Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 28th May 2025

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

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** *Welcome:* *Apologies: Prof Jo Coast, Kevin McNamara*	Information	**Chair**
2.	2.02 – 2.04pm	**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.	2.04 – 2.06pm	**Minutes of the meeting held 26th March 2025**	Approval	**Chair**
4.	2.06 – 2.10pm	**Action Log & *Matters Arising - updates***	Discussion	**Chair**
		Business Items		
5.	2.10 – 2.15pm	**Questions from Members of the Public**	Discussion	**Chair**
6.	2.15 – 2.30pm	**Impact of health and wellbeing grants on people and local communities:** Voluntary Sector	Discussion	**Will Mansell from Grace Network, VCSE**
7.	2.30 – 2.45pm	**Developing the VCS Model:** Shift from Sickness to Prevention	Discussion	**Siobhan Farmer, Gemma Artz**
8.	2.45 – 2.55pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	2.55 – 3.05pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.05 3.20pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Mark Walkingshaw, Tracey Cox Marie Crofts Cath Leech**
11.	3.20 – 3.30pm	**Intensive and Assertive Outreach Plan**	Discussion	**Karl Gluck / Sadie Trout**
		Decision Items		
12.	3.30 – 3.35pm	**Constitution and Scheme of Reservation and Delegation Updated**	Approval	**Tracey Cox, Christina Gradowski**
13.	3.35 – 3.45pm	**ICS Infrastructure Public Summary**	Approval	**Cath Leech, Andrew Hughes**
14.	3.45 – 3.50pm	**System Resources Terms of References**	Approval	**Ayesha Janjua**
		Information items		
15.	3.50 – 3.55pm	**Chair's verbal report from the Audit Briefing** held on 8th May 2025	Information	**Julie Soutter**
		Chair's verbal report on the Primary Care & Direct Commissioning Committee held on 3rd April 2025 and approved minutes from 6th February 2025		**Ayesha Janjua**
		Chair's verbal report on the System Quality Committee held on 23rd April 2025 and approved minutes from 5th February 2025		**Prof Jane Cummings**

		Chair's verbal report on the Resources Committee held 1st May 2025 and approved minutes from 6th March 2025		**Ayesha Janjua**
		Chair's verbal report on the People Committee held 17th April 2025 and approved minutes from 16th January 2025		**Karen Clements**
16.	3.55pm	**Any Other Business**	Information	**Chair**

Time and date of the next meeting

The next Extraordinary Board meeting will be held on Wednesday 18th June 2025 – 2.00-2.30pm

Boardroom, Shire Hall

Withdrawal of the press and public

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

(for reasons of commercial in confidence discussions)

Gloucestershire Integrated Care Public Board Meeting

To be held 2.00 to 5.00pm on Wednesday 26th March 2025

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

Members Present:		
Prof Jane Cummings (Chair)	JCu	Deputy Chair, NHS Gloucestershire ICB
Ayesha Janjua	AJ	Non-Executive Director, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Claire Procter *(deputising for Siobhan Farmer)*	CP	Assistant Director of Prevention, Wellbeing and Communities, Gloucestershire County Council
Gemma Artz *(deputising for Ellen Rule)*	GA	Deputy Director Strategy & Transformation, NHS Gloucestershire ICB
Dr Jo Bayley	JB	Chief Executive, GDoc Ltd.
Prof Jo Coast	JC	Non-Executive Director, NHS Gloucestershire ICB
Julie Soutter	JS	Non-Executive Director, NHS Gloucestershire ICB
Karen Clements	KC	Non-Executive Director, NHS Gloucestershire ICB
Kevin McNamara	KM	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Marie Crofts	MC	Chief Nursing Officer, NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, NHS Gloucestershire ICB
Rosanna James *(deputising for Douglas Blair)*	RJ	Director of Improvement and Partnership, Gloucestershire Health and Care NHS Foundation Trust
Sarah Scott	SS	Executive Director, Adult Social Care, Wellbeing & Communities, Gloucestershire County Council
Tracey Cox	TC	Director of People, Culture and Engagement, NHS Gloucestershire ICB
Participants Present:		
Ann James	AJa	Executive Director Children's Services, Gloucestershire County Council
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHS Foundation Trust
Dr Emma Crutchlow	EC	GP and Primary Care Network Perspective, NHS Gloucestershire ICB
Graham Russell	GR	Chair, Gloucestershire Health & Care NHS Foundation Trust
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Mark Walkingshaw	MW	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
Richard Smale	RS	Interim Director of System Coordination, NHS England, South West
In Attendance:		
Ryan Brunsdon	RB	Corporate Governance Secretary, NHS Gloucestershire ICB
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Becky Parish *(Agenda Item 5)*	BP	Associate Director, Engagement and Experience, NHS Gloucestershire ICB
Dr Elinor Beattie *(Agenda Items 6 & 7)*	EB	Consultant in Emergency Medicine, Gloucestershire Hospitals NHS Foundation Trust
Dan Offord *(Agenda Item 11)*	DO	Head of Digital Transformation and Portfolios, NHS Gloucestershire ICB
Haydn Jones (*Agenda Item 11)*	HJ	Associate Director of Business Intelligence, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 The Chair welcomed those present to the meeting. Apologies had been received from Gill Morgan, Siobhan Farmer, Benedict Leigh and Ellen Rule. The meeting was declared to be quorate.

