrointestinal (GI) Surgical services		
Author /Sponsoring Director/Presenter	Executive Sponsor: Professor Mark Pietroni – Medical Director & Al Sheward – Chief Operating Officer. Authors: Mags Coyle (Chief of Service), Sarah Mather (Divisional Director of Quality and Nursing), Simon Burchfield (Divisional Director of Operations).		

Purpose of Report		Tick all that apply ✓	
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

In 2022 the GI service line completed an assessment of service configuration across the two acute sites, seeking to align service provision on the Cheltenham site by creating four distinct Centres of Excellence (Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer) and moving Colorectal resectional work across to the Gloucester site.

The Surgical Division evaluated the evidence presented by the service line triumvirate that formed the basis of the report submitted for Trust Leadership Team (TLT) consideration and support.

Outcome: TLT November 2022 (as per the minutes)
"DL (Deborah Lee – former CEO) asked members to confirm their support for the proposals set out below.

- *The transfer of c1500 short stay and day case general surgery patients to CGH from GRH*
- *The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.*
- *Co-location of all resectional Upper Gastrointestinal Surgery at GRH*
- *Co-location of all resectional Colorectal resectional surgery at GRH*

DL asked members if they were supportive of the four proposals which has been put forward, noting implantation planning would be contingent of the approval of a decision-making business case. She further acknowledged the views that had emerged in the meeting that a number of elective services that continue to provide aspects of service on the GRH site will remain in scope for further review as part of our Centres of Excellence strategy. ***MEMBERS UNANIMOUSLY SUPPORTED THIS PROPOSAL****".*

This was on the proviso that the Division demonstrated the financial and activity assumptions listed within the analysis were accurate to provide further assurance on the decision made. ***This move was considered to be on a medium-term basis until the surgical division could relocate all resectional work (Upper and Lower GI) to the CGH site, recognising that the barriers to achieving this (e.g. theatre capacity) would take longer to achieve.*** Feedback given to the clinical teams post-TLT was given on this basis.

In order to achieve this via an impartial process the Commissioning Support Unit for South/Central (CSU) were engaged by GHFT via the Strategy & Transformation Executive Director to undertake this assurance work between January 2023 and April 2024. The CSU report concluded that there is patient level data

which supports the estimated activity transfer in the Proposal, and that financial analysis of proposal was accurate based on the evidence provided (Appendix 1).

This report was subsequently discussed at TLT in **July 2024**. The outcome was:

"Members supportive of reconfiguration subject to understanding the position with regard to having closed the loop on the public consultation".

It has subsequently been confirmed that in December 2022 the proposed GI reconfiguration was discussed at the Health Overview and Scrutiny Committee (HOSC). This concluded that **"this change did not require further public consultation"**.

In addition to the business case being presented to the Trust Leadership Team meeting in July 2024 the plans have been further scrutinised and agreed with at the Integrated Care Board Strategic Executive (**October 2024**).

The proposal has now been approved at the Gloucestershire Hospitals Trust Board **(November 2024)** so the Division is seeking final approval from Gloucestershire ICB.

Recommendation

The Surgical Division has now concluded the external review and received approval to proceed at Trust Board. The service line and Division are therefore seeking:

- Final approval to complete the moves of clinical services as described in detail in the paper.

Enclosures

Appendix 1: SCW GI Proposal Review
Appendix 2: Critical Care Mitigations in Support of Acute Medical Take Move

Surgical Division: Gastrointestinal Surgical Reconfiguration

1.0 Introduction

In November 2022 the surgical division presented to Trust Leadership Team (TLT) a final proposal on reconfiguring GI services across the two core sites of Cheltenham General Hospital (CGH) and Gloucester Royal Hospital (GRH) as part of the trust's Fit for the Future (FFTF) programme. The drivers for this proposed change included improved patient safety, reduced inequality of patient care and reduced cancellations of planned operations.

2.0 Summary

The plan looks to expand our surgical service on the CGH site with the establishment of Centres of Excellence for Bariatric, Biliary Disease, Pelvic Floor Surgery and Early Rectal Cancer, resulting in around 1,500 more patients having their operations in CGH. This will reduce the risk of cancellations and will enhance the experience for patients undergoing this type of surgery. In order to achieve this, around 140 resectional colorectal cases will move to GRH.

3.0 Background

Historically known as "General Surgery" (GS), the Gastrointestinal (GI) surgical service line is split between the two core specialties of Upper Gastrointestinal (UGI) and Colorectal Surgery (CR). To date, UGI surgery has been performed on the GRH site but Colorectal surgery has been performed in Cheltenham and Gloucester hospitals. Fit for The Future (FFTF) / Centres of Excellence have previously focussed on Colorectal. However, this proposal focussed on all of GI Surgery and how best to align a centres of excellence model as summarised in Table 1.

Table 1: Summarised Centres of Excellence model

Proposals:		Status
The creation of dedicated day surgery lists at CGH	This will reduce cancellation for bed pressures.	Agreed by all
The creation of specialised centres at CGH for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer.	Highly specialised units can be created to maximise efficient theatre lists and reduce cancellation as above	Agreed by all
Co-location of all resectional Upper Gastrointestinal Surgery	This will continue at GRH where it is aligned with EGS and forms a longstanding Three Counties Oesophagogastric surgery centre	Agreed by all
Co-location of all Colorectal resectional surgery	Ultimately the intention is to co-locate to one site - GRH	Difference of opinion

Within the service there has been a difference of opinion as to where resectional colorectal surgery should be performed. While it is possible and safe to complete resectional work on both acute sites, continuing to do so will not permit the other benefits of the reconfiguration to be achieved.

In April 2020 (during COVID wave 1) the emergency component of the workforce was centralised at GRH which has reduced high risks related to staffing, training and inequitable patient care. This means that GI patients requiring emergency care are managed via GRH ED and primarily cared for via the Surgical Assessment Unit (SAU) and GI inpatient wards (located on the 5th floor of the Tower block in GRH).

The service line has for some time been considering future service reconfiguration of elective surgery across the CGH and GRH sites; this evaluation seeks to explain the proposed placement of services on the understanding that the

service line team believes that for GI Surgery to be best placed to deliver Centres of Excellence, UGI and CR need to centralise services and work together. The service is in agreement on the principles of the following strategic moves to establish Centres of Excellence of Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer in CGH. These services were included in the FFTF proposals and therefore no further public consultation was required (as confirmed at the Health Overview and Scrutiny Committee in December 2022).

There are numerous benefits that are anticipated through this reconfiguration, both to the GI service and the wider trust:

- The transfer of c.1,500 short stay and day case GI patients to CGH from GRH – in 2023 the trust opened the £17m Chedworth Day Unit on the CGH site and in 2024 the two additional theatres linked to this development also opened. The creation of the specialised centres for Bariatric, Biliary, Pelvic Floor and Early Rectal Cancer at CGH will mean the specialty can make best use of this new facility and increase the volume of surgical activity being delivered at CGH.
- Due to the emergency surgical pathway at GRH there are often competing demands for beds, with routine benign cases at greatest risk of cancellation due to emergency pressures. With a greater proportion of these cases being completed in CGH following this proposed reconfiguration, there will be a reduced risk of cancellation.

An evaluation of further risks and benefits relating to this proposed change has been completed by the service line triumvirate and is summarised in Table 2 below.

Table 2: Benefits and risks of reconfiguration

Benefits	
Strategic development discussions	Robotic surgery
	Bariatric expansion
Governance	Improved discussions about complications. Currently this is not functioning to its potential due to avoidance of highlighting differential pathways and level of care
Patient experience	Reduced risk of cancellation of higher volume, lower acuity cases
	Ongoing access to outpatients and endoscopy on both sites
Staffing	Fully staffed rotas for our sickest patients
	Rapid access to interventional procedures (theatre or IR) for our potentially sickest patients (resections and emergencies)
	Improved wellbeing
	Avoidance of good will, onerous weekend working (Currently 1 in 2.18)
	Sustainable rotas
	Separation of emergency and elective work to allow our nursing staff to concentrate on their roles
	Development and career progression for our nursing staff through other roles e.g. ACPs
Training	Improved firm structure with clearer lines of escalation for resectional and emergency patients on GRH site
	Greater emphasis of continuity of care with equitable introduction of postoperative ward rounds for resectional patients leading to earlier decision making and more rapid discharges
	More equitable distribution of work amongst junior staff
	Dedicated access to day case and short stay surgical cases on CGH site
Office Space	Greater presence of consultants on the acute site during period of emergency work leading to more rapid assessment and better flow of patients
	Improved secretarial cross cover within the team leading to more even distribution of work and more rapid communication with primary care and patients

Risks of implementing the reconfiguration	
Clinical team dynamic	Potential disengagement from service line activity by a minority of consultants

Risks of maintaining the status quo
Impossible to deliver centres for bariatrics, biliary and pelvic floor
Stagnation of the service line
Loss of trust in the senior leadership team from the majority of the consultant body (the decision was made in November 2022)
Disengagement of consultants from any future processes within the service line

4.0 GHFT Strategic priorities 2024-25

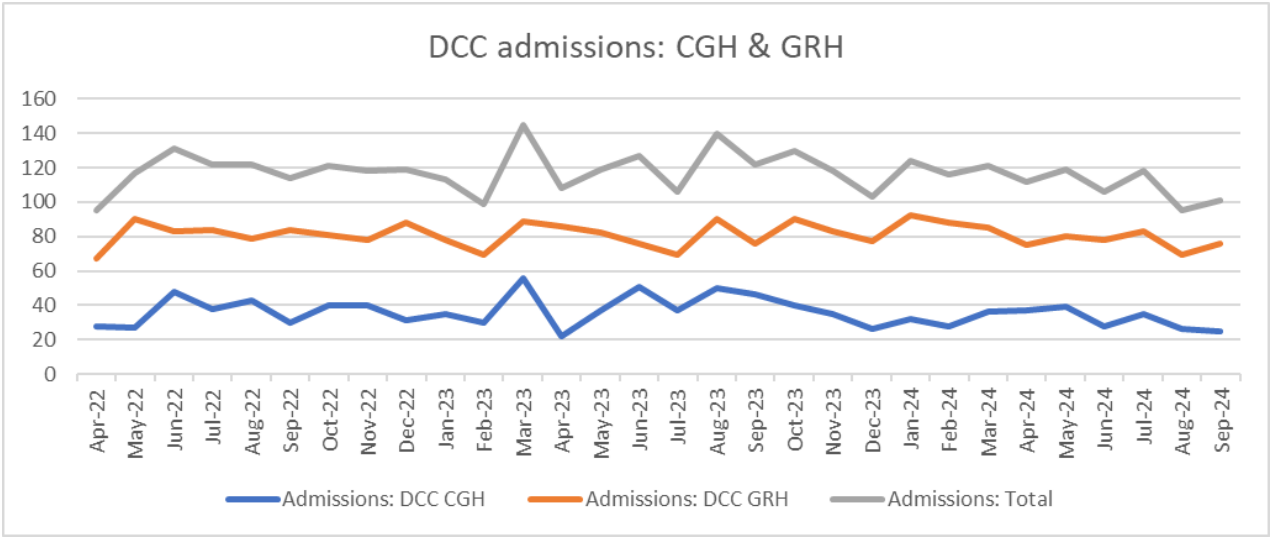
In the intervening period since November 2022 the GHFT FFTF programme has delivered the centralisation of Cardiac inpatient services and Cath Labs to the GRH site alongside the launch of the Image Guided Intervention Surgery (IGIS) hub and the centralisation of the acute medical take to GRH. There have been a series of ward reconfigurations that have impacted surgery and medicine divisions predominantly, and the launch of two new daycase theatres in Cheltenham alongside a purpose-built Day Surgery ward.

4.1 Stabilisation of Critical Care

Overall, these changes have not had a material impact on the GI reconfiguration proposed, but does provide additional strain or release of capacity within the Cheltenham Critical Care unit. The below chart (Chart 1) demonstrates that admissions to DCC have remained relatively stable over the last two years. There have been peaks in demand and these have been managed by DCC through a series of mitigations which have now been formalised through the plan which was documented as part of the planning for the move of the acute medical take.

While it is too early to make to make a full assessment of the impact of the centralisation of the acute medical take (August 2024) on DCC, as part of this move the DCC leadership produced an 8-point mitigation plan, which equally applies to GI and is included as an attachment to this paper (Appendix 2). This includes actions to be implemented at times of peak demand such as flexing staffing levels, supporting the rapid move of patients out of DCC to ward beds when fit and the identification of appropriate patients to be transferred from GRH DCC to CGH DCC.

Chart 1: DCC admissions April 2022 – September 2024

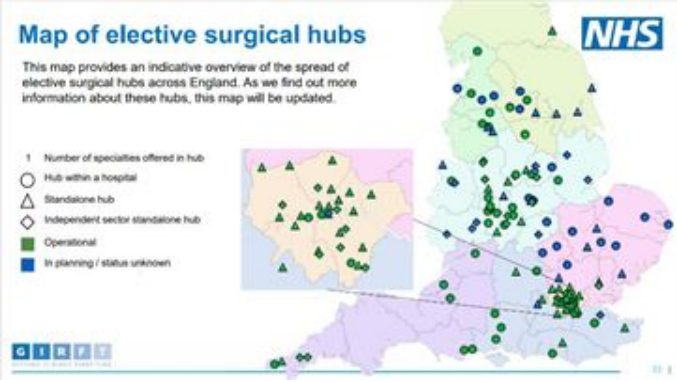


Authors: Simon Burchfield, Mags Coyle, Sarah Mather (Surgery Divisional Tri)
November 2024 FINAL

The movement of Colorectal to GRH will require a DCC-user specialty to move back to CGH to balance the bed requirements as part of a longer-term plan to retain a viable Critical Care unit in Cheltenham; the impact is between 0.5 and 1 bed of Colorectal demand moving to GRH. This was discussed at Surgical Divisional Board 24th October 2022 and was felt that the impact on DCC would be small as the Bariatric service would be part of a balancing move in the opposite direction, a service that is increasing in demand with the direct access Specialist Weight Management pathway to Tier 4 that has been in place for 18 months. Enhanced peri-operative and subsequent anaesthetic care will support the configured viability of DCC at Cheltenham. Additionally, in December 2023 ward 4a was established as the dedicated elective GI ward at GRH with an expansion of the 5th floor providing additional emergency beds to offset this move. Staff on 4a have become very specialised in the delivery of enhanced care to surgically complex patients, meaning patients can be discharged earlier from DCC.

4.2 GHFT Elective hub accreditation (Cohort 9)

The national NHSE strategy for planned care is underpinned by acute hospitals forming into elective "hubs" recognised within a national accreditation framework. This seeks to ringfence elective operating resources (including inpatient ward bases for post-operative care) recognising that during periods of extremis it is elective services that are frequently impacted by emergency demand.



There are a series of steps still to be completed prior to the on-site visit that launches the full evaluation, however it is likely that trusts in cohort 9 will need to be reviewed no later than June 2025.

Within the South West GHFT would be one of the few organisations to become a recognised elective hub, providing further opportunities to provide mutual aid across the South West as a mechanism for delivering additional income.

The criteria for becoming an elective hub are summarised below:

- In a split site organisation only one site can become the elective hub for adult operating.
- More recently Paediatric surgical elective hubs are becoming accredited which would be GRH as this is where Paediatric operating is centralised to.
- There are three distinct definitions of the types of "hubs" that organisations can apply to become; for GHFT the CGH site as an "integrated hub" is the most appropriate definition.
- Staffing and theatres must be completely split (e.g. emergency operating should only be completed on dedicated operating lists and not mixed with elective cases).
- Inpatients wards can have dedicated emergency / elective bays (hence the integrated hub model) but this needs further consideration at the CGH site.

There are a series of benefits associated with achieving accreditation that are largely related to increasing productivity within existing resources driven by the protocols that organisations are mandated to deliver as part of accreditation approval, alongside quality and patient experience improvements from ensuring pathways are delivered against the national best practice.

4.2.1 Impact on operationalisation of GI reconfiguration on elective hub strategy

The move of biliary, bariatrics and pelvic floor surgery to CGH fits well with the elective hub strategy. The reciprocal move of colorectal resectional work to the non-accredited site does not contravene the requirements for elective hub accreditation. There are no specific requirements for all elective work to take place on the elective hub site (recognising that across the UK community theatres are used to provide operating capacity).

4.3 Robotic strategy 2024 and beyond

There is a multi-specialty robotic programme spanning 10 years within the proposed elective hub accredited site in CGH (Da Vinci and Aquablation robots) along with two training simulators and a dual-console robot. The theatre estate is now well configured to deliver robotic surgery (both in size of theatres and the storage space located alongside the theatre itself). Equally, the workforce is well trained in terms of surgeons, theatre staff and Surgical Care Practitioners (in both Urology and Gynae-Oncology) and proctoring is delivered without impact on core service delivery.

There is a smaller programme of robotic operating (GI surgery) on the GRH site since 2021 (CMR robot) that shares theatre space with non-robotic specialties, and has a proctoring programme that is beginning to widen significantly the theatre team and surgeon experience of completing Oesophageal procedures robotically. The service is considered a UK leader in the use of robotic intervention on the CMR robot and is nationally publicised on this basis. A smaller colorectal robotic programme exists on the GRH site using the CMR robot.

4.3.1 Future robotic opportunities

At present there is no case of investment for additional robots on either site, however there is anticipated interest in the following specialties:

Table 3: Robotic expansion per specialty (declared)

Specialties	Interest
Head & Neck	Da Vinci (small scale opportunity at present)
Bariatrics	Da Vinci (small to medium scale opportunity anticipated)
Colorectal	Da Vinci and CMR (large scale opportunity)
Elective orthopaedics	Smith & Nephew (small scale opportunity for Knee procedures)

A lack of clarity around reconfiguration plans has hampered any meaningful discussion about the development of a robotic service and as a result the Trust has fallen behind other organisations in providing this service.

4.3.2 Horizon scanning

Nationally, in the next 18 months it is anticipated that there will be an increase in the use of robotic surgery for colorectal resection patients. In 2023-24 24% of all rectal cancer procedures were performed robotically (HES Data) and this is similar to trends observed within Urology. A large-scale conversion to robotic prostatectomy was driven by the improved functional outcomes in patients post-operatively alongside length of stay savings and improved oncological outcome.

In 2023-24 a significant volume of robots was gifted by NHSE to acute trusts across the UK in order to stimulate robotic surgery becoming more widespread; contravening the previous assumption made that regional robotic centres would pull all complex work into a smaller number of acute hospitals.

Several large acute hospitals across the UK recently presented at a national conference that they aim to move emergency GI operating (laparotomies) to fully robotic within 2024-25. GHFT undertakes no emergency operating robotically at the GRH site and very limited emergency operating at the CGH site. All organisations listed Da Vinci as their robotic provider for emergency surgery provision, although CMR is not yet tested in this field.