2. Declarations of Interests

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

3. Minutes of the Public Board meeting held on 29th January 2025

3.1 The minutes from the meeting held on 29th January 2025 were approved by the ICB Board members.

4. Action Log and Matters Arising - Updates

4.1 The Action Log had been updated with input from Directors. A significant number of actions related to Board Development sessions. Actions around mental health and homelessness could be reframed around Severe Multiple Disadvantage (SMD) and a Board Development session arranged to explore the subject.

4.2 The Chair recognised since the last meeting that unexpected national announcements about organisational changes had been made, which would have a significant impact on staff, who would be supported throughout the process. MH stated that this was a challenging time, with the approach to year end having been followed by the announcements made on the necessity to reduce the running costs for the ICB, along with the changes to NHS England (NHSE) staff.

4.3 MH confirmed that work would be taking place with colleagues across systems to understand the implications for these changes, what it would mean for staff and what mechanisms would be used throughout the process. MH described how the news had been delivered very suddenly with the detail behind it still being clarified. As soon as further details become available, this will be shared with staff and partners. In the meantime, thought was being given as to how staff could be supported, and MH expressed her gratitude around staff continuing to work hard during this very difficult situation and particularly as year-end approached.

5. Questions from Members of the Public

5.1 The Board had received questions in relation to the work to engage patients and the public in its commissioning and financial plans. This was in line with the requirement to submit questions five days prior to the Board meeting. Subsequent questions had been submitted outside this deadline, which would be responded to separately following the Board meeting.

5.2 There had been three questions received for the Board with responses provided by Becky Parish and Tracey Cox. A summary response from the Board was read out by Tracey Cox during the meeting and in line with protocol, a formal and full written response would be sent, and the questions would be included and responded to on the Public Board Questions and Answer section on the website.

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

Resolution: The ICB Board members noted the questions from the members of the public and the responses given during the meeting.

6. Patient Stories – Virtual Ward

6.1 GA and Dr EB presented a film on the subject of Virtual Wards https://youtu.be/t-Ludxu5Z-I, which explained that virtual wards had been established to provide a safe and efficient alternative to hospitalisation for certain cohorts of patients, enabled by technology, offering a hospital level of care for people to be able to recover in their own homes, whilst potentially reducing hospital admissions and/or shortening hospital stays. The film described the process around the respiratory virtual ward with the monitoring equipment available, enabling patients to be cared for at home and demonstrated those benefits and the positive experiences of patients who had enjoyed recovering at home in familiar surroundings, with intervention from clinical specialists if and when required.

Resolution: The ICB Board members noted the Patient Stories on the Virtual Ward presentation.

7. Virtual Ward Programme Update

7.1 GA explained that the development of an integrated hospital at home service across Rapid Response and Virtual Ward (VW) Medical Hub teams, had taken place to deliver a community component to the virtual ward pathways. Raid Response provided designated nursing staff and Health Care Assistants (HCAs) which provided great support. The team could deliver the community activity following specialist assessment, either by the VW Hub team or the Rapid Response practitioners.