Transanal Endoscopy Microsurgery (TEMS) is a rectal tumour procedure that limits the number of incisions required to remove the cancer and is only practiced at a small number of acute trusts in the UK. Nationally, the equipment required to continue to provide this procedure is being discontinued by 2028 and repairs are no longer able to be supported by the supplier (Wolf) as of 2023. GHFT have two scopes in total, one on loan from Worcester acute having had to remove a damaged scope from circulation in May 2024. Nationally, the alternative for TEMS is TAMIS but in the medium-term robotic surgery is likely to be the platform of choice. Therefore, it is highly likely within the next 18 months we should consider investing in robotic capacity for colorectal to deliver this service.

Bariatric surgical outcomes can potentially be improved with robotic surgery, with faster recovery after surgery. The changes to bariatric referral services with enhanced Tier 4 mean that there are likely to more bariatric cases being performed in the future. Robotic bariatric surgery is established in the USA with around 20% of cases performed robotically. In the UK, Portsmouth has an established programme. Reconfiguration would permit the development of this service helped by a reduced risk of cancellation of patients.

5.0 Operationalisation of the GI reconfiguration plan

5.1 Engagement approach

Clinical engagement on the subject of reconfiguration has been largely positive except in the discussion of centralisation of colorectal resectional work to GRH. This issue has been the subject of specific working groups, external opinion and several attempts to consider different models proposed by CGH and GRH colleagues that offer no compromise. Recent engagement has been limited due to the significant delay between the TLT decision in 2022 and the completion of the CSU external review in 2024. More recently in July 2024 the clinical team were updated on the current position of the governance approval, received the CSU report and were invited to ask questions about the process.

To support the implementation of GI reconfiguration, a communications and engagement plan has been developed. This plan, which has been collaboratively developed between the Surgical Division and the Communications Team, sets out key messages, stakeholder map, internal and external communications as well as our aligned approach to engagement and involvement.

5.1.1 Secretarial staff

There is a small-scale organisational change triggered by the introduction of this model (the centralisation of administrative staff to GRH) and a people impact assessment has been generated that will be triggered following final approval. There is sufficient capacity within the GI administrative offices at GRH to accommodate this change.

5.2 Impact on other services

- **Gynae-Oncology (GO) –** support to GO will not be affected by the service reconfiguration. Elective list support is provided on a sessional/funded basis via Locums Nest booking and careful consideration is given to the planning of these cases across the management teams in Surgery and W&C. Two colorectal surgeons have time allocated in their job plans to support GO. There will continue to be GI surgeons in CGH theatres who will be able to provide an opinion to a GO theatre if a joint case has not been pre-planned. The service line has provided several mitigations that seek to demonstrate consideration has been given to how the Gynae-Oncology service can continue at CGH, including short and longer term out of hours support for the rare occasion a post-operative patient deteriorates whilst in a CGH ward. Previous concerns raised by GO related to emergency support Out of Hours (OOH) and deterioration or returns to theatre that require GI support. There is an on-site F2/core trainee covering Urology, GI, T&O and GO overnight. The return to theatre requirement, should it arise, would follow a protocol similar to that of the emergency pathway, with a transfer to GRH preferable, but if not feasible, clinical support to the GO team will be provided by the on-call GI consultant.

  There is no indication of a safety risk OOH that demonstrates a reduced service to Gynae-Oncology or a compromised pathway due to the mitigating actions suggested. On this basis the division does not support the view that the Gynae-Oncology service is required to move to GRH and there are no other specialty concerns raised.

- **Urology** have maintained their view that this reconfiguration will not materially impact service delivery within Urology but does represent a strategic change that is not in the best interest of Cheltenham General and the benefits to patients from co-located working, nor the delivery of a Centre of Excellence for Pelvic-Oncology.

- **Gastroenterology** support will continue to be via the emergency surgical team; there will be no change to this service. The teams are aware that the emergency surgical service changed in April 2020 and acute surgical admissions all go to GRH with GI consultants providing support in CGH. When requested, the on-call GI consultants review gastroenterology patients in CGH, although, on occasions, transfer to GRH is arranged to permit emergency surgery. The proposed reconfiguration will not affect the emergency surgical service and therefore will not impact on the support provided to gastroenterology.

5.3 Inpatient bed requirements CGH

This model delivers a high volume daycase workload with minimal inpatient elective operating in Cheltenham (80 bariatric patients per year / 0.2 beds per day required when converted into bed modelling). Analysis in table 2 below demonstrates a reduction in colorectal bed occupancy usage at CGH in 2023/24 compared to previous years, relating to reduced resectional operating by 1 WTE consultant in CGH, and an increase in the use of day surgery operating.

Table 4: Bed modelling / bed occupancy data (BI source)

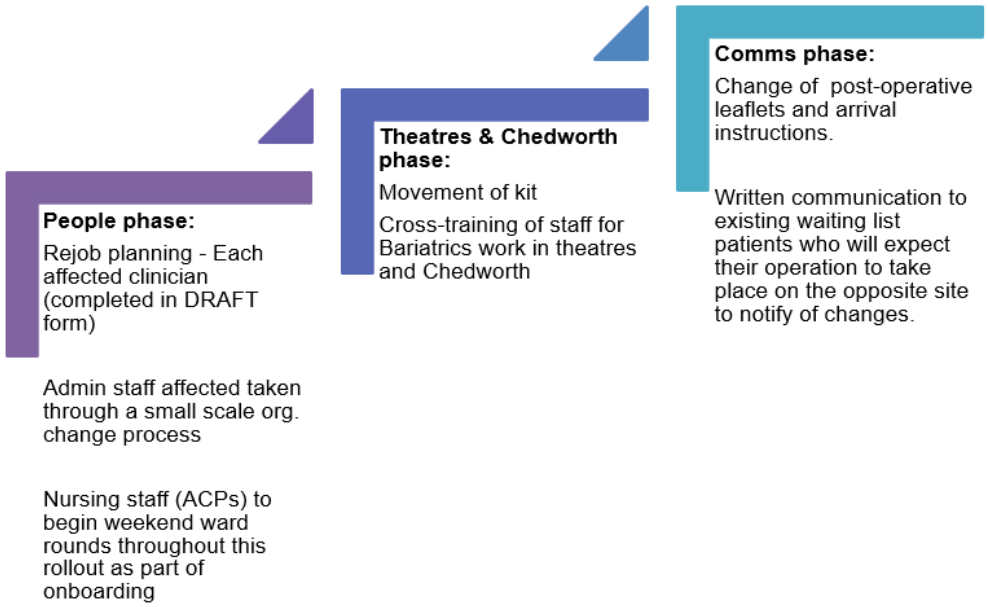
Specialty	2020	2021	Sept 23-Feb 24 Av. Daily occupancy)		Net change 2021 to 2023/24
			Dixton	Tivoli	
Urology	26.3	13.3	0	13	-0.3
Gynae-Oncology	4.7	4.8	2	1	-1.8
Colorectal	8.8	8.4	2	1	-5.4
			Medical outliers	1	

Overall, the division believes that this service move of 3.8 beds to GRH will be absorbed within ward 4a (already factored in during the 2023-24 GRH bed base realignment process) leaving a residual demand of 0.2 beds for short stay Bariatric operating, which can be absorbed within Tivoli ward.

5.4 Timeline for delivery

The service has been working on the implementation plan ahead of the anticipated final decision. Implementation will focus on reducing the number of job planning changes (e.g. trying to move existing theatre days to the same frequency but on the alternative site) and minimal changes to outpatient clinics in order to avoid any further delays to delivery. Ward changes are minimal given the small elective footprint on the CGH site for Colorectal and the nursing teams have already started to consider training needs both in theatres and post-operatively in inpatient or daycase wards.

The GI Surgery Centres of Excellence model can therefore be delivered by Q4 2024-25.



6.0 Conclusion

The Division have provided oversight in terms of strategy, mobilisation and a summary of the original November 2022 TLT proposal, refreshed for 2024. The Division are asking for this proposal to be approved and allow the GI service to move to the implementation phase of this strategic programme.

Reconfiguration of GI Services Review

Gloucestershire Hospitals NHS Foundation Trust

Final Report

April 2024

Joining the dots across health and care

Introduction

In November 2022, the Trust Leadership Team for Gloucestershire Hospitals NHS Foundation Trust (GHFT) received and approved a Proposal for the Reconfiguration of GI Services.

SCW were asked by GHFT to review specific elements of the Proposal document from November 2022. After a series of clarification conversations between the SCW and GHFT teams, GHFT confirmed that there were two elements of the Proposal for SCW to review and these were:

- Activity analysis – reviewing the activity assumptions related to resectional work that led to the statement in the proposal that approximately 140 patients would transfer to Gloucestershire Royal Hospital from Cheltenham General Hospital
- Financial analysis – Reviewing the financial summary included in the proposal and checking the assumptions that were used to support that analysis

Approach

SCW provided the following delivery team:

- Kat Littlewood — Business Intelligence Consultant
- Adonis Sithole — Deputy Head of Financial Consultancy
- Geoff Underwood — Programme Director
- Katie Bowden — Transformation Director

The SCW team met and worked with the following team at GHFT:

- Ian Quinnell — Interim Director of Strategy
- Alexandra Matthews — Divisional Director of Operations – Surgery
- Tom Devitt — Senior Finance Business Partner – Surgery
- Chloe De Jong — Business Intelligence Business Partner – Surgical

Through a series of meetings and discussions over a number of weeks between February and April 2024, the SCW and GHFT teams agreed data to be provided and GHFT provided data and other information as requested.

Findings

Activity Analysis

These were the key lines of enquiry for the activity analysis:

1. Reconciled data taken from Trak to show how the estimate of 139 patients transferring was calculated

We were asked to review the analysis behind the estimate that approximately 140 patients would transfer from Cheltenham to Gloucester if three surgical consultants were relocated from Cheltenham to Gloucester. Data was shared with us that showed that 354 relevant surgical cases were recorded during the 2021/22 financial year for a team of 8 consultants. Using the calculation shown in the table below, this activity number can be used to generate an estimate that 139 cases would transfer to Gloucester if 3 surgeons were relocated.

Calculations	21/22
Total Spells	354
No of consultants	8
Avg per consultant	44.25
Consultants to move to GRH	3
Growth	5%
Activity to move over to GRH	**139**

This estimate assumes that all consultants see the same number of patients each year and that each of the procedures takes a similar amount of time.

We have seen that there is patient level data which supports the estimated activity transfer in the Proposal.

Financial Analysis

These were the key lines of enquiry in the finance review:

1. The GHFT Option C Financial Model backing file.
2. Evidence that the funding gap of £490.5k (477.8k + 12.7k) was funded through the 23/24 budget.
3. Budget papers to confirm that the gap was covered.
4. Evidence that the capital investment was included in the 23/24 capital programme or was funded via FFTF funds.
5. Confirmation that the other role in the Option C Financial Model was funded through alternative funds.
6. The Contract Variation that approved funding £104k versus the £109.9k recurrent gap.

7. Evidence that the recurrent gap is not a funding shortfall.
8. Any other confirmation that the FM will not lead to a cost pressure.

We were commissioned to undertake a review of the financial analysis performed in relation to Option C as described in the Proposal and accompanying papers presented to the Trust Leadership Team in November 2022. The purpose of this review was to establish whether the evidence shared with SCW substantiated the financial model and subsequent analysis.

Our review of the financial analysis included making enquiries, primarily of persons responsible for financial and accounting matters, and applying analytical and other review procedures.

Our review was substantially less in scope than an audit conducted in accordance with International Financial Reporting Standards and consequently does not enable us to obtain assurance that we would become aware of all significant matters that might be identified in an audit. Accordingly, we do not express an audit opinion in this report

Based on our review, which is not an audit, we have not become aware of any matter that leads us to believe that the financial analysis of GHFT's Option C was inaccurate.

Conclusion

The SCW team were asked to review two elements of the Proposal for the Reconfiguration of GI Services:

- Activity analysis – reviewing the activity assumptions for resectional work that led to the statement in the proposal that approximately 140 patients would transfer to Gloucestershire Royal Hospital from Cheltenham General Hospital
- Financial analysis – Reviewing the financial summary included in the proposal and checking the assumptions that were used to support that analysis

We have been able to review patient level data that supports the estimate in the Proposal that, based on data from 2021/22, 139 patients would transfer from Cheltenham to Gloucester as part of the proposed reconfiguration. We have also reviewed financial data and been provided with other information supporting financial statements in the Proposal and we have not become aware of any matter that leads us to believe that the financial analysis of GHFT's Option C was inaccurate.

Our review has been strictly limited to these two elements of the Proposal. We were not commissioned to and have not reviewed any other elements of the Proposal or reviewed the Proposal as a whole.

Version history

Version	Version date	Authors / Amended by	Approved by
1.0	18 April 2024	Kat Littlewood Adonis Sithole Geoff Underwood	Katie Bowden

NHS Gloucestershire ICB People Committee

Thursday 18th July 2024, 14.00 – 17.00pm

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
Dr Ananthakrishnan Raghuram	AR	Chief Medical 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
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
In attendance:		
Charlie Presley	CP	We Want You Careers Engagement & Outreach Lead, ICS
Nikita Davis	ND	HR and Governance Project Officer, ICB
Ryan Brunsdon	RB	Board Secretary, ICB
Susie Durrell	SD	One Gloucestershire ICS Advanced Practice Lead, ICS

1 Introduction & Welcome

1.1 KC welcomed everyone to the meeting.

2 Apologies for Absence

2.1 Apologies were received from Sarah Scott (SS), Marie Crofts (MC) and Mary Hutton (MH).

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 16th May 2024 were approved as an accurate record of the meeting.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **08.02.2024, Item 7.13** – Workforce Intelligence Report. This was not discussed at the meeting but post meeting note to acknowledge changes had been made to the report to reflect Operating plan monitoring requirements and so this item can be closed.

5.1.2 **16.05.2024, Item 7.2** – Op Planning Data. This action was requesting closure. The document was circulated by ND. **Action closed.**

5.1.3 **16.05.2024, Item 7.4** – Apprenticeship Strategy. This action was requesting closure. This item was included on the July meeting agenda. **Action closed.**

5.1.4 **16.05.2024, Item 7.9** – Leavers Data. This action was requesting closure. The document was circulated by ND. **Action closed.**

5.1.5 **16.05.2024, Item 8.9** – ICS Programme Priorities. CR, NS and TC gave an overview of individual organisational priorities as follows:

Gloucestershire Hospitals NHS Foundation Trust (GHFT):

- Workforce sustainability and oversight – to include recruitment and onboarding, digital (particularly e-rostering), temporary staffing, sustainable workforce, and workforce controls.
- Staff experience – focus on leadership and teamwork capacity and capability, anti-discrimination, supporting a safe speaking up culture, and the People Promise exemplar programme.

Gloucestershire Health and Care (GHC):

- Recruitment and retention;
- Inclusive Culture – to include Equality, Diversity, and Inclusivity (EDI), anti-racism, cultural competency, and restorative, just and learning culture programmes.
- Workforce transformation and skill mix – a new priority with a focus on new roles, new ways of working and operational and strategic workforce planning.

Gloucestershire Integrated Care Board (ICB):

- Leadership development support and line manager training.
- Staff survey results - focus on bullying and harassment, appraisals, and staff wellbeing.
- Supporting staff productivity – including better usage of ESR.

TC highlighted a support offer from the regional team to systems to assist with projects relating to workforce planning and the Long-Term Workforce Plan (LTWP). Two areas ARRS roles in Primary Care and Pharmacy workforce planning were being scoped as potential areas for support.

KC proposed a separate meeting to discuss how the People Committee would have visibility of progress against the priorities. **KC / TC**

5.1.6 **16.05.2024, Item 10.3** – Social Work Placement Risk. This item was not discussed. This item remained open, but a short briefing note has been shared with Emily White. **Action closed.**

6 **<u>Integrated Care System (ICS) People Function Summary Report</u>**

6.1 TC highlighted a briefing provided by Capsticks following the recent change to the government which explained potential changes to employment law and practice, noting

that the proposed changes will strengthen and increase rights to employees, for example around zero-hours contracts and access to paid carers leave.

6.2 TC advised that a pay offer had been accepted by Speciality and Specialist grade (SAS) doctors and added that due to ongoing conversations between the British Medical Association (BMA) and the new government regarding junior doctors pay, on-going industrial action had been stood down.

6.3 TC referenced the new Worker's Protection Act due to come into force in October 2024 which placed increased responsibility on employers to take steps to prevent sexual harassment of employees.

6.4 TC drew attention to the recent Leadership Conference that had focussed on Health Inequalities and the subsequent discussion at the Strategic Executive meeting around future leadership support offers. TC reported that the conversation was positive, and the overall One Glos conference methodology and support for shared leadership development approaches was supported, but further conversation would be needed on how to get best out of the events and to confirm priorities.

6.5 CR queried whether the proposal had been agreed. TC advised that it had strong support in terms of the approach, content, and sharing of ideas but there hadn't been enough time to discuss the sustainability and resourcing of the proposal. CR discussed the need to ensure that adequate time is allocated to discuss proposals like the leadership one. TC agreed and invited committee members to participate in the follow-up discussion that would be held at the next Strategic Executive meeting.

6.6 AR emphasised that during the meeting MH had stated the proposal was important and should be at the forefront, but stipulated that all of the background work, discussion and debates should be had prior to the proposal going to Strategic Executive in order to aid easier decision-making and backing.

6.7 NS concurred with CRs statement and stressed the importance of prioritising conversations around leadership and management development, and the link between this and how organisations are most likely to deteriorate from the top down.

6.8 JC and KC queried the detail of proposal and what was being requested. TC offered to circulate the presentation and a summary of the feedback from the meeting which was agreed. **TC**

6.9 JC commented on the reduction in vacancy rates and reflected that the proposed changes to zero-hours contracts could have a significant impact on the social care sector, particularly in the independent sector where a significant proportion of the workforce are on them.

RESOLUTION: The People Committee noted the content of the ICS People Function – Summary Report.

7 Workforce Intelligence & Programme Highlight Report

7.1 SEA provided a programme update:

- Final operational plan had been submitted in May.
- All plans on a page had been approved at steering groups and by the People Board.

- Cohort five of the Systems Thinking programme had finished; further conversation was required to determine how to continue to deliver the programme and would be looked at as part of the wider leadership development review that is underway.
- Gloucestershire County Council (GCC) have launched a website called 'Proud to Care' that details educational opportunities for the independent social care sector.
- T-Levels are being expanded into social care and dental and pharmacy had been identified as areas that would like to get involved with apprenticeships.
- Health and wellbeing champions participated in a well-received support day in July and starter conversations were piloted in May in social care. This also received positive feedback so would now be piloted with the Trusts.
- Draft infographics for organisations' Equality, Diversity, and Inclusivity (EDI) dashboard had been completed and joined up work planning for Black History month in October had begun.
- Planning for cohort three of the System Inclusion Allies programme due to run in Autumn had begun.

7.2 SEA outlined the general metrics and confirmed the ICS leaver rate was 12.2% which equated to 13% for the trusts and 11.2% for social care.

7.3 The ICS vacancy rate was 11.9%. SEA noted that the trusts were doing well to reduce this figure which had fallen to 8.6% for GHFT and GHC, stating this was partly driven by bank staff applying for substantive roles as a result of a reduction in the number of bank shifts available. SEA highlighted that remaining vacancies are in specific areas and reported that there is work ongoing to raise the profile of these areas through shadowing and additional opportunities for student nurses. SEA further added that both trusts had seen a significant decrease in agency usage.

7.4 The ICS sickness rate was 4.1% which was lower than outlined in the operational plan and continued to reduce.

7.5 SEA explained that systems had not been heavily monitored against the operational plan in terms of workforce but would be this year. Monitoring against the plan had been added to our dashboard and the first review meeting with NHSE would shortly take place.

7.6 SEA reported that GHFT had an agency spend of 3% and GHC 2%, combined totalling 2.7% which meant they had met the 3.2% agency spend cap for month one and two, however there was a risk that the new UEC contract may impact on temporary staffing usage around November.

7.7 SEA reported off-framework usage had been identified as a high-priority area for NHSE and questioned whether further scrutiny within Gloucestershire was required due to the monitoring now in place and the specialist areas, namely mental health, and seasonal variation where use of off-framework agencies would still be required.

7.8 NS commented that both the regional and national teams had confirmed there was still a break-glass permissible arrangement for off-framework agency usage where organisations had been through an appropriate process and was a matter of patient safety. NS added that the regional team had asked organisations to consider an internal audit to give further assurances to provider Boards and ICBs that enough is being done.

7.9 AR queried whether, based on the knowledge that there are times of year where more staff are required, staff could be offered the flexibility to work less hours during the summer with the understanding that they would be working more hours during the busier periods thus further reducing the usage of temporary or agency staff. SEA responded that bank staff often chose this type of employment over a substantive position due to the flexibility it afforded them but still have a certain amount of money that they need to earn per month, so this wouldn't make a difference for them but reiterated that there had been a noticeable shift in bank staff applying for substantive roles.

7.10 JC commented that when previously working in a paediatrics team many of the staff had annualised hours contracts, working less hours in the summer and more hours in the winter, and that had worked well.

7.11 CR gave an overview of the off-framework usage for GHFT which included no medical, dental, or non-clinical staff:

- April: 4 out of 800 shifts
- May: 4 out of 738 shifts
- June: 2 out of 619 shifts

CR added that numbers were low, and controls were good so GHFT were not hugely concerned about off-framework usage, but that the primary reason for bank staff leaving for substantive posts was due to a reduction in enhancements.

7.12 NS confirmed that GHC offered a range of contract options, which included annualised hours, as part of a flexible working policy. NS reflected on previous experience in a different hospital where the use of annualised hours had helped with seasonal workforce demands in a planned way but stipulated that in GHC it would not be of use for non-acute services, which have highly specialised areas that would always require some off-framework usage.

7.13 KC stated that she had some queries regarding the sustainability of the overall WTE numbers but would send a separate email outside of the meeting.

7.14 JC requested information on the following queries:

- was there a way to monitor the impact of the proposed changes to overall head count reduction?
- How was the last bullet point on the operational plan relating to productivity of nursing, midwifery and medical staff going to be monitored, what does it mean, and what would NHSE be expecting in terms of data?

Regarding the second query SEA advised that they would discuss this in the upcoming review meeting with NHSE and would inform JC of the response.

Action: Update the People Committee on how workforce productivity is being measured **TC / SEA**

7.15 CR advised that GHFT had introduced a workforce controls and oversight process so have some insight into the impact this has had on patient safety and could share some of the detail outside of the meeting. **CR**

RESOLUTION: The People Committee noted the content of the Workforce Intelligence & Programme Highlight Report.

8 **Apprenticeships Update & Strategy**

8.1 SEA explained that the apprenticeship strategy had been approved at the Education and Training steering group (ETSG), shared with the two other steering groups, virtually approved by the People Board, and was being presented to the committee for ratification.

8.2 A pre-recorded presentation created by Mandy Tuckey (MT), ICS Apprenticeship and Widening Participation Programme lead, was shown to the Committee and had been circulated to members as part of the papers.

8.3 The key points presented were as follows:

- The long-term workforce plan set a target for 16% of all clinical training to be delivered via an apprenticeship by 2028, and to rise to 22% by 2031. To date, this is at 7% nationally and 2% in Gloucestershire.
- The Gloucestershire apprenticeship strategy sets out local workforce challenges and the need to maximise awareness and accessibility of learning opportunities across all staff groups.
- The strategy would be overseen by the Apprenticeship Network and ETSG.
- Government announcement on apprenticeship funding delayed until Autumn.
- The number of apprentices who had withdrawn from programmes and expiration of levy had both reduced across the system.
- There was a reduced number of apprenticeship starts this year which had been raised as a risk and could impact the viability of key programmes for Higher Educational Institutions (HEIs) and other educational providers.
- The 2024/25 focus included delivery of the apprenticeship strategy in key areas identified by the long-term workforce plan and future gaps in workforce needs, the onward journey of T-level students in the system, and promotion of the opportunities and careers within health and social care.

8.4 TC commented that the update from the We Want You team and MT had illustrated the current variance from assumptions in the LTWP at system level (where it currently is and where it would need to be), and queried whether there was good visibility within GHFT and GHC around the challenges at both organisational and system level. TC discussed whether it would be useful for MTs presentation to be disseminated within each organisation or made available to teams for information and to aid in understanding the strategy.

8.5 NS explained that with the particular focus on finance, managers had found it increasingly difficult to find space and budget to support these innovations, and that workforce transformation had been added as a new BAF risk for GHC. NS added that the information should be shared and activity around apprenticeships continued as much as possible, but service pressures and onus on finance had definitely impacted on the number of apprenticeships available.

8.6 RT agreed that the opportunities for entry level apprenticeships had reduced more recently, and managers had cited a lack of flexibility in budgets as one reason for this. Another reason was the lack of opportunities available to (mainly non-clinical) apprentices once they had completed their programme.

8.7 CR commented that she had found the discussions helpful and had not been fully aware of the extent of the opportunities that existed and proposed that more attention be paid to the challenges in this space, as well as the potential for collaboration across organisations.

8.8 CG stated that the view from managers within the ICB was that the time and effort to support someone on an apprenticeship was a lot, and were already feeling stretched, so there was a need to look at how managers could be supported to take them on.

8.9 KC agreed adding that T – level and apprenticeship students had significant impetus to increase an organisations' diversity further and suggested that managers may find it easier to support as part of an organisational strategy with longer-term gains. KC added that as local people tend to stay local it could also generate positive impact on future retention of the workforce.

8.10 KC confirmed that the committee approved the strategy. JC suggested a further conversation to discuss the implementation of the strategy at a system-wide level to mitigate risk further down the line. TC to arrange a follow-up meeting to discuss – member participation to be agreed. **TC**

RESOLUTION: The People Committee approved the Apprenticeship Strategy.

9 We Want You Team Update

Charlie Presley (CP) joined the meeting.

9.1 CP shared a presentation and gave an update on the project to date and next steps. CP identified the main drivers for the project which included recognition of a significant shortfall in health and social care employees identified in the long-term workforce plan, the need to widen access to health and care roles for young people, and the promotion of One Gloucestershire as an employer of choice.

9.2 CP outlined that the project had focussed on supporting young people to reflect on their skills and personal interests, and how these could be matched to a future career in health and care. The team engaged with over 8,000 students across nineteen schools across Gloucestershire via face-to-face workshops, commissioned drama performances, careers fairs and guest speaker talks.

9.3 CP listed the teams project highlights:

- asked to participate in a case study with NHS Employers to discuss how the project was conducted and the teams' engagement with young people;
- in June they had been part of a panel discussion about supporting new people into the workforce at NHS Confed; they have since been invited to another conference in September.
- the team had been entered into the Health Service Journal (HSJ) award for workforce initiative of the year.
- funding for the project had been secured until May 2026.

9.4 CP discussed interventions used by the team to support established routes into healthcare, and described some new initiatives which would include working with Public Health to develop new workshops for students, such as an anti-vaping workshop which had been successfully delivered to over 500 students; the centralisation of work experience listings across the system and offer of one-to-one career coaching support for students aged fourteen and above.

9.5 While discussing career pathways, CP highlighted the importance of availability of apprenticeships and T-levels which could provide young people an alternative route to University for certain career pathways.

9.6 CP shared a video which had been co-produced with drama students from Cleeve School and NHS professionals and outlined what the project aimed to achieve. Committee members provided positive feedback on the video and its' emotive qualities.

9.7 TC queried what the quality of existing career coaching support within schools was like. CP replied that it was variable based on the level of involvement of the career lead but remarked that the same could be said of the conversations that young people were able to have with parents and how knowledgeable they were about potential next steps and career pathways, so the team may also look to focus some work in that area. CP informed the committee there are two new employees who bring valuable insight and experience in these areas to the team.

9.8 CR sought detail on the interaction and collaboration between the We Want You team and the widening participation teams that sit within GHFT and GHC. CP advised the teams all work closely and had arranged monthly touchpoint meetings which would be used to plan who attends what events, with the general consensus being that the We Want You team would be the main, front-facing outreach team. They also work closely around the apprenticeship and work experience agenda and placements. SEA added that a task and finish group looking at recruitment events would be set up to ensure best use of resource and minimal duplication of work.

9.9 KC queried when the team would be able to measure the impact of the work undertaken in schools and how it had resulted in people in enrolling in apprenticeships and other programmes. CP explained that the team capture data after every intervention, for example a survey is completed after every workshop, and that next year they will speak to the same students again to understand how many may now be considering a career in health or social care or an apprenticeship, what their career aspirations are and have they changed, so year on year will build up ongoing data.

9.10 NS mentioned the recent King's speech and speculated whether the announcement of the new Skills England set up, and focus on upskilling staff, may provide future opportunity for the team.

9.11 CR remarked that due to present focus on finance and reduction of headcount that the number of apprenticeships on offer has been reduced and suggested a future conversation around the implications and risk of this would be prudent.

9.12 JC agreed with CR and debated if there is a risk of raising students' expectations around career pathways and apprenticeships without having the physical placements to offer. SEA confirmed that the team are looking at this closely and agreed that the short-term finance focus is a risk. SEA added that this had been flagged at meetings with NHS England (NHSE) as it has already begun to impact certain areas. The University of Gloucestershire (UoG) had raised that there was a lack of roles for newly qualified physiotherapists to go into and insufficient numbers for the September nursing associates cohort. SEA concluded that the regional team have listened to concerns but identified that it may not have the same impact at national level.

9.13 KC summarised that the committee recognised the emerging risk of short-term versus long-term workforce plans and suggested taking the discussion to the next Board development session. JC stated that she would be happy to participate and discuss her

previous experience in this area. TC to organise a meeting to discuss how to take this forward. **TC / KC**

RESOLUTION: The People Committee noted the content of the We Want You team update.

10 <u>One Glos. Advanced Practice High-Level 5-year Strategic Ambitions</u>

Susie Durrell (SD) joined the meeting.

10.1 SD shared a presentation that discussed high-level strategic ambitions for advanced practice which would be circulated to the committee following the meeting. SD stated workforce transformation in relation to advanced practice was fundamental to the delivery of new models of care as outlined in the long-term workforce plan, and would be central to attracting, building, and retaining staff in Gloucestershire.

10.2 SD advised that advanced practice had been defined in 2017 by NHSE in the multi-professional framework as experienced, registered healthcare practitioners who have a high-level of autonomy and the ability to make complex decisions, which is underpinned by a master's level award (or equivalent) across four pillars of practice. Through working in multi-professional teams to support the new models of care, advanced practice should also impact quality of care.

10.3 The NHSE Centre for Advancing Practice was established in 2020 to put in place a national standard, to accredit academic institutes with advanced master, level 7 accredited programmes, and development of an ePortfolio to be used to support current, highly experienced practitioners to become advanced practitioners (APs).

10.4 SD referenced the centre's governance maturity matrix which aimed to assist providers and systems with credible governance, and reflected that Gloucestershire still had a way to go in this area. SD stressed that organisational leadership would be key to progress as this was complex, transformational change.

10.5 SD discussed issues regarding data quality in Gloucestershire about advanced practice WTE, advising that the figures for primary care and GHFT had likely been overestimated. SD highlighted that advanced practice had not yet been developed with adult social care, voluntary or end of life sectors and therefore could provide future opportunity. Current AP involvement across the system would include GHFTs Fit for the Future strategy, acute care response team, same-day emergency care, and the virtual ward, with many further and significant opportunities to be explored.

10.6 SD gave an overview of AP trainee numbers which had increased from 19 in 2022 (4 continuing trainees and 15 expressions of interest) to 42 in 2024 (20 continuing trainees and 22 expressions of interest), with 83% of those undertaking the preferred apprenticeship route.

10.7 SD emphasised the funding potential aligned to AP trainee education and supervision, which for 2024 totalled £438,400.00. Funding per trainee could be up to £8,600 of which a minimum of £2,600 must go towards their supervision. SD advised that additional funding had been secured for a learning and disability and autism AP trainee in GHC and two critical care trainee APs in GHFT and that the ICS lead funding of £40,000 was non-current.

10.8 SD explained the significant stakeholder engagement and oversight that had gone into producing the strategy and had produced sixteen themes showing the breadth of work to be done. A prioritisation exercise had then been completed which had demonstrated the limited experience within the system of workforce and financial planning in an integrated way, and how important the leadership and cultural work would be in delivering change for advanced practice and enabling multi-professional teams to work well together.

10.9 SD raised issues with the current model in Gloucestershire, specifically:

- there was no recurrent funding for the ICS AP lead role from December 2024 and would require a business case.
- GHFT had recently appointed a part-time Trust AP Lead in May, however GHC have not yet been able to determine how to fund a designated lead role.
- Primary Care, whilst having secured funding for 0.1WTE AP lead had not been successful recruiting to the role in the last year.
- NHSE had indicated that their support role would reduce, and oversight would be passed to system and Board level.

10.10 SD summarised that the request to the People Committee was to approve the high-level ambitions in the strategy, recognising the risks to delivery relating to the lack of funding around leadership infrastructure to deliver the strategy and provide oversight, and to provide guidance and support for pursuing future funding. SD finished by expressing particular thanks to NS and ZP who had supported putting the information together.

10.11 KC thanked SD and commented that the information presented had given further depth to the papers circulated prior to the meeting that they could reflect on.

10.12 NS also offered thanks to SD and recognised the huge amount of work and engagement undertaken by SD in developing the plan. NS reflected that it was an ambitious and challenging vision for advanced practice but would need to be delivered on to enable the provision of high-quality services. NS connected the work required in this area to the already noted importance of leadership development and rightly skilled leaders across the system, alongside the consideration of how the system could optimise and mature the longer-term workforce panning and clinical engagement required to deliver on the plan.

10.13 AR expressed strong support of the plan and put forward that there needed to be a clear picture of the future demands and requirements of the emerging workforce in order to progress it. The committee discussed whether early recognition of talented staff should be pursued, and development opportunities made available to them sooner which could aid in growing the workforce needed for the future.

10.14 SD concurred with the general idea but reiterated that advanced practice was mid-career development aimed at established individuals who already have significant credibility within their area and scope of practice. SD elaborated that there would be extremely robust interview processed to ensure the right people are trained but acknowledged that it would not be for everybody, nor was it an easy development route.

10.15 SD expressed concern at the diminished number of consultant level roles within Gloucestershire which was at odds with the career progression associated with training staff to be an AP. RT agreed and emphasised the need for available roles for staff to go into once qualified, and that this was not just about finding money to send staff on a course, but was about career progression, changing way the system works to deliver

services and would require a complete shift in way service plans and workforce development was reviewed.

10.16 JC added that there would be a socio-economic impact as more experienced clinical staff tend to deliver safer patient care and thus the AP role would impact positively on patient outcomes and could also enable positive changes in terms of length of stay and productivity.

10.17 TC stated that the discussion illustrated the risk of how aspirations in the long-term workforce plan deviated from the current climate and financial focus and stated that the loss of the ICS AP Lead role in December had been rated 15 on the risk register. TC added that it would be important for the business case to outline not only the discussed risks but the wide-ranging positive impacts, and also visibility of the income that would come into the system. TC and ZP offered to work on the business case with SD.

10.18 The committee discussed the importance of having clearly defined models of care and how it could support better workforce planning. AR stated that alongside MC they would be looking into this, specifically relating to Clinical Programme Groups (CPGs).

RESOLUTION: The People Committee supported the One Glos. Advanced Practice High-Level 5-year Strategic Ambitions.

11 Staff Health and Wellbeing Strategy

11.1 ZP introduced the strategy that had been circulated prior to the meeting and advised that Marie O'Neil, who could not attend the meeting, had been key in putting the strategy together. ZP outlined that the strategy had been under development for a long time and had undergone many iterations and review through a number of system-wide groups before arriving at the committee and is focused on the health and wellbeing (H&W) of staff, what is on offer to support staff and also wider leadership and cultural efforts that would support staff to feel valued.

11.2 ZP drew attention to the vision statement and broad strategic themes around culture and leadership, access, and inclusion, ensuring that all offers are available to and used by all staff in all demographics, and focused H&W programmes. A delivery plan had been included on page 128 of the papers.

11.3 ZP discussed that whilst each organisation rightly provided access to a range of H&W offers and services, they did not resolve some of the wider determinants of self H&W outside the immediate scope of the H&W strategy, such as needing to work additional hours because there aren't enough staff, and that the strategy did include a list of examples of other things that would also be important to consider.

11.4 ZP confirmed that the strategy was linked to the Board Assurance Framework (BAF), specifically the risk associated with providing a compassionate working culture for staff. ZP also raised the link between H&W and EDI and how despite offers being made available, certain demographics of staff do not access them, and that there is ongoing work looking into this. ZP offered to answer any questions and summarised that the strategy had been presented to the committee for ratification.

11.5 JC commented that the strategy stated that each organisation had its' own H&W strategy and queried why, acknowledging that challenges and priorities would vary across organisations but that the actions required from each organisation based on a singular vision could be different. ZP responded that work had begun on the ICS

strategy after individual organisations had already developed their own, and that whilst it had been challenging to balance the need at organisational-level against what made sense to do at system-level, going forwards any review of individual organisations' strategy would consider and reflect on the new ICS strategy.