7.2
- Patients could be stepped up or stepped down thus giving patients the best care they needed at the time they needed it.
- Moving towards a condition related model would allow flexibility within the virtual ward capacity and would ensure that any patient who is suitable for care at home, is able to access the virtual ward
- Clinical responsibility and governance within an integrated model would be a key enabler.
- A system solution was being sought for access and visibility.
- A systemwide pharmacy solution was being developed.
- The focus on prevention in the long term was important and the team will build a closer relationship between telehealth and virtual wards to provide a continuity of care.

7.3 Discussion:

- There were no significant differences in the use of virtual wards between rural and urban areas, but more resources were needed across various locations to reduce staff travel time and for Core20PLUS5 patients to be recognised.
- There would need to be a focus on patients who would otherwise be hospitalised to ensure the financial sustainability of virtual wards. Virtual wards were very cost-effective compared to building new hospitals.
- KM recognised the importance of integrating virtual wards with existing community services, providing comprehensive care, and reducing hospital admissions.

***Resolution*: The ICB Board members noted the update on the Virtual Ward Programme.**

8. Chief Executive Officer Report

8.1 MH provided updates to the Board on the following:

Asthma and Lung UK ICS Respiratory Review 2024/2025
MH reported that between September and December 2024, Asthma and Lung UK had undertaken a review of all 42 Integrated Care Systems (ICS's) respiratory services nationally, whereby Gloucestershire had improved its ranking by 29 places in services since 2023, with significant gains in diagnostics and reduced admission rates. The ICB now stood at 8th in the country for admission rates and 5th for mortality rates, which placed us 4th overall in the country.

Social Action Programmes
MH highlighted the success of the We Can Move programme, part of the Enabling Active Communities portfolio, which is a whole-system approach aimed at increasing physical activity levels across Gloucestershire. Led by the team at Active Gloucestershire, one of our trusted Voluntary, Community, and Social Enterprise (VCSE) partners, the programme is driving both cultural and practical change. By creating the social action programme, which had attracted significant investment with the aim to increase physical activity among residents by 2030.

Joint Forward Plan
It was noted that the Joint Forward Plan was being refreshed and would be shared with the Health and Wellbeing Board prior to publication.

Operational Plan 2025-2026
This year's planning round had been particularly challenging with all ICBs needing to strike a balance between financial sustainability and delivery of national performance objectives. All ICBs within the region had reported a challenging financial position. The full Operational Plan submission was due on 27th March.

Connect to Work
This was part of the Government's "Back to Work Plan" to support 100,000 people each year, with disabilities or health conditions, to enter the labour market and to help them to sustain their jobs. This programme is led by Gloucestershire County Council. The programme would be supporting care leavers from October 2025, and this was a rich opportunity for the ICB to be able to support people, with an advantage of being ahead of the game with current programmes of work.

8.2 RS commented, in relation to the We Can Move programme, that there were currently five projects in development around bringing in artificial football pitches into Gloucestershire to support local communities, so this was a positive opportunity for physical and mental health.

8.3 AJa spoke about the Local Authority Parents Strategy which would set out five priorities, to help children and suggested that this might be a topic for a future Board Development session to look into building that network for families in the county.

***Resolution*: The ICB Board members noted the Chief Executive Officer Report.**

9. Board Assurance Framework (BAF)

9.1 TC informed members that the BAF had been discussed at the Audit Committee at the beginning of March, and since then, Directors and risk leads had reviewed and updated their risks. Changes had been made to BAF 5, 11 and 12 and had been highlighted in red for ease of reference for members.

9.2 BAF 6 related to the resilience of Primary Care where changes had been made to the narrative, particularly around the recent national announcement regarding the GP contract for 2025/2026, whereby national collective action had been paused. Coming towards the end of this financial year, strategic risks would be evaluated as part of the Operational Plan for 2025/2026.

Resolution: The Board members noted the content of the Board Assurance Framework.

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

10.1 *MW updated on Performance:*
MW announced that the ICB was on track to deliver a plan which would culminate in a compliance position against national standards; albeit there were significant risks in those plans. Targeted investments would help to deliver improved performance against delivering the financial challenge.

- Progress had been made around reducing the longest waits within the county and the Elective Recovery Fund (ERF) was close to achieving the 118% target.
- The forecast for those waiting over 52 weeks for treatment was at 200 with huge efforts being made by colleagues to deliver that improved performance.
- The Pharmacy First service had to date helped over 35k people over a wider Urgent Care plan, making a real difference to the local population.
- There had been a deterioration in cancer performance, partly due to workforce challenges within pathology, which were being addressed.
- Urgent and Emergency Care (UEC) performance continued to fluctuate, with the end of February seeing a deterioration in Emergency Department (ED) waiting times and ambulance handover times, as demand increased. Work around system plans for 2025/2026 included maximising the use of out of hospital care and improving support for patient discharge, which were continuing as part of the operational planning process.

10.2 *TC updated on Workforce:*

- Apprenticeship numbers had dropped over the last 12 months, however, it was hoped to support staff in existing roles with training and development, with 28 staff across the system undertaking the qualification in Level 4 Associate in Project Management which was positive.
- Regarding the new Arts, Health & Wellbeing Centre, this week, an assessment would be made of 14 small grants to support people with new research proposals with a Dragon's Den approach this week, and another session on 4th April.
- More work was proposed around Equality, Diversity & Inclusion (ED&I), particularly around the workforce system levels.
- Regarding the organisational changes, TC and Directors in HR were working on a systemwide redeployment protocol so that staff could be supported to stay not only within the ICB, but with providers across the system. Colleagues at Gloucestershire County Council were keen to support the ICB with this way forward.

10.3 *MC updated on Quality:*

- The BAF and Risk Register were being updated from a quality perspective.
- Gloucestershire Hospitals NHS Foundation Trust (GHFT) GHFT had given a detailed presentation at the last System Quality Meeting (SQC), with respect to the Breast Service not achieving the national performance target of 93%. The Trust was working hard to improve on this target and had now reached 86.5%. There was an improvement plan in place which detailed how Saturday clinics had been set up to tackle the backlog. This work would continue to be monitored by SQC.
- Maternity Services were still under surveillance with two workstreams having been reverted to Business As Usual. One long standing serious case had now had all the actions and issues signed off
- A review of the Local Maternity Neonatal System (LMNS) had been taking place which had involved KM and others and confirmed priorities for next year were being examined.
- Care Quality Commission (CQC) Maternity Patient Survey 2024 – Women/Birthing People reported a positive experience of maternity care in the recently published report, although the focus on maternity care and services would continue.
- There was a current campaign, launched on 17th March, to raise public awareness about the importance of foetal movements during pregnancy, which included social media, information on local buses and other resources.
- Colleagues had made significant progress around mortality with a desire to better understand out of hospital mortality, ensuring there were no care quality concerns. Coding had also improved, and it was noted that mortality data from NHSE was running six months behind so covered the period up to September 2024.

10.4 JS referred to the Year 6 obesity levels in the report which were significantly lower in Cotswold than the level in Gloucester last year and queried why this should be.
Action: CP will examine the data on obesity for Year 6 pupils in Gloucester, comparing this with the Cotswold figures to examine this over a longer time period and inform at a future Board meeting. **CP**

10.5

- KM wanted to make members aware that the Trust was about to submit a plan to set a commitment to approve a 12 hour wait position at the front door in UEC, which was lower than the ambition intended, but would be aided by pockets of other work which would push that forward.
- Good progress had been made by the GHFT on almost eliminating boarding of patients and some of that work had supported the front door and the hospital mortality figures.
- Elective care progress – March should see the figure drop to around 116 waiters and so there was something about celebrating that work in terms of productivity.
- A national Pioneer Programme had been suggested for Gloucestershire due to its success around elective care, with an aim of meeting the 92% Referral To Treatment (RTT) standard by March 2029. The Trust had decided to participate in this programme which was likely to bring in some extra funding to help enhance the estate further, thus confirming Gloucestershire's position as being one of the best places in the country for elective care.

The Chair recognised the hard work of GHFT over recent months around bringing down the waits for elective care, and how this had delivered benefits for the population of Gloucestershire.