11.6 JC suggested that the word 'unconsciously' used on page 104 of the strategy in the middle pillar that talked about access inclusion be removed or changed. JC queried the language used in a non-specified section of the strategy and whether it was strong enough. This related to projects and JC advocated for this to be changed to something more action orientated and to call them actions or priorities rather than projects. JC also expressed a need for further work to be done around pastoral care and support for internationally educated staff who don't culturally feel comfortable or able to speak up.

11.7 ZP acknowledged the points raised by JC, adding that some of the EDI elements were more strongly reflected in separate EDI strategies.

11.8 KC remarked that there should be some core elements of support staff should expect to receive irrespective of which part of One Gloucestershire or organisation they work for, so working out what would need to be consistent across the system could be key.

11.9 CR reflected that the finalisation of the ICS H&W strategy could now be used to facilitate system-wide conversations about H&W, and possible future approaches to resourcing and services which previously had not been possible.

RESOLUTION: The People Committee approved the Health and Wellbeing Strategy.

12 People Committee Risk Register and Board Assurance Framework Update

12.1 TC advised this month's risk register included risks rated 12 and above, and that the layout had been amended slightly to align with the preferred format and style of the audit committee. TC highlighted that some of the highest rated risks did relate to conversations had during the meeting and specifically the risk related to the reduction in apprenticeship starts which had been rated 12.

12.2 TC stated that the meeting had clearly illustrated some of the challenges in the system in terms of the current financial focus and the effect of this on aspirations for fulfilling requirements of the long-term workforce plan and would deliberate on how to reflect this in the BAF, as there is limited visibility of this in the wider system.

12.3 CG commented that Gill Morgan had requested a dedicated session with partners on the BAF and wanted a couple of areas they could look at in depth and then would agree on an approach, and that workforce could be a good area to put forwards. KC and JC agreed.

RESOLUTION: The People Committee noted the content of the risk register and BAF.

13 Any Other Business

13.1 KC queried whether, in light of the recent Too Hot to Handle report, the systems' EDI plans should be reviewed to provide further assurance that they would stand up to scrutiny, and suggested that TC, NS, CR and KC look at the plans again and reflect on them against the recommendations of the report.

13.2 CR stated that she would be happy to but added that the EDI framework that seemed most commonly used, and included senior leadership, was the high impact actions framework that all organisations have to report against and could be linked to the findings of the report.

13.3 JC commented that the traditional ways of addressing the types of issues identified were tick box exercises and supported the suggestion of reviewing the plans.

13.4 TC shared that there had recently been a regional conversation about the report in which frustrations emerged as despite ongoing effort, there had been little change, and that the next system-wide development session in November could be used to facilitate local discussion around the report, how it could interface with existing work, and so may focus on the leadership and accountability aspects.

13.5 KC stated that the biggest difference she had noticed moving to the public sector was that this agenda is seen as being owned by human resources (HR), whereas in the private sector it is owned by Chief Executives and Boards with support from HR and so the conversation could perhaps focus more on what our leader could do to help drive the agenda as it is everyone's responsibility.

13.6 NS advised that GHC Board had spent a day last month discussing the report and EDI agenda, but the heart of the matter always led back to leadership. NS offered to share information about the approach and exercises that the team used with the board.

13.7 KC thanked the committee for their time.

The meeting ended at 17.02pm.

Date and Time of next meeting: Thursday 17th October 2024 at 2pm in Shire Hall.

Minutes Approved by: NHS Gloucestershire People Committee

Signed (Chair): Karen Clements
Date:17th October 2024

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Public Session

Thursday 8th August 2024, 14.00-17.00pm
Via MS Teams

Members Present:		
Ayesha Janjua (Chair)	AJ	Non-Executive Director, NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Prof Jane Cummings	JC	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MC	Chief Nursing Officer, NHS Gloucestershire ICB
Participants Present:		
Carole Alloway Martin	CAM	Cabinet Member for Adult Social Care Commissioning, GCC
Declan McLaughlan	DM	Head of Primary Care Contracting, NHS Gloucestershire ICB
Christina Worle	CW	Dental Strategy Clinical Lead, NHS Gloucestershire ICB
Katrice Ewers	KE	PCN Service Implementation Manager, NHS Gloucestershire ICB
Julie Symonds	JS	Deputy Chief Nursing Officer, NHS Gloucestershire ICB
Jo White	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
Becky Parish	BP	Associate Director Engagement and Experience, NHS GICB
Nigel Burton	NB	Director, Healthwatch Gloucestershire
In attendance:		
Christina Gradowski	CGI	Associate Director Corporate Governance, NHS Gloucestershire ICB
Dr Emma Crutchlow	EC	GP and Clinical Director Inner City Gloucester PCN
Andrew Hughes	AH	Associate Director, Commissioning, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Meryl Foster	MF	Primary Care Senior Programme Manager, NHS Gloucestershire ICB
Kirsty Young	KY	Programme Manager, Primary Care, NHS Gloucestershire ICB
Jeanette Giles	JG	Head of Primary Care Contracting, NHS Gloucestershire ICB
Sian Williams *(Item 15)*	SW	Community Pharmacy Clinical Lead, NHS Gloucestershire ICB

1. Introduction & Welcome

1.1 The Chair welcomed members to the public session of Primary Care & Direct Commissioning (PC&DC) Committee. The meeting was declared to be quorate.

2. Apologies for Absence

2.1 Apologies were received from Ellen Rule, Helen Edwards, and Ryan Brunsdon.

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)

There were no new Declarations of Interest to note for this meeting.

4. Minutes of the Previous Meeting held 6th June 2024

4.1 The minutes of the meeting held on 6th June 2024 were approved as being a true and accurate record.

5. Action Log and Matters Arising

5.1 **Action 4 – TWNS PCN Evaluation.** Ongoing review around Quality Improvement (QI) which could take three to four months.
August Update: Added to the October meeting. Action closed,

5.1.1 **Action 19 - Audiology & Optometry Services.** Item to remain open until it can be added to the Primary Care Highlight Report and then discussed as Deep Dive. **Action to remain Open. August Update:** Audiology and Optometry Services to be added to the Forward Plan and date to be confirmed for future meeting. **Action to remain Open.**

5.1.2 **Action 21 – Radiology Requests.** AR is to meet with Paul Atkinson and Mark Pietroni to try to resolve. AR will send an update to RB following the meeting and then the item can be closed, but until then: **Action to remain Open.**
August Update: AR informed that an interim solution had now been found for outpatient radiology results via the Business Intelligence team. **Action Closed.**

5.1.3 **Action 23 – GP Sickness Pay.** Shofiqur informed that work was ongoing. To come back with more information at a future meeting. **Action to remain Open.**
August Update: Further analysis required. **Action to remain Open.**

5.1.4 **Action 24 – POD Governance.** Revised paper to be brought to August meeting. **Action to remain open. August Update:** POD Governance on Agenda for today. **Action to be Closed.**

5.1.5 **Action 28 – Community Pharmacies.** Included within the June agenda but a revised paper to be brought to August meeting. **Item to remain Open.**
August Update: Community Pharmacies On Agenda for today. **Action to be Closed.**

5.1.6 **Action 29 – Practice Boundary Changes SOP. August Update:** Added to the forward plan but date to be confirmed for future Agenda item. **Action to be Closed.**

5.1.7 **Action 30 – Digital Tools & AccuBook Renewal. Item to remain Open.**
August Update: A Paper was circulated during the June PCDC Meeting. **Action to be Closed.**

5.1.8 **Action 31 – Integrated Neighbourhood Teams. August Update:** Integrated Neighbourhood Teams been added to the October Forward Plan. **Action to be Closed.**

5.2 **Matters Arising – Interface Working Group Update**

AR updated on the Interface Working Group, informing that good progress had been made. The Interface document was nearly complete and was ready to be signed off by the two Medical Directors. Due to collective action the actions had been split into two lists, the Immediate and the To Be Resolved actions. A progress update was anticipated from the Primary Care Liaison Officer around funding and Richard Thorn would be writing the job specification. The role would require acting as liaison between Gloucestershire Hospitals NHS Foundation Trust (GHFT) and general practice and addressing any issues with GHC to examine how this could be managed without the

involvement of senior clinicians. AR felt that the meeting had highlighted the understanding of respective positions and there had been a realisation as to how much pressure general practice was under. Further events would be able to progress some of the actions.

In terms of next steps, AR informed members that a paper showing the actions and progress made on those, would be brought to Strategic Executives in mid-September. The Chair acknowledged that positive progress had been made. **Action: AR to provide verbal updates on the Interface Working Group to future committee meetings.** **AR**

5.3 The Chair thanked the Primary Care team for the format of the paperwork for the formal part of the meeting, stating that the compilation and presentation for reporting had been very helpful. The Chair welcomed any further comments or feedback on the new format from Committee members.

6. Direct Patient Care Additional Role Reimbursement Scheme (ARRS) process

6.1 JW explained that the paper was straightforward, with the form (which had been based on that from another ICB from the South West) referring to how any new request for proposed ARRS roles would be dealt with.

6.2 The Chair referred to the pharmacy roles having been nationally approved but Primary Care Networks locally were still being expected to go through the process. The Chair wondered whether it was necessary to duplicate this process.

6.3 KE responded to this, saying that the pharmacy roles had been detailed in a national document and paperwork was still needed to support this, although this had been evaluated with two Business Managers and a Clinical Director, who had made minor changes to the form, and which had been agreed by the Primary Care Operational Group (PCOG).

Resolution: The Committee endorsed the suggestion from PCOG to take forward the paperwork and the ARRS funding process, having noted the amendments to the form.

7. Enhanced Access Plans 2024/2025

7.1 JCu had read the background to the Enhanced Access Plans and queried a reference to three Primary Care Network (PCNs) not being informed. JW explained that this meant the PCNs had not shared any updated plans with the Primary Care team. No further changes had been shared, so the plan being seen by the Committee was their existing plan that they would be continuing with. JW confirmed to JCu that this intention had been confirmed with the individual PCNs.

7.2 AJ referred to the part in the paper which said it had been approved by PCOG based on confirmation that this could be clearly identified and audited and met the Gloucestershire approved criteria. JW clarified by saying PCNs had a requirement to meet the needs of their patients and to deliver the specification, and this referred to PCNs conducting their own audits.

7.3 JCu asked whether there was a way of examining from the audits, that what was being delivered was meeting the needs and expectations for patients as far as possible, understanding the current pressures in Primary Care. Although the ICB had scored

above the national average for the Patient Survey in Gloucestershire, there had been quite a deterioration in several of the measures around access and contact.

7.4 JW said that as part of Enhanced Access, PCNs were expected to survey their patients using population health management to understand and to ensure that patients' needs were being satisfactorily met. PCNs did survey their patients and checked in with Patient Participation Groups (PPGs). There would be flexibility to conduct services around lifestyle challenges and around appointments. The PCN models are reviewed for agreement by the ICB when any changes are requested.

Resolution: The Committee approved the recommendation of PCOG to approve the Enhanced Access Plans for 2024/2025.

8. South West NHSE Proposal for Stabilisation Programme

8.1 PCDC were asked to note that since the PCOG meeting on the 9th of July, an updated paper had been received from the Regional Team (31st July 2024) and therefore the new recommendation was as follows: Approval for Option 5 - contracting model for the South West Stabilisation commissioning of existing and new Stabilisation contracts.

8.2
- Option 5 noted a hybrid contracting model (Option 3) of continuing with Contract Variations for existing NHS dental contracts and procuring new Personal Dental Services (PDS) agreements, with suitable non-NHS mandatory dental providers.
- The ICB team had reviewed the changes and had welcomed this addition. The PCOG minutes had raised concerns around the potential risk of PDS agreements, enabling NHS providers the option to hand back GDS (Mandatory services) contracts, replacing their NHS commitment with a short-term Stabilisation service. Option 5 would mitigate this risk, and also allow competitive procurement opportunities for non-NHS dental practices who would be awarded the PDS agreements.
- The flexible commissioning model would enable practices with NHS contracts, to rebase a proportion (no more than 25%) of their contract for the sessional equivalent of Stabilisation or urgent Out of Hours sessions. This would be at no additional cost to the ICB and would sit within existing allocated contracted amounts, being a helpful option for practices who were unable to recruit, and where sessional working might attract dentists into NHS contracted work.

8.3 MH said this activity was backed up from GHFT's waiting list and counted as their Elective Recovery Fund (ERF). MH asked if it counted as ERF for the ICB and CL said that it would not be counted as ERF for the ICB.

Resolution: The Committee endorsed the recommendation from PCOG to accept the Option 5 contracting model for the South West Stabilisation commissioning of existing and new dental contracts.

9. Gloucestershire procurement proposal for an interim Oral Surgery Tier 2 delivery model in General Dental Practices

9.1 It was brought to the Committee's attention that the Commissioning Support Unit's (CSU) regional team capacity issues could potentially limit and delay delivery for the ambition of a 5-month time frame procurement exercise. The waiting lists at GHFT would continue to increase should further capacity not be sourced via skilled Intermediate Minor Oral Surgery (IMOS) trained dentists within the county.

9.2 The Chair asked whether there was anything that needed to be added to a Risk Register or flagged from a risk perspective, or were the risks included within the dental risk incorporated in the Corporate Risk Register (CRR).

9.3 MF informed that the procurement element did still fit into some of the risks that were being measured. AJ observed that Risk 8 in the CRR related to dental and suggested if the procurement element of dental had not already been added, it could be incorporated into Risk 8.

9.4 CL mentioned that she would like to see the financial impact of the procurement proposal added to the cover sheet and requested this as a standing format for all cover sheets. **Action: JW to amend cover sheet format to include the financial impact of the paper as a standing section.** **JW**

Resolution: The Committee endorsed the recommendation from PCOG to approved Option 2 for further increasing the IMOS capacity and joining the regional procurement approach already being undertaken.

10. Dental Mapping Tool Procurement Proposal

10.1 The Dental Mapping Tool had been discussed at various South West (SW) Dental Forums, i.e., the SW Dental Operational Group (SW DOG) and SW Primary Care Operational Group (SW PCOG). There was nothing to add to the papers previously circulated to members of the Committee.

10.2 The Chair had found it interesting that one of the concerns in the paper had been "Requires a collaborative agreement with all SW ICBs" and saw this as a positive, realising at the same time that this could potentially create further work.

10.3 The Chair said the only thing she had seen in the papers around the tool and the impact would have been an example to provide information to support national priorities of a dental van in Core 20 areas. The Chair asked what difference the tool had made in using it, versus not using it. The Chair said that there was probably a supposition that once procurement had taken place, then impact would be realised and built up.

10.4 JW said this would help support the ICBs dental strategy and enable the understanding of future dental requirements. MF added that the collation of huge amounts of data from various sources would reflect the future positive impact.

Resolution: The Committee endorsed PCOG's recommendation to approve Option 1 for the regional procurement of the Dental Mapping Tool at a cost of £4.3k per annum for a three-year contract with the ability to extend the contract by a further two years.

11. Changes to Community Pharmacy Professional Advice Service

11.1 NHS England South West (NHSE SW) had advised the South West Clinical Commissioning Hub (SW CCH) that the current arrangement for Community Pharmacy Professional Advice had ended in June 2024, due to a NHSE SW restructure.

11.2 Continuing access to Community Pharmacy Professional Advice was essential for the Clinical Commissioning Hub (CCH) , including input into the Pharmaceutical Services Regulations Committee, Fitness to Practice applications and complaint/incidents or investigations.

11.3 The request via South West PCOG had been for the procurement of a clinical resource across the seven ICBs at a cost of approximately £800 per annum per ICB. DM had confirmed affordability with the Finance Team. It was noted that as NHS Somerset already hosted CCH colleagues, that this arrangement be extended to the new role(s).

11.4 There had also been a discussion as to whether the ICB could in future access this advice for more dedicated ICB support, even if it might incur additional cost. This would be investigated. There was nothing further to note from members of the Committee to the papers circulated prior to the meeting.

Resolution: The Committee endorsed PCOG's recommendation to support Option 1 in order to secure continuity of Community Pharmacy Professional Advice.

12. Board Assurance Framework (BAF) and Risk Register

12.1 JW informed members that the Committee had a total of 14 assigned risks with a score of 12+. Three new risks had been added since the last meeting in June 2024. There was still an overarching risk around instability in general practice with the addition of collective action, increasing the risk score from 15 to 20.

12.2 JW spoke about the Special Allocation Scheme (SAS) for patients who had been barred from their GP surgeries, informing that the SAS provider had capped the service. It was hoped that spaces could be found for those being added to the list, by following appropriate discharge of other patients on the scheme following clinical review.

12.3 There was a risk in how the split in the Forest of Dean's PCN would be managed. This was a large PCN, and JW was working with key colleagues involved to recognise and mitigate any arising risks, enabling a smooth transition.

12.4 JW explained that the Primary Care Training Hub contract was another risk that had been added to the register.

12.5 The Chair referred to the report which had detailed four new risks. JW said one of these had been around Drybrook Surgery, where the risk had since been closed due to the surgery now having received their Care Quality Commission (CQC) registration. This risk would therefore be removed from the next PC&DC Risk Report.

12.6 The Chair asked whether there would be updates for this Committee about the risks and implications regarding the PCN split in the Forest of Dean. JW said that this would be the case, with discussions still being in early stages. It had only just recently been confirmed to JW which practices would be on which side of the split. This would involve a lot of work, including how the split would affect patients and how communications needed to be organised.

12.7 JCu queried whether there were any financial implications regarding the Forest of Dean PCN split. JW explained that funding was paid on a "pay to population" basis but this along with the underspend would have to be worked through. Support was provided to practices if they merged around legal and accountancy issues, but it was too early to say whether this kind of support would be required and would require sign off from CL and HG. Any support for roles given to practices by Clinical Programme Groups, if required, would not involve large sums of money.

12.8 AH asked whether other practices in the area might want to become involved with the Forest of Dean split, thinking that this might be a better configuration for them. JW said she did not believe this to currently be the case.

12.9 MCr said she recognised the new risks on the register as being current (therefore they had not been listed previously), but there were a few that had been listed for some time which were still showing the original risk score. MCr thought this meant that the mitigations were probably not working, or might just be holding, and wondered if anything further could be done to address this situation.

12.10 JW said that there were some risks which were outside of the control of the Primary Care team and mitigations were put in, closely working with practices around (for example) recruitment or finances, but often the overarching influences were outside the sphere of the control of the team.

12.11 CGi said the financial risk was well known and suggested some risks could be re-opened every year showing the current date. Some of the risks would not move as they were intractable; auditors knew about this and had said that acknowledgement could be made at year end, that risks had been reviewed, and that the date of 1st April 2024 (and then consecutive years) could be added, giving clarity, and demonstrating that these risks were longstanding. JW thought this would be a very helpful approach.