10.6 KC recognised the progress having been made on the Maternity Improvement Plan but queried the spikes being seen in stillbirth and neonatal mortality rates, and was seeking reassurance that there was nothing systemic underlying those spikes. MC confirmed that

any stillbirths were investigated and reviewed by the Maternity Improvement Advisor and assurance had been received from GHFT that there were no systemic issues underlying those incidents.

10.7 KM confirmed that two reports had been commissioned following a Panorama programme on maternity. Ted Adams, Consultant Obstetrician, would be helping on the maternity death review and the neonatal death report would be undertaken by another healthcare system. These reports would need to be visible, transparent, and have the right challenges to meet the governance requirements and align holistically with one another. Work would be taking place over the next couple of months to ensure that everything followed the correct governance routes to ensure that nothing important was overlooked. AR recognised that changes were implemented immediately rather than waiting for the system to fluctuate and so credit was due where there were immediate responses to any occurrences.

10.8 DE recommended that members read the annual report MBRRACE-UK reports which provided more detail on perinatal mortality and gave the national picture on stillbirths. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports

10.9 *CL updated on Finance:*

- The forecast for 2024/2025 was forecasting a break even financial position. Savings schemes had progressed, however, there was under delivery and the value of recurrent savings lower than needed to maintain or improve the underlying financial position. This would impact on the position for 2025/2026 and had been included in the 2025/2026 plan.
- GHFT - To achieve breakeven on the Capital programme, a number of high priority equipment scheme mitigations were being progressed. These offset an assessed forecast underspend position of £2.4m with further known risks included within the forecast. The delivery of these schemes woud continue to be carefully managed through the remaining months of the financial year.
- Gloucestershire Health & Care NHS Foundation Trust (GHC) - Capital spend was behind plan but would be expected to catch up by year end. The Trust increased its capital forecast following confirmation of funding for Endoscopy scopes and washers. The Trust no longer requiref any disposal income to be deferred into 2025/2026 as some asset disposals had now been moved back to 2025/2026.

The Chair exgended thanks to CL, her team and all providers who had worked so hard to bring the finances into this position and the partnership working demonstrated the great teamwork involved.

10.10 AJ observed that Gloucestershire was one of the few ICBs who were coming in on financial balance and stated this was a positive place to be. She commented that it would be good to hear about where the ICB could get support to continue the good work, and to maintain the incentive for balance and to share the learning with others.

10.11 MH responded that benchmarking across the country enabled the ICB to see where there were areas of opportunity to improve and make savings. Some information needed to be mapped out and benchmarked more clearly but good conversations promoted good ideas and shared learning. There were good relationships across system partners in Gloucestershire with opportunities for transformation and to bring in extra funding to help maintain incentives and strong performance.

Resolution: The Board members noted the content of the Integrated Performance Report.

11. Draft One Gloucestershire Data Strategy

11.1 PA, HJ and DO presented the ICS Data Strategy, emphasising the importance of data-driven decision-making and next steps for implementation. The Data Strategy was taking a clear steer from the ICS Digital Strategy's key transformation themes and aligned its ambitions with the numerous subsidiary digital strategies (digital workforce, infrastructure, empower the person). Its vision - 'To become an intelligence led system; using data and sharing information to wrap care around the person and enable our One Gloucestershire ambition" was drawn from engagement from across all ICS partners.

11.2 Long-term effective data sharing had the capability of streamlining services thereby reducing unnecessary travel, and holding one version of data would reduce the requirement for multiple solutions and servers, which would have a positive impact on our carbon footprint. Engagement and the views of the public would be part of the development of workstreams and Strategy implementation.

11.3 Next steps were explained for implementing the Data Strategy, including mapping data flows, enhancing clinical systems and improving data literacy amongst the workforce. The Strategy had been developed with extensive stakeholder engagement, including interviews, surveys, and workshops, to ensure it met the needs of the system.

11.4 JC queried which parts of the roadmap were the real priorities. DO explained that this was where the system needed to come together and bring services into a single entity, including how the system performance would be suppoorted by having a single source, which would benefit and service the population. The focus would be on the enterprise architecture through those different sorts of use.

11.5 RJ fully supported this work where co-production had been absolutely essential, working in an integrated way in order to be able to attain an improved digital infrastructure. This digital roadmap would enable changes that would help the communities to benefit from the delivery of modern healthcare. The Board agreed that this Strategy would be of huge benefit to both staff in the healthcare sector and to the Gloucestershire population as a whole.

Resolution: The ICB Board members approved the draft One Gloucestershire Data Strategy.

12. Joint Commissioning Strategy for Special Educational Needs and Disabilities (SEND)

12.1 AJa presented on this topic. The SEND Strategy has been through an extensive governance process which was detailed in the covering paper. The Board noted that until recently, SEND was under the auspices of the Director of Integration. However, SEND and other aspects of children's services including Children's Continuing Care, had been moved into the Chief Nursing Officer's portfolio of work and MC was now responsible for this.

12.2 Section 3 of the Children and Families Act (2014) and the SEND Code of Practice (2015) sets out the commissioner duties of ICBs which included jointly commissioning services for children and young people with SEND, with local authorities. There was not currently a joint commissioning strategy for SEND in place between the ICB and the Local Authority and so this Strategy had been brought to the Board today for their approval.

12.3 The aim of the Strategy was to improve services for children and young people with special educational needs and disabilities by committing to the priorities within the strategy, and the enabling principles. This strategy aimed to ensure that services were holistic, effective, and tailored to meet the specific needs of individuals and to bring about a positive impact on health inequalities. As part of its final sign off route to cabinet, the Head of SEND at the Local Authority was completing an Equality Impact Assessment (EIA). When signed off by Cabinet, the report would be published and would be likely to sit on GCC's Local Offer pages as the central Hub for SEND Information, with a link through from the ICB SEND Page.

Resolution: The Board members approved the SEND Strategy.

13. Public Sector Equality Duty (PSED) : Equality Delivery System 2 (EDS2) Progress Report

13.1 The report this year had been shortened to be more concise. There was a requirement for the ICB to report on its duties under the PSED and EDS2 to the Board and to make this available on the website, as the Equality and Human Rights Commission would be reviewing the Board report.

13.2 The specific duty required the ICB to be transparent about its work on equality and to show how it was meeting the requirements of the general duty. Each year the ICB had to publish equality information which demonstrated how the organisation was performing on ED&I additionally this report covered how the system worked together on addressing equality across services being provided and commissioned, and the employment of staff. Progress was highlighted together with areas of improvement.

Resolution: The Board members approved the PSED Progress Report.

14. Budgets (Revenue and Capital) 2025-2026

14.1 The Capital Budget was included in the papers circulated prior to the meeting. CL was still working on seeking a balanced budget for 2025/2026.

Resolution: The Board members approved the Capital Plan for 2025/2026.

15. Committee Meeting Updates

15.1 **Chairs verbal and ARAC report from the Audit Committee** held on 6th March 2025 and approved minutes from December 2024

15.1.1 The external and internal audits were Green and there was a discussion around the BAF and amendments which needed to be made. A variety of digital policies were also approved. Thanks were extended to the Governance team for their contributions.

15.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee held 6th February 2025

15.2.1 A detailed discussion covered risk in Primary Care. There was a presentation from Churchdown Surgery on the use of their frailty whiteboard where Gloucestershire was well ahead on this compared to other areas.

15.3 **Chair's verbal report on the System Quality Committee** held 5th February 2025 and approved minutes from December 2024

15.3.1 The February meeting discussed the standard reporting from providers. The GHFT 2WW Breast Service update had been very useful and the Committee approved the EPRR Policy and the Business Continuity Policy. Jan Marriott had been thanked for all her work for the Committee meetings as it was her last one.

15.4 **Chair's verbal report on the Resources Committee** held on 6th March 2025 and approved minutes from January 2025

15.4.1 The minutes from the January meeting were circulated in the pack and the March meeting discussed various planning documents with early discussions around metrics for equity that might be adopted.

Resolution: The Board noted the verbal updates on the Committee meetings.