12.12 The Chair asked whether the Committee could be assured that the plans and controls that had been suggested for the longstanding intractable risks, were being implemented, that updates were being provided and that there was nothing further that could be done regarding mitigations. If that were the case, then the Chair thought that CGI's proposal to close specific risks and then to reset the current date of revision, sounded sensible.

12.13 Further discussion revealed the following considerations:

- High risks would require the appropriate assurance; actions required would need to be comprehensive, flagging any barriers for the implementation of controls and mitigations. Any mitigations (including those for worst case scenarios) put in place should be able to demonstrate positive impacts on those risks.
- Watching briefs could prepare for any escalations in risks, recognising that risk itself was subjective.
- It was suggested a reason that intractable risks should *remain* on the register in order that Primary Care could be better socialised and understood, both in this Committee and system-wide.
- Rapid changes around current and future collective action could affect the level of risk scores.
- High numbers of people on the workforce market were unable to be recruited due to costs, giving a different aspect to the workforce risk.
- Risk appetite in the ICB was fairly cautious and might therefore influence any risk score reduction.

Action: JW and CGi to have a conversation about risk tolerance and to work on refreshing the narrative on the PC&DC risk register, with an update to be brought to a future Committee meeting. **JW/CGi**

<u>Resolution</u>: The Committee noted the content of the Primary Care and Direct Commissioning (PC&DC) Risk Report.

13. General Practice Collective Action

13.1 JW informed the Committee that 98.3% of GPs had voted to take collective action. Local Medical Committees (LMC) were surveying practices in order to understand what actions they would be taking. There were ten actions listed, the tenth one being around the National General Practice Pilot and a recommendation not to sign this.

13.2 The Gloucestershire LMC had requested GPs to limit daily patient contacts per clinician to 25 per day and it was believed that many practices had either moved to this position or were close to it.

13.3 Another action was to cease interface work which LMCs were keen to stop, as this was seen as not being part of the core GMS service. The Primary Care offer was however an Enhanced Service where there was potentially some overlap, so this was being worked through with the LMC, with the potential that Gloucestershire would fare somewhat better in the ensuing situation.

13.4 LMCs were encouraging practices not to sign any new agreements around data sharing which could lead to an emerging risk locally around Joining Up Your Information 2 (JUYI2), meaning the introduction of a new provider would mean an additional signature from each practice is required in order to be able to share that data.

13.5 JW said Primary Care team were working through complexities around collective action with the weekly system-level Task and Finish Group. A twice weekly cadence was also being held to discuss collective action at a regional level. Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) were managing risks through their own action groups and the ICB were working with Gloucestershire Health and Care (GHC) on building mitigations.

13.6 The outcome of the survey from practices was still awaited from the LMC and in the meantime, closer monitoring had been implemented around appointment data to enable impact visibility in the system. Patient communications would be issued centrally and addressed at a local level.

13.7 MH informed members that a recent meeting with the LMC discussed the Primary Care offer, recognising the importance of practices not becoming financially disadvantaged and remaining viable across the system. MH also emphasised that should collective action have a massive impact, particularly around urgent care, then mitigating actions would have to be taken, despite the likelihood of an impact on system funding.

13.8 A group had been set up with executive leads enabling the monitoring of this work, hoping that the good relationships held in Gloucestershire would be maintained without impacting the urgent and elective care system. Collaborative working with the LMC would continue to minimise the impact on the population of Gloucestershire, whilst considering those individual stances on various issues.

13.9 EC queried the Advice & Guidance aspect around not engaging in data, and MH said this was in the Primary Care offer, and the LMC had not yet suggested that this was an area that needed to be considered first.

13.10 AR said that collective action needed to be separated from what was essentially a reset in Primary Care. There were a number of areas taken care of by general practice which really should have gone to secondary care quite some time ago. Part of what was being done via the primary secondary care interface group was to ensure that

specific work where appropriate was repatriated to secondary care and to allow sufficient time for colleagues be to be able to do this.

13.11 AR explained that specific actions had arisen around collective action with a good narrative from the LMC having been sent to practices, enabling them to decide which actions (if any) that they could decide to take up.

13.12 The impact around seeing just 25 patients per practitioner per day had to be seen in the context of triage and the LMC had been working hard to achieve the best possible outcome, whilst preserving the future of Primary Care and general practice in the county.

13.13 AR felt this reset, rather than being seen as some kind of industrial action, was collective action, aiming to try to move things forward and it was felt that this should be approached with an attitude of goodwill and support towards general practice colleagues, who gave excellent value for money for the Gloucestershire population. Despite good working relationships between the ICB and the LMC, this did not detract from current national and local difficulties, with the hope that discussions would ultimately lead to a mutually satisfactory solution. The Chair agreed with this positive approach regarding collective action.

13.14 EC commented that for at least the past five years or so, many GPs had often had secondary care referral concerns which had caused them huge amounts of administrative work, taking away from their clinical work, and utilising valuable time out of their working day.

13.15 JS agreed with the comments thus far, saying that in secondary care, the discharge information which patients received, needed less primary care emphasis with numerous examples of appointment duplication having been seen in some of the patient feedback. JS felt that some of the conversation today would reflect a positive quality impact being seen in future.

13.16 JCu also agreed with AR's positive "reset" approach and asked how the describing and communicating of the potential reduction of appointments would be managed by any practices who had already commenced collective action, in a positive and constructive manner to their patients.

13.17 MH said this would be something that would have to be examined but some practices were already operating the 25 appointments system and supplementing this with triaging, so were able to offer routine or urgent appointments, according to need on the day. MH said any plans to move away from a model that did not see patients on the day would require further monitoring and greater clarity. Depending on any subsequent decisions from the government around collective action within the next month or so, this could result in fewer problems for Gloucestershire, but should collective action continue for another three to six months, then this would give rise to further conversations.

13.18 JW agreed and said that pockets of action had been seen over the last few months, particularly around the 25 appointments. Having spoken to some practices, there were a few who were not interested in becoming involved and letters had been received from them to say that they would not be engaging in Collective Action. A meeting was to be arranged with the LMC about OptimiseRx (data sharing) to ensure that people understood the implications of what they were doing because in some cases, practices might find it more difficult in terms of the frustrations and challenges it may cause. The full picture would be clearer once the results of the survey were known.

13.19 JCu referenced the letter that Wes Streeting had sent out about the British Medical Association (BMA) taking collective action, had referred to "6% pay awards for all your staff." This did not state all the doctors, just that there would be an uplift to pay for all staff. JCu asked whether this meant that every member of staff that GPs employed, would actually receive 6% and if so, queried whether there would be enough money going into the contract to cover this.

13.20 JW said that it was unknown as to what the staff profile was at any one time for practices, with some paying more for staff than others, often at the expense of their own earnings as GPs. It was thought this could have a massive impact on them and the issue had been raised as a concern with the Primary Care team.

13.21 MH said the minimum wage had increased by 9.8% and so it was not clear as to how that linked into the 6% rise, which did not add up. There would undoubtedly be some more work to be done on this. ARRS roles were excluded as they were not paid through the General Medical Services (GMS) contract, so somehow the PCNs would have to find that 6%, which would prove very difficult for the Business Managers involved.

13.22 The Chair asked how the Committee would be kept up to date and be assured without creating any additional work for the Primary Care team. JW said that as things were rapidly changing and would continue to do so, it would be helpful to be able to deliver regular verbal updates. Statistics could also be provided along with any other relevant information. Collective action changes and metrics received would be filtering in through the regular reports. **Action: JW to provide regular updates on GP collective action to the Committee.** **JW**

13.23 MH suspected that from the many regional meetings being held, that some templates would appear, as things evolved, and these could be shared rather than having to do something separate. JW agreed saying that there was talk of a national dashboard being developed.

Resolution: The Committee noted the current verbal update on General Practice collective action.

14. National General Practice Pilot Update

14.1 MH said that Gloucestershire ICB had been one area asked to participate in the pilot and had spoken to Primary Care Networks (PCNs) at length on this. There had been big issues, as well as being one of the 10 actions, raised by the BMA and LMC, in particular around freedom of information regarding which data could be shared, and at what stage, during the pilot.

14.2 The process and the funding concerns of the pilot had been discussed which had resulted in two PCNs coming forward to bid. There had been 71 bids overall into the process, with Gloucestershire's two high quality bids both being selected. The national intention was to use money which had been set aside for the Long-Term Workforce Plan and the pilot would test best practice across Integrated Neighbourhood Teams and to understand how that could work.

14.3 MH explained that further funding information about the pilot had recently become available, with a baseline assessment requiring completion. There would be different levels of funding for the different items going into Primary Care alongside the GMS

contract, which could present some difficulties for those participants starting at different levels of funding, in the testing of the pilot.

14.4 It was felt there had been a lack of recognition around some of the practicalities from the national team with some of the issues raised by Gloucestershire as not being relevant. The pilot would not be covering additional premises funding, which was not logical and the ICB had informed practices that if this situation were to continue, then funding assistance for premises would be given by the ICB. It was hoped that the eventual realisation of premises being required would resolve this particular issue.

14.5 MH was of the opinion that some of the money should be used for project management which would be needed for the pilot, with collective agreement from everybody involved around funding utilisation.

14.6 During recent pilot discussions, MH had stated that should monies set aside from the Long-Term Workforce Plan not be made available at the end of the pilot period, then practices should be aided with redeployment of staff or any potential redundancy costs by the ICB. Although this risk was minimal and involved the same process as that of all the other contracts, system-wide agreement would still be required.

14.7 The national team had also stipulated that monies could not be used for recruitment costs or for system roles. Other areas had not raised many issues, but MH did think that a common viewpoint would soon be realised. Gloucestershire PCNs were already ahead on some of this work and would be requiring assistance from other partners in the system, potentially leading to some workforce pressures.

14.8 The Chair queried whether other areas had been contacted around some of the issues experienced so far. MH thought that without collective discussion on common issues with other participants, then the pilot would not be a success.

14.9 After sitting on the national panel, JW said it had become apparent that other PCNs had not been thinking similarly to Gloucestershire, although there had been recognition of some problems that needed resolutions. JW hoped that the national team would be able to demonstrate a supportive approach by listening and engaging with PCNs as the pilot progressed,

14.10 MH realised the importance of Gloucestershire having a voice in this process, but it was very likely that the inevitable pressure of collective action on practices could perhaps result in this work being temporarily paused.

Resolution: The Committee noted the verbal update on the National General Practice Pilot.

15. Community Pharmacy Presentation – Current Challenges and Risks

15.1 JW presented on this and spoke about the Pharmacy Needs Assessment (PNA) which was being managed by Public Health and would eventually link into the Primary Care Strategy. Over the past year pharmacy colleagues had demonstrated resilience over pharmacy closures and had worked very hard to minimise impact on their communities, for which they were to be commended.

15.2 A good deal of change had happened in community pharmacies around the county over the recent years, bringing pressures involving changes of pharmacy ownerships, closures, and consolidations.

15.3 In 2021, the available opening hours for patients had been 6178 which had reduced to 5457 and although the number of sites looked similar, the changes behind the scenes had put pressure on the remaining community pharmacies.

15.4 EC queried future contingency plans for patients in Podsmead regarding a pharmacy closure. EC was informed that a contract had been issued to the pharmacy who had until September 2024 to establish a plan and until March 2025 before they could activate this, otherwise the contract would go back out to tender.

15.5 SW gave some prescribing percentages and spoke about the huge demand on pharmacies, stating that there had been challenges in this tough environment, in the sourcing and securing of medicines for patients due to global and national shortages.

15.6 SW listed some of the many mandated services which community pharmacies offered:

- Dispensing of medicines and appliances
- Dispensing of repeat prescriptions
- Disposal of unwanted medicines
- Public Health and Health Promotion
- Signposting
- Support for self-care
- Clinical Governance
- Discharge Medicines Service

15.7 SW spoke about the National Advanced Services (Opt-In) that pharmacies could offer:

- New Medicines Service
- Seasonal Influenza Vaccination Service
- Hypertension Case-finding Service
- Lateral Flow Device Service
- Pharmacy Contraception Services
- New Pharmacy First Service
- Seven common conditions – advice and assessments given by pharmacists
- Minor illness on referral
- Emergency prescriptions

15.8 JS referred to the clinical risk involved in additional competencies and asked whether there had been higher rates of antibiotic prescribing as a result. SW said for all medicines supplied against all those clinical pathway consultations for the seven common conditions, a medicine had been supplied only 47% of the time and antibiotics had been even less.

15.9 JS queried check-in mechanisms for pharmacists who were more isolated in the community around the assessments and prescribing for the public. SW said a national Oversight and Assurance Group had been set up to look at some of the consultations around outliers and potential higher numbers in certain areas for prescribing. The seven clinical conditions had very robust pathways and assessment criteria, with a pain score requiring completion prior to an antibiotic prescription. Greater experience had led to greater confidence, leading to very few numbers being reported to the national Oversight and Assurance Group.

15.10 The Chair asked how many pharmacies had opted to undertake the National Advanced Services. SW said all 105 pharmacies had opted in for Pharmacy First, blood pressure was in the high 90's, contraception was at 75-80, and the new medicines service was at 103, showing that appetite for engagement was extremely good.

15.11 SW informed members about a new locally commissioned incentive scheme called Only Order What You Need (OOWYN) which had been widely accepted, to address medicines waste and to improve the green sustainability agenda. Patients were being encouraged to check their items before leaving the pharmacy rather than afterwards, meaning any incorrectly prescribed items could go straight back into stock rather than having to be destroyed which not only would save money but also benefit to the green agenda.

15.12 EC queried how a regular user of a hormonal contraception would be flagged. SW informed that there was an increasing number of community pharmacists that were getting an independent prescribing annotation to enable them to provide some clinical and therapeutic choices to patients.

15.13 Some local enhanced services had been commissioned from the 105 community pharmacies in the areas of sexual health, such as the supplying of emergency hormonal contraception and substance use disorder (SUD) drugs such as Methadone and Subutex and there was also a needle exchange scheme.

15.14 Closures from Lloyds and Boots chemists had impacted Devon and Dorset far greater than Gloucestershire and changes of ownership had also caused some problems and challenges for teams involved with this.

15.15 Community pharmacists had been working hard to minimise the impact of medicines shortages on patients. Healthwatch feedback identified that this had been, and still was, proving a real challenge for all involved. It was taking longer to source and access certain medicines for patients which often meant a request for another prescription for general practice teams, leading to more work for them.

15.16 Due to a shortage of community pharmacists and pharmacy technicians, efforts were being made to attract more pharmacists into the county. The workforce skill mix needed to be robust whilst community pharmacy tackled transformation. 90% of income for the smaller independent pharmacists was derived from the NHS who had asked for a focus on increased clinical services, resulting in the successful implementation of Pharmacy First.

15.17 SW said the recent delegation to the ICB for Optometry and Dental services had been helping community pharmacy teams to understand that they were now commissioned by the ICB. It was hoped to continue to build those good relationships between pharmacies and associated colleagues across the county.

15.18 SW spoke about current risks:

- Workforce - skill-mix opportunity/availability/clinical supervision
- Investment in new technology - pharmacy digital systems, connectivity with general practice and wider systems and Artificial Intelligence (AI) opportunities
- Relationships with key stakeholders, and other professional bodies, LMC, PCN's, individual practice and pharmacy teams
- Market Conditions – Potential further closures could increase pressures in general practice teams and remaining pharmacies
- Challenge of enhancing CCH support within quality assurance, monitoring and improvement.
- Lost Opportunities – Potential for surgery teams to reduce non-urgent/low acuity appointments and to utilise the skills of Community Pharmacists, in order to provide further resilience to general practice

- Reduced Patient Access - Changes of ownership could result in changes in opening hours, especially at weekends
- Collective Action across both the community pharmacy (CP) and GP sectors. CP had a day of action planned on 19th September 2024.

15.19 JW highlighted that if patients were directed straight to pharmacies during collective action, then this would mean a referral to Pharmacy First from the GPs would not occur, therefore funding could be lost for the pharmacy, which was of concern. It was also of concern that some communications which had gone out to the public had said that they could go to their community pharmacies for advice rather than to their GP, but this was not so straightforward and would need further exploration.

15.20 JW explained that some LPCs received more money than Gloucestershire due to having been successful in various bids and implementing a increased levy. It was hoped in the future that further liaison and closer working with our LPC would help develop the support offer to pharmacies to benefit the people of Gloucestershire.

15.21 SW explained enablers for community pharmacists which included investment in the workforce, legislative changes, digital advances, and the encouragement of building good relationships to support patient care. The ICB would also be hosting an initial engagement event in October 2024, and a Pharmacy First Extranet page was being considered that could be accessed by community pharmacists. There would be active engagement with the CCH and other ICB's to understand and collaboratively improve processes and commissioning strategies.

15.22 Next Steps:

- Forthcoming Communication and Engagement paper – Sept PCOG
- Update on Community Pharmacy Independent Prescribing Pathfinder Programme, with a focus on hypertension and medicines optimisation
- Update on developments/initiatives via SW PCOG e.g., Community Pharmacy Assurance Framework plus ICB observations
- PCN Engagement Leads with revised service specification.
- Update on developments, e.g., DHSC consultation outcome on pharmacy/medicines supervision
- Update paper post new government and negotiation conclusion between DHSC & CPE with the intention to broaden the seven common conditions in Pharmacy First
- Ongoing refinement of highlight and performance reporting via PCOG and also asking the Committee what matters to them.

15.23 JS referred to the proportion of calls that related to repeat prescriptions and wondered how this could be linked in with some of the aforementioned initiatives. There could be an opportunity to work differently with patients who had repeat prescriptions. SW said this was difficult until the majority of community pharmacists were independent prescribers and could potentially become a locally enhanced service. Ellen Rule had informed colleagues that the top number of calls coming through NHS 111 was around dental with the second highest number being around repeat prescriptions due to people running out of medications and sometimes being without medicines for some time. Not everybody could use the NHS app, but continuing efforts needed to be made to encourage this. The Pharmacy First prescription route was via NHS 111 or patients could use the online request service, which patients had found easier to do rather than going through general practice.

15.24 SW said electronic repeat batch prescribing was not used enough and would save time and worry for patients who had long term conditions. Patients could go to their pharmacy and take the next batch prescription directly from the spine.

15.25 EC said her PCN wanted to examine the possibility of putting on some sessions for patients to help them with some digital training and the uploading and use of the NHS app. MH this could be one of the priorities for a Digital Inclusion Group and training sessions could be held with different PCNs in order to demonstrate the use of the NHS app to groups of people, for whom once this had been set up, would be easier for them to navigate.

15.26 NB said, by way of an example, he had run out of medication, saying that he used to be able to request a repeat prescription from his GP online with medications ready for collection within three days. However, despite having ordered some ten days ago, these had not arrived due to not being able to build stock due to rigid timescales, to carry over from one supply to the next, so if a sensible timescale were *not* adhered to, the patient would run out of medication with nothing being in place for preventing this.

15.27 NB felt that it was not really about the alignment, just that the service had become slower, with GPs seeming to take longer to click the button for repeat prescriptions and pharmacists becoming slower at delivery, which was not acceptable to patents. Despite having been without medication for 4-5 days, NB felt that nobody was willing to take responsibility for this.

15.28 SW said in cases such as NB's, where the same medication was repeatedly required, then it could be useful to obtain a batch prescription, which could be explored at a practice level. The Chair asked SW whether this issue was increasing, being measured, what was causing it, and what the system response would be to mitigate the impact on patients.

15.29 BP said that there had been a great deal of activity taking place across the county with voluntary and community sector organisations, who were providing digital training for people. Some PPGs had been very proactive, and others had been taking an interest. The Chair thought that wider communications around processes would also be useful for patients **Action: To co-ordinate training for PPGs more strongly with the Digital Inclusion team and to communicate more widely around processes with patients.** **TBC**

15.30 JCu wondered whether there may be an issue with some pharmacies sending some prescriptions off site which would result in a huge volume of medications being returned to pharmacies, adding extra time to proceedings. Improved communications could help patients to build that in when requesting their medications.

15.31 EC referred to NB's request for medication, thinking that this would go through a pharmacist or pharmacy technician rather than a GP, who would be controlled by the system computer as to what they could issue, and when. NB said that approval needed to be made with GPs earlier and should not be controlled by dates on forms. NB said this was a system problem rather than a patient communication problem.

15.32 SW said this would become more problematic as increasing numbers of pharmacists chose to send prescriptions offsite due to efficiencies and legislative changes. A recent Healthwatch Report – "Pharmacy: What People Want" had examined this. https://www.healthwatch.co.uk/report/2024-04-30/pharmacy-what-people-want

15.33 Conversation, Discussion points and next steps:

- Ensure the public understand (via good and clear communications) as to how to proceed with their repeat prescriptions, explaining the delays properly so that they could plan ahead
- Encourage greater use of the NHS app
- Empower pharmacy teams in GP surgeries to take control of computers
- Offer digital training sessions to PPGs and PCNs via the digital team
- Overcome delays to meet the overall needs of patients
- Explain batch prescriptions adequately to patients

15.34 BP said the Patient Engagement Team with SW and other colleagues, were working with Healthwatch Gloucestershire and the LMC, on an information resource for patients about Primary Care services. This was currently in draft, and it would include GP practices, Pharmacy and Dentistry. The resource would be available both in print and online and a draft would be circulated shortly for comments. **Action: BP to circulate a draft of the Healthwatch Gloucestershire Primary Care Services information resource to Committee members when this became available.** **BP**

15.35 **Action: JW to share the presentation slides on Community Pharmacy with members of the Committee.** **JW**

Resolution: The Committee noted the presentation and verbal update given on Community Pharmacy.

16. Primary Care Highlight Report

16.1 JW advised that the highlight report includes a new Issues Log with specific issues for members to take note of. On this log from a Primary Care perspective was GP collective action, and in terms of GP partner numbers, this indicated being 24.7% away from the baseline which was also a concern.
The other two items to note on the log were Migrant Health and Engagement and Experience.

16.2 The booster campaign for Covid had finished on 30th June 2024 and whilst uptake had been low in most places, spring booster levels for 2024 had been reached.

16.3 The dental UDA increase to £30 had been enacted with a number of contract support meetings in place to examine practices which had been under-performing. A meeting had taken place with BUPA on 7th August 2024 who had staff who were in charge of BUPA's NHS contracts. They had demonstrated great enthusiasm and positivity around working with the ICB and had some great ideas to bring forward.

16.4 An evening engagement event had also taken place for dental on 27th June 2024 which had been attended by primary Care colleagues.

16.5 JS updated on Migrant Health and informed members that the arrangement for Operation Lazurite at Beachley Barracks was that there was no cut off point agreed. The 1 Rifles Regiment were due to return in March 2025 and so alternative accommodation would have to be found for those people currently residing at the barracks. JS was working with MOD colleagues around this with the possibility of using an empty RAF base in Shrewsbury and further updates would follow.

16.6 This operation had been a quite a strain on the NHS in terms of complex referrals into secondary care but the support that had been offered to those Entitled Persons had been very good with three GPs having been assigned along with nursing staff. One of

the rooms at the barracks had been converted to avoid additional pressure on a local GP surgery.

16.7 Due to recent disruptions which had been well documented by the press, MOD colleagues had been working closely with the police around security at Beachley Barracks. No concerns had yet been raised but close monitoring would be continued.

16.8 There was just one migrant hotel in Gloucester remaining open and there had been significant flow through that hotel with over 100 people moving in and out over the last four weeks. All new residents had been registered with GP practices although there was a significant number of children in the hotel, amongst whom were four babies. A risk assessment was in place for any health visitors and community midwife staff and security remained in place for this hotel, although no issues had been reported which had been positive.

16.9 BP updated on engagement saying that the team had been supporting primary care around workforce initiatives with a survey on GP experiences of transfers between secondary and primary care in respect of workload.

16.10 The Insight Manager had been visiting underserved communities to build good relationships there and also with the farming and travelling communities. The ICB Engagement Team had been supporting various community-led fayres and events over the summer months, including the Jamaican Independence Day, where some good conversations around general health and wellbeing had been held.

16.11 The National GP Patient Survey results had been published in July 2024 and Gloucestershire had received above average results although there was a fair amount of variation between GP practices and PCNs. There was no trend data for this year due to many questions having been changed to reflect the new ways of working in Primary Care. It was clear that there were challenges within GP services but also in pharmacy and dental experiences.

16.12 Shared care for Attention Deficit Hyperactivity Disorder (ADHD) and adult ADHD assessment waiting times were still a concern, along with long waits for Continuing Health Care (CHC) checks to be completed, where the CHC team had been working hard to address the backlog.

16.13 A recent patient story on Pharmacy Health Services had been highlighted at a recent meeting and feedback on that would be followed up by the team.

16.14 JCu said she had found the pharmacy patient story quite shocking and wondered whether it was standard policy for a patient to have to check to see whether their prescription was there, or whether it related to just the one particular GP practice. JCu wondered whether action might need to be taken to find a better process for that particular patient, as this set of circumstances did not seem right.

16.15 JCu referenced CHC delays, saying this had not been heard recently and it had been stated at the System Quality meeting on 7th August 2024 that fast-track was really good, but if there were issues with CHC delays, then this would need to be examined in greater detail and picked up by the System Quality Committee.

16.16 The Chair queried the risk for nurse numbers for long term conditions (LTCs) and asked whether this was something that needed to be added to the Risk Register recognising that there may be things that needed to be flagged around assurances.

Action: JS to check to see whether a risk around numbers of nurses for LTCs needed to be added to the Risk Register and update at the next PCDC meeting in October 2024. **JS**

16.17 The Chair noted that the Issues Log had not detailed any actions and comments around Patient Engagement and Experience.
Action: BP/JW to update the Primary Care Issues Log with details of Patient Engagement and Experience actions and comments. **BP/JW**

Resolution: The Committee noted the content of the Primary Care and Quality Highlight Report.

17. Primary Care and Quality Performance Report

17.1 JW explained that this had been split into two tables, the Exception Report had been designed to look slightly different and this was still a work in progress.

- Exception Report – this showed any significant variances to draw to the attention of the Committee
- Primary Care and Quality Performance Report – covered indicators across Primary Care contractors; further indicators were to be added. Operation Planning targets were indicated in red.

17.2 JW informed that no key issues had been identified; however, performance was being regularly reviewed and monitored and support was being offered, where appropriate, to GP practices and PCNs.

17.3 MCr said that following the last meeting, discussions had taken place around quality indicators and where these fed into and the consensus had been that any contractual metrics would be reported at PC&DC and quality indicators would be reported into the System Quality Committee.

17.4 The Chair said it would be useful for her and JCu to meet with MCr once background work had been done so that PC&DC were not looking at things outside the scope of the meeting.

17.5 JCu noted that the minutes from PCOG had said that patient safety and clinical effectiveness would form part of contractual quality and needed to be defined in PC&DC, recognising that there would be overlap and potentially discussed at both PC&DC and System Quality Committee meetings due to some members being part of both of those Committees.

17.6 JCu said with EC and Hein Le Roux now being involved, she would be keen to properly examine quality in primary care along with POD colleagues in those areas. JCu felt that a solution had not been found for the last few years. Quality outcomes were not examined enough in primary care, and it was thought that a different approach on how this were examined should be taken about looking at things that were really meaningful.

17.7 The Chair said that not everything could be measured, with the primary care and BI teams' capacity needing to be considered, so focus would need to be on the important things without becoming involved in reporting for no particular reason.
Action: Task and Finish Group to be implemented to examine work around quality and what could be reported and discussed for the future PC&DC Committee meetings. **MC/JS**

Resolution: The Committee noted the content of the Primary Care and Quality Performance Report.

18. Finance Report

18.1 CL reported at the end of the May 2024, the ICB's Delegated Primary Medical Care co-commissioning budgets were showing a £0.278m underspend position on a £20.799m year-to-date budget. The Month 2 forecast position was breakeven on a total budget of £124.796m.

18.2 The Month 2 Pharmacy, Optometry and Dental (POD) position was breakeven on a £53.475m budget, and a year-end breakeven position. There was a query around Pharmacy which was being investigated with the CCH and more information should be available at the next meeting.

18.3 The Chair referred to funding for Pharmacy First not be being included and asked if the overspend forecast for Pharmacy would be mitigated when Pharmacy First funding was received or had that already been included. CL said this was currently unknown and was one of the issues around Pharmacy that was being investigated.

18.4 The Chair asked about the reviews which were ongoing with challenged practices and the potential of this impacting the delegated budget. CL said this meant there were a number of practices who were operationally and financially challenged with ongoing work taking place to examine whether there were areas in which their spending could be reduced.

18.5 It may result in the Primary Care team deciding that further intervention or support may be needed from external training providers for example, and this would be non-recurrent but there were provisions that could cover some of this. Sometimes a practice may need more investment on a recurrent basis so it was just to highlight that there could be a financial risk sometimes, in areas of exception.

Resolution: The Committee noted the content of the Finance Report.

19. Draft PCOG Minutes of the meeting held on 9th July 2024

19.1 There were no other areas of discussion raised that had not already been addressed in the meeting today.

Resolution: The Committee noted the content of the draft PCOG minutes of the meeting held on 9th July 2024.

20. Any Other Business or Items of Escalation

20.1 The forward plan for October would be including:

- TWNS Evaluation including other QI projects.
- Integrated Neighbourhood Teams.

The meeting formally closed at 16.57pm

Date and Time of next meeting: Thursday 3rd October 2024, 14:00 – 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: PCDC Committee

Signed (Chair): Ayesha Janjua
Date: Thursday 3rd October 2024

NHS Gloucestershire System Quality Committee Meeting

Wednesday 7th August 2024, 2.00–5.00pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Prof Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Ananthakrishnan Raghurum	AR	Chief Medical Officer, GICB
Hannah Williams	HW	Deputy Director of Nursing, Therapy and Quality, GHC
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marie Crofts	MC	Executive Nurse & Director for Quality, GICB
Nicola Hazle	NH	Director of Nursing, Therapy and Quality, GHC
Suzie Cro	SC	Deputy Director of Quality & Chief Nurse, GHNHSFT
Participants Present:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Becky Parish	BP	Associate Director Engagement and Experience, GICB
Christina Gradowski	CG	Associate Director of Corporate Affairs, GICB
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Julie Symonds	JS	Deputy Chief Nurse, GICB
Mel Munday	MM	Associate Director Integrated Safeguarding, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Trudi Pigott	TP	Deputy Director of Clinical Quality, GICB
In Attendance:		
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Moses Dube	MD	Matron for Learning Disabilities, GHC
Ryan Brunsdon	RB	Corporate Governance Secretary, GICB
Kalpna Mistry (Item 6)	KM	Programme Manager - Earlier & Faster Diagnosis of Cancer, GICB
Martin Pratt (Item 7)	MP	Chief Pharmacist, GHNHSFT
Pauline Edwards (Item 10)	PE	Designated Nurse for Children in Care, GICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the meeting.

1.2 The Chair welcomed NH to the System Quality Committee who would be attending as the Director of Nursing, Therapy and Quality, Gloucestershire Health & Care NHS Foundation Trust (GHC).

2. Apologies for Absence

2.1 Introductions were made by the Committee members.

Apologies were received from Sarah Scott, Emily White, Siobhan Farmer, Katie Hopgood, Sarah Morton, and Matt Holdaway.

2.2 The meeting was declared to be quorate.

2.3 It was noted that Sam Foster was the new Non-Executive Director for Quality and Performance at GHNHSFT. Invitations were subsequently sent to her for these meetings.

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).

3.2 NH declared the following interests that she was still currently employed as a bank Mental Health Inspector with the Care Quality Commission (CQC) and was also a lay panel member for the College of Optometrists, which was a voluntary role.

4. Minutes of the last meeting held 5th June 2024

4.1 The minutes from the last meeting held on 5th June 2024 were approved as an accurate record of the meeting.

5. Matters Arising & Action Log

5.1 **Action 4 - Self-harm in Children and Young People.** Rob Mauler (RM) and Trudi Pigott (TP) to collate information on self-harm in Children and Young People and bring this back to a future meeting. **August Update:** BP stated that a meeting with Healthwatch and the Health Overview Scrutiny Committee (HOSC) with colleagues from GHC and the ICB had taken place on Children's and Young People's Mental Health last week. **Action: BP to send material from the Healthwatch and HOSC meeting on Children's and Young People's Mental Health to CGi. Action to remain Open.**

Action 51 - 2WW Breast Cancer Referrals. August Update: This had improved to 27.9% in July. There was a plan in place and monitoring at GHNHSFT would continue. Things to consider, would be inequality issues, speed of recovery and the clinical impact on delays and whether delays could potentially cause harm, which would not be picked up in the Performance Group. **Action: Paper to be brought on breast services to the next SQC meeting.** **SC**

Action 56 - Health Inequalities. Katie Hopgood (KH) to bring information from Power BI dashboard around health inequalities to a future meeting. **Action to remain Open.**

Action 61 – **Risk Report and BAF. Action Closed.**

Action 62 - **Future Reporting and dashboards.** MCr to work with both CNOs to streamline information. **Action Open and ongoing**

Action 64 - **ED&I Future Plans.** Agreement needed on processes, inequalities and outcomes, with work needing to be aligned to all areas. To be brought to a future meeting TBC. **Action Open.**

Action 65 - **GHC future reporting.** Still ongoing. **Action Open.**

Action 68 - **IPC. Action:** To come to October meeting. **Action Open.**

Action 72 - **ADHD.** To return only if any further issues arise. **Action Closed.**

Action 73 - **Committee Effectiveness Survey.** Under People Committee. **Action Closed.**

Action 74 - **EPRR Risk.** Risk score to be left as it stands. **Action Closed.**

Action 75 - **Lung Health**. On Agenda for today. **Action Closed.**

Action 76 - **GHNHSFT Performance.** New narrative for operational metrics added. **Action Closed.**

Action 77 - **FFTF** - Urology included in consultation. **Action Closed.**

Action 78 - Care Home Data. Action: To be taken back to System Quality Group for further updates. **Action:** MCr to contact Cheryl Hampson for further discussion. **Action Open.**

Action 79 - **PSIRF.** RM to bring a progress update to the October/December meeting. **Action Open.**

JSo said she would like to better understand the types of risks in the care market and how these were captured and rated. There were intentions to take some of this through Audit Committee and JSo would welcome further information on this topic to enable thinking and to provide support to other Committees. **Action: Risks and information around the Care Market to be brought to a future meeting, date to be confirmed.**

6. Risk Report & Board Assurance Framework (BAF) Update

6.1 CGi explained the processes and priorities about the Board Assurance Framework (BAF) which were constantly changing. The risks were regularly reviewed and updated with involvement from system partners and the Strategic Executive Group. Key changes since the previous report had been outlined on Page 4 of the Report, circulated prior to the meeting. Each time the BAF was updated, Directors gave the latest report on where actions had been taken.

6.1.1 JSo queried BAF 4 which related to GHFT SR1 - Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System (risk rating 25). JSo said this meant it was imminent if it did happen and would be catastrophic. The overall BAF risk had been increased from 15 to 16 and wondered what was in place from a strategic system perspective that would manage that risk rating of 25 down to 16, because failure to deliver Urgent and Emergency Care (UEC) would affect everybody. This would also be examined at the Audit Committee.

6.1.3 MCr responded saying that this had been taken to the ICB Board and as this risk belonged to the Acute Trust, she would go back to Matt Holdaway (MHo) for further discussion. Risks were aimed to be aligned, which was where this had come from. UEC remained in a challenging place however, there was uncertainty as to what had led to this rating of 25. Maternity was also in a challenging place which had led to an increase in the rating from 15 to 16.

6.1.4 JSo asked whether there were other mitigations in place that were not yet listed in the BAF that would reduce this high score of 25 that would give assurance that things would not be catastrophic. It was recognised that the situation was constantly changing in the current climate but if there were mitigations and assurances, it would be good to flesh those out.

6.1.5 MCr said that GHFT's controls would be listed in their BAF and these were not detailed in the ICB's BAF. It could be possible to transfer some of those for the UEC into the ICB's report but MCr did not want to interfere with the Risk Register for GHFT.

CGi said on examining BAF 5 in the original report that went to the Board, which was around UEC, this was through the lens of sustaining and improvement of performance within UEC. This had come out as a score of 12. It had originally been 20. Following a detailed exploration of all the actions the system had been working on with Newton Europe, and with other things trialled within the Emergency Department (ED) the Deputy CEO and lead for UEC had reduced the score right down. Perspectives on this were differed from different organisations and a workshop would be organised in September to discuss this.

NH noted that Berkeley House was listed as a risk but was not aligned to BAF 4. Berkeley House was listed as Integration 28. **Action: CGi/RB to link Berkeley House to BAF 4 on the Risk Register.** **CGi**

6.1.6 RB reported a reduction in the number of risks from June until present, assigned from the Corporate Risk Register to the System Quality Committee. Two risks had seen a reduction from a score of 16 to 12; these were around international recruitment and Child Protection Medical Assessments.