16. Any Other Business

16.1 There were no items of Any Other Business raised.

The meeting concluded at 3.45pm

Time and date of next meeting

The next Board meeting will be held on Wednesday 28th May 2025 2.00– 4.30pm
Virtually and 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)

Agenda Item 4

NHS Gloucestershire ICB Board (Public Session) Action Log – May 2025

Future Board Items

No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
39	Sept 24	**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.	**Nov24**	AJ Emailed to confirm closure.	**Open**
46	Nov 24	**Min 10.6 Out of County Placements**	**Mark Cooke / Richard Smale**	MCo to raise the position of Out of County Placements in Gloucestershire at a forthcoming meeting with senior colleagues and report back to the next Board meeting in March 2025.	**March 2025**	MCo & RS emailed to confirm closure.	**Open**
48	Nov 24	**Min 12.10 Review of Intensive and Assertive Community Treatment for People with SMI**	**Siobhan Farmer**	SF to bring an information item to the Board at a future meeting, along with a patient story around multiple mental health needs. SF also to recirculate The Kings Fund Report conducted about 18 months ago.	**TBC 2025**	Liaising about a date for a paper/presentation on multiple mental health needs and also to identify a patient story. The report was sent out with the papers for the March meeting.	**Open**
51	March 2025	**Min 10.4 Obesity Data**	**Claire Procter**	CP will examine the data on obesity for Year 6 pupils in Gloucester, comparing this with the Cotswold figures to examine this over a longer time period and inform at a future Board meeting	**TBC 2025**		**To be Closed.**

Action 51: *In Gloucestershire, 2023/24 National Child Measurement Programme (NCMP) data shows that all districts have a similar prevalence of obesity amongst year 6 pupils to the county average. This marks a change from the previous year when the prevalence of obesity in Gloucester was significantly worse than the county average, and the prevalence of obesity in Cotswold was significantly better than the county average.*

NB: *when looking at NCMP data, GCC uses confidence intervals (CIs) rather than point values; since Fingertips uses point values, interpretations around significance may differ.*

Due to the variance in sample sizes, yearly fluctuations in obesity prevalence at the district level are common. 5-year pooled data (2018/19-2023/24) provides a more reliable picture of how districts compare to the county average:

- *In Gloucestershire, the prevalence of obesity in year 6 pupils across the past 5 years is 19.9% (19.4-20.4%). The county prevalence remains below the national average and in line with the South West average.*
- *Cotswold has a significantly lower prevalence of obesity across the past 5 years compared to the county average: 15.9% (14.6-17.2%)*
- *Gloucester has a significantly higher prevalence of obesity across the past 5-years compared to the county average: 24.3% (23.2%-25.4%)*

***NB:** the 5-year pooled rate does not include 2020/21 data due to the insufficient sample size owing to Covid-19.*

Obesity is a complex issue, with multiple contributory factors. Long-term sustainable chance requires a 'whole system' approach which addresses the environmental, individual, and social determinants of our health and wellbeing. It is also important to consider the role of health inequalities associated with childhood obesity. Nationally, children from the most deprived areas of England are twice as likely to be living with obesity compared with those from the least deprived areas.

In Gloucestershire, Beezee Maximus have been commissioned by the County Council to provide face-to-face family healthy weight programmes which have been running since May 2023. The service also provides virtual programmes for children, young people, and families in Cotswold district. The face-to-face sessions are targeted programmes and so large-scale changes in the overall prevalence of childhood obesity in the short to medium term are only possible if supplemented with national initiatives and changes in the complex factors we describe above.

Development Session Actions

No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
47	Nov 24	Min 10.8 IPR	Mark Walkingshaw	To include a concise and focused session on the Insightful Board in a Board Development session	Feb 2025	This item has been rescheduled for the Autumn/Winter	Open
	Nov 24	Min 14.13 EPRR	Marie Crofts	EPRR to be placed on a future Board Development session.	Autumn 2025	This will be scheduled for the Autumn/Winter Board Development Session.	Open
50	Jan 25	Min 7.9 Homelessness	Siobhan Farmer	SF and BP to bring a report on Homelessness in the county, to a future Board meeting.	TBC 2025	The Kings Fund Report into SMD in Gloucestershire also covers homelessness.	Open