6.1.7 RB flagged that an updated Integration Risk Register had been received this morning which had it been received prior to the Report having been written, the Committee would have seen the following three additions:

- Midwifery Staffing Level risk – from a 9 now scored at 20
- Antenatal Scanning Capacity – a new risk rated at 20
- Postpartum massive obstetric haemorrhage (PPH) – now scored at 16. This would also have shown an increase from the antenatal screening risk from a score of 12 to a 15.

These three new risks would be coming to this Committee in the October report. CGi said that risks scoring 12 and above would appear on the Corporate Risk Register. MCr queried where these risks had been discussed as all related to maternity which she is the SRO. **Action: MCr to raise this with the Local Maternity and Neonatal System (LMNS) to ensure that they were aware of the three new maternity risks added to the ICB's Corporate Risk Register and discuss whether the risk score adequately reflected the work being undertaken to mitigate the risks.** **MCr**

6.1.8 Four risks regarding safeguarding had reduced from a score of 15 to that of 9 and therefore they had not been pulled through to this report, but still appeared on the Corporate Risk Register. Kalpna Mistry would give an update on lung health checks which had now been reduced from a score of 20 to 4, with a paper produced for the meeting.

6.1.9 JCu observed that the Child Protection Medical Assessments whereby the risk had reduced to a score of 12, the Children in Care and Safeguarding for Children's risks had been flagged as red, with a comment around GHNHSFT's paediatrician still refusing to conduct the medical assessments. It was stated that this comment was a previous one and that the risks had since been reduced, but clarity was still required. Mcr stated that although there remained some outstanding issues this had progressed and the GSCP update related to this, was accepted as appropriate action. **Action: MCr and MM to revisit Child Protection Medical Assessment risks and give clarity at the next meeting.** **MCr/ MM**

Resolution: The Committee noted the Risk Report and Board Assurance Framework updates.

6.2 Targeted Lung Health Checks Update

6.2.1 KM presented a paper to the Committee around risks associated with the Targeted Lung Health Checks (TLHC) programme which was part of the long term plan to diagnose cancers earlier by 2028. This had been backed by the National Screening Committee.

6.2.2 The programme invited people who had ever smoked between the ages of 55 and 74, to come forward for a low dose computed tomography (CT) scan which would take place over 6-8 weeks in a specialist van, located close to the Primary Care Network (PCN) where patients were due to be scanned. PCNs which had the highest levels of deprivation, highest smoking levels and highest cases of lung cancers were encouraged to present first. The first PCN in the county to go live would be Gloucester Inner City, later this summer.

6.2.3 There had been some delays in starting the programme due to digital difficulties and initially the Somerset, Wiltshire, Avon & Gloucestershire (SWAG) Cancer Alliance, had acted as commissioner for the programme and undertaken some initial engagement with the PCN. However, this had now been taken on by the ICB, presenting a new risk.

6.2.4 Due to the scans taking place between the shoulder and hip a large number of incidental findings (IFs) were being revealed, which were predominantly respiratory/cardiac related and a high proportion of those needed to be managed by Primary Care. Modelling had been undertaken around the numbers for Gloucester City PCN and projected figures revealed that

about 600 Coronary Artery Calcification (CAC) IFs would be found in Gloucester Inner City PCN and about 450-500 respiratory/emphysema IFs.

6.2.5 There was currently no national funding to support the safe resource and management for patients with IFs in Primary Care, giving rise to a delay in rolling out a nationally mandated programme which was there to detect early cancers. A proposal had therefore been taken forward to provide funding for additional clinical and administrative resources to safely manage IFs. There was therefore a proposal to use Section 256 (S256) Health Inequalities funding to provide the clinical time needed to fully investigate and effectively manage IFs. This would allow the most deprived communities to be targeted and to maximise the impact of the programme.

6.2.6 AR wished to record the phenomenal amount of work that the team had put into this to bring the programme forward. AR said this was the right thing to do, particularly within Gloucester Inner City, with the aim to extend this programme eventually to the Forest of Dean, Cheltenham and beyond.

6.2.7 Previous work having been started in Manchester and elsewhere showed that it could significantly increase the earlier diagnoses. Gloucester Inner City would show more prevalence of CAC, a small number of calcified valves and with smokers, this would show underlying Chronic Obstructive Pulmonary Disease (COPD) and emphysema.

6.2.8 It was felt that patients needed to know if these things were being detected and discussions and a presentation had been made to the Operational Executives with the intention of supporting the preventative strategy for these patients with cardiovascular and respiratory diseases. Unfortunately in the current financial situation additional resources could not be allocated at his time.. Initially this may increase the workload within primary care but it was definitely the right thing to do and in the long run, it was far more beneficial to be able to diagnose patients earlier on in their health journeys. AR therefore supported the programme as it was, but it would be naïve to expect things to be able to continue with existing resources.

6.2.9 MCr said that this was recognising a health inequality in an existing population and she would expect resources to be put into a programme such as this. JCu said that failure to do would mean that the ICB would not be acting within one of its main functions, which was to reduce inequalities and improve outcomes. AR observed that by doing this, it would reduce significant spending in the forthcoming years from 2030 onwards and thus supported the economic reasoning. JCu said it would be useful to monitor impact, one area of which would be secondary care with the increase in referrals.

6.2.10 KM stated that the majority of referrals so far were into the Two Week Wait (2WW) Lung Pathway as expected, and the rest into cardiology, but so far there had been less than 100 referrals a month so the impact in secondary care had been less than that of primary care. Prior to the pilot starting, over 60% of patients had a late-stage lung cancer diagnosis and this changed after the pilot and so more patients now had an earlier stage diagnosis, following the screening. The aim was to have this for the benefit of all patients across the county and to be able to make the impact wider than the programme itself.

6.2.11 NH queried whether the S256 monies had been unallocated could now be assigned to this programme. KM confirmed that this was unallocated 2023/2024 funding (this had been checked with the ICB Director of Finance). There had been a presentation in Bath, Swindon and Wiltshire (BSW) where some of the early data had been fascinating and had shown that the programme was diagnosing unusual cancers along with other health needs, creating opportunities to have a preventative impact far wider than just the lung cancer that was being screened for.

6.2.12 KM explained that screening for Gloucester Inner City was predicted to find 15 lung cancers along with another 8 other cancers so this would help real people to have an early diagnosis and go on to lead full lives, which what this was really about.

6.2.13 KM stated she would look forward to coming back to the Committee to share a before and after progress picture in the future after implementation of the programme. JCu recognised the benefits of this programme having reduced the risks to the local population and thanked KM for her work and presentation today.

Resolution: The Committee noted the risks, mitigations and progress on delivery of the Targeted Lung Health Checks programme in Gloucestershire.

7. System Partner Highlight Assurance Reports

7.1 GHFT Exception Reporting Including Maternity

7.1.1 MP delivered a pharmacy update on the Pharmacy Manufacturing Unit at GHNHSFT, explaining that the Unit manufactured aseptic chemotherapy and parenteral nutrition, used by patients who had a gut that was not fully functional due to healing, or who did not have a functioning gut at all, and so had to receive intravenous food.

The Unit was inspected in December 2023 and the risk was raised to High. MP explained that the fabric of the facility was over 20 years old and thus there was an increased risk of contamination. This had been mitigated by reducing expiry dates by 80% so from 8 days, products were only being given 40 hours to midnight the following day. GMS and specialist contractors had been tasked with coming up with solutions but to date there had been no results.

A further mitigation would be a temporary mobile aseptic unit which would deployed once confirmation of capital had come through, as the unit would be needed beyond 12 months. Although £1.2m had been identified for an eventual rebuild of a new aseptic unit, the costs were anticipated to exceed that allocated amount.

With increased requirements for chemotherapy, the workforce had been focussing on that, at the expense of maintaining pharmaceutical quality management requirements required under licence. The Regulator reported that the unit was operating at 130% of capacity. To mitigate this, agreed additional funding for recruitment was underway. An Operational Manager was due to start on 1st September, but it could be some time before the other six posts were filled. MP was working with clinical colleagues to improve the work flow into the unit, rather than having to take last minute requests for chemotherapy.

MP confirmed that this was listed on the Trust's Risk Register as an Intolerable Risk due to necessary funding being required in this case. JCu asked about timescales and MP said the next inspection was due to take place in December and it was hoped to mitigate some of the issues sooner, although obviously, the full refurbishment would take a lot longer.

JCu asked about impacts on patient safety and whether there had been any major issues with Total Parenteral Nutrition (TPN) or chemotherapy. MP said that TPN had been outsourced, which had placed limitations on the types of TPN available to patients. Chemotherapy at the moment, was standing firm with clinicians having made some changes enabling work flow into the unit being more controlled than it was. Ongoing monthly meetings were being held with the Regulator but the unit was meeting the current level of demand for chemotherapy, albeit having taken a lot of extra work to accomplish this.

JCu was able to explain TPN to JSo and the fact that there were risks associated with intravenous feeding for patients. **Action: Update on Pharmacy Manufacturing Unit at GHNHSFT to be brought back to the next meeting in October.** **SC**

7.1.2 SC explained the Integrated Performance Report (IPR) had been provided was one that would be used to report the GHNHSFT metrics and that would go to the Board and the Quality and Performance Committees. The Report had been updated to show trajectories, actions and projected timescales for improvements.

SC commented that there was a plan for improvement to examine the difficulties in over-reporting vs. a decline in a position and it was hoped assurances would be seen here in future.

SC highlighted:

- Health and Safety Executive (HSE) violence and aggression breaches whereby the HSE had assured GHNHSFT that they were happy with the plan in place.
- A CQC inspection into medical and oncology services commenced on 16th July 2024. Feedback so far had been very positive with an update on data having provided for the CQC. A final report was being awaited by GHNHSFT.
- The Trust had been served with two warning notices around the Emergency Department (ED) and Maternity Services. The Trust had invited CQC in to visit the ED and maternity department on 27th August 2024, to which TP had been invited on a walk-through in maternity, to help the CQC to better understand current levels of staffing and the Quality Improvement work in action.
- On 9 May 2024, the Trust received a CQC Section 31 enforcement notice. It has been agreed that the ICB's assurance for the Trust's improvement plan will be monitored at the ICB's Quality Improvement Group reporting through to other ICB meetings by exception. Actions taken and next steps were provided in the Quality Report.
- Complaint response times were currently at 10%. An improvement plan was in place which would go to the September Quality and Performance Group with proactive work with the Complaints Team being undertaken around bringing those down further.

HW and BP said they would be happy to help with bringing down complaint response times for GHFT if that would be helpful. SC thanked colleagues for this offer.
Action: HW to send SC information related to how complaints had been reduced at GHC

7.1.3 MCr suggested it would be helpful to have more detail around the narrative on specific actions being taken in the report. If any services were unexpectedly deteriorating then the Committee would need to be forewarned and be aware of any serious external concerns, particularly from the HSE. The same applied to maternity with specifics on timescales and trajectory improvements.

7.1.4 JCu referenced boarded patients and SC said that GHFT had 4 boarded patients in July. Boarding was only being used for definite discharges only. August data would reveal whether this plan had worked but SC was concerned that boarding was being pre-empted and being used interchangeably. Definitions of what that meant were being worked through and what timescales were involved.

7.1.5 Today on checking, SC informed members that there had been no patients on the pre-emptied or boarding lists. For assurance there was a dashboard that people could log into which would show areas that were pre-emptied or boarded to, including the length of time involved which would be available for on call staff should it be required.

7.1.6 JCu felt that some of the Post Partum Haemorrhage (PPH) numbers were high and felt that there could be learning from the incidents and how they were brought under control. JCu said if she were a NED in GHFT she would be interested in seeing that level of detail. MCr and TP

would be conducting a review of all of those areas alongside the Section 31 where SC had done a valuable piece of work in bringing together the seven areas identified, of which PPH was one. MCr said for assurance, each of those areas had undergone a deep dive with external input from either the neonatal or maternal network and region so there had been really good review of processes around PPH. As part of the enhanced surveillance under the QIG governance, there was continued in depth work on PPH.. MCr suggested ensuring the SQC had an overview of this work at each Committee.

Action: MCr and TP to highlight work through a deep dive approach into maternity at a future meeting. Date TBC. **MCr/TP**

7.1.7 It was suggested by SC that the System Quality Committee could have sight of the Section 31 Report for information enabling the detail and metrics to be examined and for information to be referenced if needed.

SC stated that GHNHSFT was not an outlier on the National Maternity dashboard for PPH but were above average, which was 32. GHNHSFT was at 38 and had already made a drop from 42 to 38 without interventions showing, as the dashboard was reporting a month behind. June's data was being shown on the National dashboard.

MCr stated that although the trust may not be a significant outlier there were other challenges and when triangulated raised significant concerns regarding maternity services. These were detailed in the Section 31 Report. MCR stated we should be curious when some information is showing a deteriorating picture and even if one element is showing just above average trajectory, when brought together with other concerns we need to take this seriously and not wait for the situation to deteriorate further. JCu agreed that using averages was not helpful. SC stated that the stillbirths work had been started and the cases had been brought to the Patient Safety Incident investigation (PSII) Panel where a forthcoming meeting would be held to discuss systems and processes with feedback to the appropriate groups.

7.2 GHC including Berkeley House Exception Reporting

7.2.1 NH highlighted the following:

- Expansion of current patient safety data set was to include themes related to restrictive practice.
- Development of Community Nursing data and associated narrative was to be in line with key quality proxy measures as referenced by The Queens Nursing Institute.
- Mental Capacity Assessments and Best Interest forms were now live in both SystmOne and RiO which aimed to increase compliance with reporting, visibility across systems and accuracy of assessments.
- Continued progress was being made with more detailed reporting of Statutory and Mandatory training and Clinical Supervision but further work was required around data for full assurance.
- Work was continuing regarding quality concerns at Berkeley House noting challenges for colleagues against the backdrop of a new service model being created.
- The regional CQC team was expected to visit next week to look at the Sexual Assault Referral Centre (SARC) services. HW had been working with that team and colleagues to prepare for this.
- Not in the report was the work having been done on the Special Allocation Service (SAS) – this was referenced by NH and noted by the Committee.

To be redacted from the public minutes – confidential

HW said it was important to note that it had been agreed that some of the patient level details related to Berkeley House would not go into these minutes, but TP had been notified that one individual who had been discharged on Section 17 leave had to return to Berkeley House

following some very challenging situations in their Community Forever home. More detail could not be shared, as this was being examined appropriately in other private forums. All organisations involved had been confidentially notified in line with GHC's current restrictions.

HW confirmed that the data collection around community nursing, staffing and caseloads using the QNI tool would 'expire' soon as this had been paused. GHC would be able to accurately report this in the new Operational Pressures Escalation Levels (OPEL) Framework for community services. Feedback was being collected from this and it would strengthen abilities to enter accurate data into this tool from a community services perspective. Metrics were also being examined by HW and NH.

NH notified that following discussions with herself, JM and the Board, there was some work which would start now that NH was in post, to look at implementing an Integrated Performance and Quality dashboard. This would be an iterative process whereby some of the work could start relatively quickly and over time the content and format of the Quality dashboard would be examined to build on the work having been carried out over a number of years. Further conversations would follow later, around supporting that into system discussions.

JCu stated that it would be useful to know what authorisation would be expected from the external regulator relating to Berkely House. It was not appropriate to discuss this at this particular meeting and would be picked up at a later stage in a separate meeting with the appropriate people invited. TP informed JCu that the Berkeley House Quality Improvement meeting would be taking place tomorrow morning (8th August 2024). It was noted that JCu and Gill Morgan had been receiving updates from BL on Berkeley House when these were available. **Action: MCr and TP to give an update on Berkeley House to JCu following the meeting on 8th August 2024.** **MC/TP**

JCu referenced a visit that had taken place to the End of Life Services some time ago which had been very powerful. A review had been completed on Continuing Health Care (CHC). JCu had read that "There had been notable improvement in CHC FastTrack applications this quarter with none being delayed. This was a positive outcome following the implementation of associated training in case review". MCr observed that the way in which data had been presented had been around a lack of education and training about the content of referrals and so this had been a great improvement.

HW stated that it was not possible to say whether that improvement had been system wide as the training referred to was around some additional in-house practical training provided by Debbie Williams the End of Life lead as GHC had not been able to see a system training offer. HW offered to share that training via the Clinical Programme Group if this was helpful. **Action: HW to share the training given by Debbie Williams for CHC, with MCr.** **HW**

MCr was interested in reducing restricted practice relating to Rapid Tranquilisation, saying that if there was learning that could be used from other places that would be helpful. She had a feeling that the data showed things were in a relatively good place at the same time when restricted practice was not really reducing.

MCr spoke about Closed Culture work, noting there was a national inpatient Quality Transformation programme which included work on culture change. Some work had been undertaken around learning and how we spot signs of deterioration in services and there would be a System Quality workshop to explore how we can learn from the maternity reflections and the inquiries such as contaminated blood inquiry, Countess of Chester case with some of the aspects of those cases linking in to the recent Post Office scandal. JCu confirmed that following further discussion, it would then be tabled at a future Board meeting.

MCr raised clinical supervision which at GHC was still at only 45%. Professional Nurse Advocate supervision was also queried. NH stated that work is ongoing around increasing the percentages and ensuring colleagues get access to appropriate and timely supervision.

MCr noted that missed visits data for community nursing looked quite low and it was queried whether this included the rolled over visits following any risk stratification process. HW explained that the data around missed visits was a manual report as there was not the functionality within SystmOne to be able to record it there. The service leads would be linking the manual count with the Datix reports which recorded every visit missed due to capacity. In reality HW thought this was a larger number for which a solution was being sought.

MCr asked NH whether there were any concerns around the forthcoming SARC visit and NH had no concerns from the action plan. Work had been completed around the safeguarding aspect with a clear plan around the safeguarding oversight. This would be shared with the CQC next week.

MCr referred to the Special Allocation Service (SAS) with intention to look at this at the next or following System Quality Committee**. Action: MCr and JSy to bring an update on the SAS to the next meeting in October/December.** **MC & JSy**

The End of Life Audit was queried by JCu. CGi confirmed that she had contacted Jane Haros and Lindsey Bodman and arrangements were being made to bring it to the November ICB Board.

7.3 ICB Quality Report (Primary Care) Exception Reporting

7.3.1 Migrant Health

JS reported that weekly meetings were being held with the MOD at Beachley Barracks with conversations about there being a cut off point for Operation Lazurite. There was not yet an end date anticipated for this. The base at Beachley Barracks would need to return to an operating military base as from April 2025 when 1 Rifles Regiment would be returning from Cyprus. JS had been told that Nesscliffe Training Camp in Shrewsbury could be used in future to house some of the refugees but as yet more clarity was required around this.

Beachley Barracks continued to see new arrivals with currently over 600 Entitled Persons (EPs) on site. Military personnel were working closely with the police to keep the base secure, noting the recent disruptions at MOD St Athan.

Three GPs were assigned to operate through the GDoc contract and they were now in a position to support a lot of the face to face appointments that were due to go to the Lydney practice. The dispersal accommodation was predominantly around the Wheatridge Court area.

Four migrant hotels have now closed with just the Ibis in Gloucester remaining open. Quite a lot of movement had taken place in and out of the hotel over the last four weeks. All residents at the Ibis were currently registered with GPs down to the hard work of the Health Visiting Team. Due to current levels of unrest, the risk register had been updated due to how this could impact individual staff working in the Migrant Team, and GHC was invited to liaise with Tiff around that.

7.3.2 Collective action from GPs

AR spoke about the potential cap on numbers of patients that would be seen by GPs. The recommended level was 25 and so the impact on the other providers was being worked through (NHS 111, Minor Injury and Illness Units (MIIUs) and Emergency Departments (EDs), as to how this would be managed. There had been healthy conversations with the Local Medical Council (LMC) about what that would mean, given that many of providers in general practice were

working towards this already, but had a separate triage to look at those patients and the variants therein. A piece of work was being completed on that.

The second major piece of work where interface with the acute providers had become critical was around work that ought to be done elsewhere (particularly in GHFT) which was currently being undertaken in general practice. Agreement around the interface principle had almost been agreed, which was a set of agreed documents that had been adapted to suit Gloucestershire. AR was presenting this to the LMC and if agreed, this would be ready to go. This had, after considerable work, finally come to fruition.

Impact on Quality - If GPs chose not to use Advice & Guidance (A&G) and instead reverted to referrals, then this could impact waiting lists and the ability to see the patient. A weekly Task and Finish Group had been set up, chaired by Helen Goodey to look into what the impact could be in terms of providers within the wider community.

AR confirmed that there were some very good relationships within general practice, MH had been particularly supportive with the system aiming to find as much money as possible, but this was more than purely industrial or collective action. This could be a reset of how general practice would be going forward in Gloucestershire. AR would like to use this opportunity to make general practice sustainable for the future and rediscover and reinforce this across the community. AR said that without general practice, healthcare in this county and the enormous amount of work put in, would not happen. MCr (as AEO for Emergency Preparedness, Resilience and Response (EPRR) and AR were working closely together. There had been no noticeable increased attendances in ED as a result of any action.

Individual practices would be letting the LMC know if they were to take collective action
There were a set of 10 measures that individual practices could potentially take. There was a general idea of what was to come with preparations being made but it was unknown at the moment as to which practices would take what action.

Returns from practices regarding any collective action were expected next week and in terms of other professionals, such as nurses, there had been no changes to their regular duties. JS was checking other areas of duty but at the moment things were looking very stable. Clinical triage would be key in terms of safety about who would be receiving the urgent, on the day appointments. GPs did not have a contractual duty to inform their patients if they were to act. Individual practices were updating communities as to how things stood via social media, websites and notice boards. It was important that the public knew that GPs were still going to be providing some services.

BP said that the LMC had asked GP practices to indicate to them what they were planning to do and the LMC would then work with the ICB around that. Helen Goodey was credited for maintaining that positive relationship with the LMC.

7.4 Adult Social Care Exception Reporting

7.4.1 This paper had been circulated for information with the pack. Due to an upcoming CQC inspection, there was no representation available from Gloucester City Council to update at today's meeting.

7.5 Verbal Report from System Quality Group and Draft June Minutes

7.5.1 The minutes had been provided for Committee members for reading with the pack circulated prior to the meeting.

***Resolution*: The Committee members noted the updates on the System Partner Highlight Assurance Reports.**

8. Paediatric Audiology Service Action Plan

8.1 SC informed members that NHSE had undertaken a desk top review of Paediatric Hearing Services in October 2023. The conclusion of the review was that the service was rated "Red" which was a serious risk.

8.2 However, recent feedback received, showed that performance ratings were now A's and B's and accreditation for the service was being mapped through. The CQC was also interested in Paediatric Audiology and so had also seen the report. A recent medical oncology visit had given very positive feedback on the day.

8.3 JCu asked whether organisations wrote up what the CQC had told them verbally and sent reports back to them to verify those instructions. SC confirmed that this was the case.

***Resolution*: The Committee members noted the update on the Paediatric Audiology Service Action Plan and were assured that the Trust was committed to delivery of this Improvement Plan.**

The meeting today was shortened due to external circumstances and therefore the following items were only briefly discussed.

9. Transition to the new Cervical Screening Management System (CSMS)

9.1 MCr said that a letter had been received from NHSE giving details of the new system that would be replacing a 35 year old system and so it was very important that all staff concerned with this work had access and would be trained before using the new CSMS system. The letter from NHSE had been included with papers circulated prior to this meeting.

9.2 JS confirmed that Primary Care was involved in this and were aware of where to raise any concerns around this.

***Resolution*: The Committee members were assured that preparations for transition to the new Cervical Screening Management System had gone live.**

10. Children in Care (CIC) Annual Health Report

10.1 This report was presented annually to the ICB and onwards to senior leadership team in GCC, Corporate Parents, senior leaders in GHC, GHT and the CiC health teams to highlight the progress, good practice, gaps and risks for specialist health services for children in care in Gloucestershire.

This report outlined how the children's health and care system promoted and protected the health and well-being of children in care, in line with statutory guidance (DfE DoH 2015) in Gloucestershire.

The report was a summary of the activity and performance by the specialist health services in Gloucestershire over the period April 2023 to March 2024. It could also include relevant updates beyond this timeframe.

The report also highlighted external pressures on the services and outlines other areas of work carried out over the financial year ending 2023/2024, highlighting areas for priority, risks and future plans.

10.2 PE spoke about succession planning for the whole service which needed to demonstrate having the people with the right knowledge, skills and competencies in place to step into statutory roles as recruitment to those roles was often difficult. It was acknowledged that even though there had been additional investment, this had not made things easier.

10.3 JM thanked PE for this great report and asked whether any more could be done by raising the profile at a national level of so many children being moved into this area which was known to be wrong for them and was also the case for adults with learning disabilities. JCu asked whether the local system could be informed that this was inappropriate and that facilities were not there rather than having an independent provider asking for large amounts of money and not acting in the right way.

10.4 This was something that had been raised with the Named Nurse in GHC as it was an issue not just for Gloucestershire but right across the Country. It did not make sense that local children were being sent outside Gloucestershire and that other local authority children were being brought into Gloucestershire that often had very complex needs meaning that there were often difficulties in placements. This not only caused a huge amount of work but all the evidence demonstrates that it was not good for them to be so far away from home.. PE said this subject would be raised with appropriate colleagues and would be discussed at meetings and was very much a hot topic.

10.5 PE informed members that Gloucestershire local authority were in the process of opening their own children's homes but these could only take a limited number of children. Gloucestershire's Efficiency Strategy that looked at places available would be looking at planning decisions at district levels to pull all this together and to try to influence independent local advisors by including a contractual clause that meant they would have to prioritise Gloucestershire children.

10.6 A meeting had been arranged for September which PE would be attending so some progress was being made. Information sharing and handover of care from out of area LA's was poor and often the first that was known about a looked after child was when they presented in ED at GRH, presenting a high level of risk to themselves and also the staff supporting them. It was therefore a very difficult situation for staff to manage and there was something about the consistency of information sharing that needed to be highlighted.

Work was ongoing and PE asked if colleagues could support and highlight the points raised in the meeting today. **Action: JCu to follow up out of county placements for children with NHSE lead.**

Resolution*: *The Committee members approved the Children in Care Annual Health Report.

11. ICB Strategic Safeguarding/Children In Care Team Quarter 1 Assurance Report

MM said this was the first quarterly report and the Safeguarding team was open to any comments or suggestions on how this could be made more user friendly if there were any. It reflected the team's workplan based on some good examples from other ICB Safeguarding teams.

11.1 MM highlighted:

- ICB Safeguarding supervision Standard Operating Procedures (SOP) had been developed across the providers and had been really well received.

- MARAC (high risk domestic abuse) information sharing workstream to progress a service review via external audit/project resource to review health information sharing, streamlining and collaborative working.
- Business cases had been developed to increase capacity of under-resourced statutory safeguarding and children in care roles currently highlighted in the ICB Safeguarding risk register (Designated Doctor and Designated Nurse Children in Care roles).
- GP practice safeguarding support visits were made following completion of safeguarding self-assessments in Q4 2023-2024. Working with the ICB Primary Care team to update PCO Safeguarding section in line with statutory safeguarding requirement for all NHS health services.

MCr noted that the Chid Protection Medical Assessments (CPMA's) risk did not align with the risk register as this had been reduced to a score of 12 and it would be helpful to look at the wording and also to circulate the letter which had been sent to the GSCP by MCr.

SC added that there had been a fair amount of interest in the CQC Safeguarding training and there was a CQC "Must Do" list for Stroud and for Children and Young People's Services around medicine and oncology services. The Section 29A for maternity mentioned the Level 3 training for Safeguarding.

Resolution*: *The Committee members noted the content of the ICB Strategic Safeguarding/Children In Care Team Quarter 1 Assurance Report.

12. Mortality Update

12.1 The presentation circulated prior to the meeting had given an overview of mortality in Gloucestershire and issues cause by Standardised Hospital Level Mortality Index (SHMI). SHMI at GHNHSFT remained outside of control levels and plans had been developed to support improvements.

There was a number of projects reviewing the accuracy of coding of patients and there were a number of steps around care, being taken within GHFT. A project around the depth of coding would be reported on at the end of the month. There was a problem with the way that dementia coding was being recorded and there was a drop in numbers being recorded following the pandemic which was being addressed. There were other projects around sepsis, fracture neck of femur and COPD and results were expected later this month or early next month.

There had been concerns regarding patients admitted at weekends who had demonstrated disproportionate mortality and an audit was being carried out to determine if this was accurate. This audit was half way through completion. There had been some learning in that if the patient had multi-morbidity and was moved through several wards, they did not do well. Uncontrolled SHMI risked harm to patients and brought greater scrutiny to the system. Within the next few weeks, AR would be writing to region requesting that an ICB-led review be supported by the regional team and hopefully, there would be more results and updates available soon.

Next Steps - A paper would be going to the Strategic Executive Committee in September with progress to date and a more formal paper would be presented to the ICB Board at the next meeting. This would be part of a much wider piece of work being undertaken with regards to Delay Related Harm. The Working as One team would be supporting this and further updates would be brought back to this Committee and to the ICB Board as and when they became available.

Resolution*: *The Committee members noted the mortality update and supported the ICS plans around mortality.

13. Meeting Review, Items for Escalation to the Risk Register & Any Other Business

13.1 There were no items of Any Other Business.

The meeting concluded at 16.35pm.

Time and date of the next meeting:

Wednesday 22nd October 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 System Resources Committee

Meeting Held at 4.00pm on Thursday 5th September 2024 as Hybrid Meeting via MS Teams and in ICB Board Room, Shire Hall Gloucester

Members Present		
Prof. Jo Coast	JC	Non-Executive Director, ICB _ Chair
Ayesha Janjua	AJ	Non-Executive Director, ICB
Mary Hutton	MH	Chief Executive Officer, ICB
Ellen Rule	ER	Deputy Chief Executive Officer and Director of Strategy & Transformation, ICB
Cath Leech	CL	Chief Finance Officer, ICB
Julie Soutter	JS	Non-Executive Director, ICB
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Participants Present:		
Jaki Meekings-Davis	JMD	Non-Executive Director, GHFT
Karen Johnson	KJ	Director of Finance, GHFT
Des Gorman	DG	Interim Director for Strategy & Partnership, GHC
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Dr Paul Atkinson	PA	Chief Clinical Information Officer, ICB
Louise Holder	LH	Senior ICS Programme Manager, ICB
Haydn Jones (*Agenda Item 7*)	HJ	Associate Director Business Intelligence, ICB
Kat Doherty (*Agenda Item 8*)	KD	Senior Performance Management Lead, ICB
Mark Golledge (*Agenda Items 6&7*)	MG	Programme Director- PMO & ICS Development, ICB
Chris Buttery	CB	Finance Programmer Manager, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members and others present.

2. Apologies for Absence

2.1 Apologies were received from Sandra Betney, Graham Russell and Jason Makepeace.

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 on 4th July 2024

4.1 Minutes of the meeting held on 4th July 2024 were approved as an accurate record of the proceedings.

5. Action Log & Matters Arising

5.1 Action Log

5.1.1 **16/01/2024, Action 30.** Investments & Benefits Review. A small set of strategic schemes was brought before members to consider the impact of investments. It was suggested that a proposed list should be brought back to the System Resources Committee, and criteria should be developed on what schemes would be considered. Members continue to monitor the impact of schemes. An update presented showed evidence that actions to maximise value of schemes was progressing well and more updates would be circulated to members. **Item remains open.**

5.1.2 **04/07/2024, Action 38.** Sharing and Learning from Productivity. SB had previously stated that GHC employed a model of measuring productivity which differed from that employed by GHFT. SB had agreed to present before members the GHC productivity model in the New Year. **Item remains open.**

5.2 Internal Audit Annual Report and Statement of Assurance

5.2.1 The Chair presented and members discussed the report. The Chair stated that the audit conducted provided evidence that overall, the ICB had effective systems in place and processes were complied with.

RESOLUTION: The System Resources Committee noted the Internal Audit Annual Report and Statement of Assurance.

6. Risk Management Report

6.1 MG presented risks held in the Board Assurance Framework (BAF) and were within the remit of the System Resources Committee. MG explained that the BAF before members had been presented to the Board. MG stated that the risk metrics before members did not show a significant shift from the position presented previously. MG asked members for assurance over risk tools employed and risk management trajectory.

6.2 AJ stated that as Chair of Primary Care & Direct Commissioning (PC&DC) Committee, she highlighted that the report did not include some system level Primary Care risks which required the attention of members. **Action: MG and AJ to explore the Primary Care risks and the extent they fell within the remit of the System Resource Committee.** JS drew members' attention to BAF5 risk. This was the risk of failure to meet Urgent & Emergency Care (UEC) performance metrics. JS **MG & AJ**

reminded members that the risk had been reduced from a score of 16 to a score of 12; and it appeared the scoring did not factor in, the impact that GP Collective Action might have on UEC performance. Members requested that the risk be reviewed, and feedback be provided. **Action: ER to investigate and update members.** **ER**

RESOLUTION: The System Resource Committee noted the Risk Management report.

7. ICS Finance Report inc. Savings Plan System Financial Risk Share

7.1 CL presented and stated that the ICB and the ICS were focusing on breaking even. CL outlined the assumptions informing the forecast. The assumptions included a positive projection of elective recovery performance. CL cautioned that GP collective action however remained of concern but reassured that mitigation measures were in place to reduce the probability and impact of risk, and annual plans were unlikely to be significantly impacted.

7.2 In terms of cost savings, there was clarity regarding the level of Savings required to be delivered by each organisation. CL stated that the system was strengthening its financial governance and paying attention to potential drivers of pressures. KJ concurred and added that the savings effort was aided by a robust oversight role demonstrated both within the individual organisations and the system.

7.3 CL presented proposals for risk share metrics for the ICB, GHC and GHFT. CL added that the metrics before members had been circulated to respective Executive Committees. CL highlighted the effort put in attaining organisational Savings and the collective effort employed to build Working as One cashable Savings plan.

7.4 CL presented the Financial Risk Share Agreement for 2024-25 and explained that good planning considered the interdependence of processes between partner organisations within the system. CL added that performance relating to the Financial Risk Share would inform monthly reports which would be submitted to members for assurance. JC raised a concern that whilst the reports would be prepared on monthly basis, members were charged with providing oversight and assurance convened on bi-monthly basis. **Action: CL, KJ and SB to review reporting arrangements for the Financial Risk Share measures.** **CL, KJ &SB**

7.5 JS probed the risks associated with prescribed Savings. CL explained that assessment of pressures associated with prescribing pointed toward a potential exposure of about £1,000,000. CL stated that Business Intelligence believed that the probability of risk to savings was low and there was reasonable expectation of price reduction in some of the prescription drugs.

7.6 Medium Term Plan

7.6.1 CL outlined the system's 10 strategic priorities and target outcomes. MG presented the Medium-Term Plan and explained that it derived from the long term Joint Forward

Plan which was refreshed every year. MG updated members on the preparation of the Medium-Term Plan and emphasised that planning included a focus on identifying issues of greater concern within the system. MG highlighted that the Medium-Term plans were joined up in terms of delivery and timeframe.

7.6.2 MG highlighted that a joined-up service delivery system would provide more effectiveness exploration for Savings opportunities. HJ concurred and stated that the ICB was co-ordinating with system partners on Savings schemes to avoid duplication and to identify areas where variance exist. HJ described how the ICB benchmarked against outside systems to facilitate comparative analysis of performance. Members commended the efforts and stated that cross boundary benchmarking aided assurance process.

RESOLUTION: The System Resource Committee:

- **Agreed with the terms of the Risk Share Agreement.**
- **Noted the Medium-Term Plan.**
- **Noted the IPR Performance report.**

8. Performance Report

8.1 MW and KD presented the report and MW explained that this was an interim report, and a full report would be presented to the Board next month. MW explained that Government was focusing on need to perform within set standards. MW stated that NHS111 was impacted by pressures during the month of August 2024. MW also stated that the ICB and its partners were getting close to meeting the 65-week wait national standard.

8.2 KD explained that cancer performance remained an area of concern and she highlighted that overall slippage was exacerbated by the low performance in urology. KD stated that GHFT continued to focus on improving the 28-day Faster Diagnosis Standard (FDS) performance which would in turn impact the 62-day Referral to Treatment Standard. KD reassured that a deep dive into the gynaecology and Lower GI pathways had been carried out and action plans were being taken to improve performance.

8.3 MW stated that Urgent Care performance faced challenges during the summer period but there was improvement in August and September 2024. MW emphasised that partners remained resolute in their efforts to reverse slippage. ER concurred and reiterated that transformation programmes were identifying gaps and incrementally improving delivery of HealthCare services. ER highlighted that in addition to improvements in other workstreams, improvement in Urgent & Emergency Care (UEC) was evident as demonstrated by the disappearance of the phenomenon of patients being accommodated in hospital corridors.

8.4 KD stated that August 2024 data pointed toward improvement in Category 2 performance. KD emphasised that the 31.9 minutes performance witnessed in

August was one of the lowest times recorded in months. ER reassured that the ICB and its partners maintained clear and well utilised communication channels with both the local population and NHS England.

RESOLUTION: The System Resources Committee noted the Performance report.

9. Any Other Business

9.1 There was no other business.

The meeting ended at 4:50pm

Date and Time of Next Meeting: 5th November 2024

Minutes Approved by: System Resource Committee Signed (Chair): Prof Jo Coast Date: 07/11/2024