Patient Story Actions

No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
23	Mar 24	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.	TBC 2025		Open

BRIMSCOMBE
MILL
WELCOME
weber

Brimscombe Mill- part of the healthcare system

- *At the time, we were still small. We had the beginnings of anchor status—but barely. The turning point was a single anchor grant into the Brimscombe Hub. That investment gave us breathing room. The rest is history.*
- *The health benefits of these enterprises are tangible. For example, The Great Plate is improving the nutritional wellbeing of hundreds of schoolchildren every day, ensuring they receive balanced, locally prepared meals that support concentration, behaviour, and long-term health. Meanwhile, Kitchen Companions is doing more than just delivering meals—it's combating loneliness and malnutrition among older and vulnerable adults by combining food with friendly, regular human connection. It's food as care, not just calories.*
- *Today, Grace Network is made up of 10+ CICs operating across multiple hubs, with each one addressing a vital community need—whether it's food security, social connection, sustainable transport, or circular economy services. What began as a survival response has grown into a regional infrastructure of care, resilience, and innovation.*

Cringey or not, these stories matter. And if we don't name it, we risk forgetting it. Without the ICB team, led by Will C we wouldn't be here today. Co-creation works when done well.

Brimscombe Mill- part of the healthcare system

Building on the Beveridge Report of 1942

Five Giant Evils":

1. **Want** (poverty)
2. **Disease** (ill health)
3. **Ignorance** (lack of education)
4. **Squalor** (bad housing)
5. **Idleness** (unemployment)

- Beveridge proposed a **universal welfare system**, based on **social insurance**, available **"from cradle to grave"**. It was revolutionary for its time—laying the philosophical groundwork for the NHS, state pensions, child benefit, and more.

Brimscombe Mill- part of the healthcare system

When Beveridge envisioned a health system ‘free at the point of need,’ he wasn’t just dreaming of hospitals—he was dreaming of a society organised around care. Brimscombe Mill lives into that vision. While the NHS treats illness, we tackle what causes it: poor diet, loneliness, stress, and disconnection. We offer hot meals without judgment, community without cost, and dignity without forms. We’re not an alternative to the NHS—we’re part of the same dream. One built on the conviction that a healthy society starts with belonging, not bureaucracy

“The making of a good society depends not on the state alone, but on the active co-operation of citizens through voluntary action.”
— *Beveridge, 1948*

“The danger is that the State, in seeking to do too much, may smother voluntary action and kill the spirit which makes it possible.”
— *William Beveridge*, **Voluntary Action** (1948), p. 6

“The task of rebuilding society is not for the government alone; it is a work for all citizens, freely given and joyfully undertaken.”
— *William Beveridge*, **Voluntary Action** (1948),

“There is a grave danger of the social services being regarded as a machine, instead of a living organism built out of human sympathy and voluntary effort.”
— *Voluntary Action* (1948), p. 12

Brimscombe Mill 24/25 Social Impacts

- There were roughly **199,200** visits to Brimscombe Mill and social enterprises last year. This is 199,200 community interactions that took place at Brimscombe Mill last year.
- **40,762** meals produced by Long Table and eaten on site. That is **157** meals every working day.
- **542** activities and events were hosted at Brimscombe Mill last year. These include craft activities, music events, book launches, art courses and maternal journalling.
- **1,171** referral packages were given out for free or heavily subsidised to individuals and families in need. These include children's bundles, gift cards to our shop, furniture and bikes.
- Community events run include:

- Brimscombe Mill Run Club
- Long Table Teenage Kitchen cookery course
- NHS Community Health Check Clinic
- Pop Up Tailor and Barber on site

Brimscombe Mill Community Spotlight

NHS Community Sessions

This year we have joined forces with the local NHS to use our space to offer community health checks. The community team come on site and offer free services to the community. The aim of these sessions is to provide a local space that people can come to for health checks without having to go to the GP. These sessions are supporting the Blood Pressure Uk campaign 'Know Your Numbers' in a bid to reduce heart attacks and strokes. They offer simple health checks, including blood pressure and chatting to people about simple changes they can make to their lifestyle.

- 2 sessions have been run on site so far with another booked in for the summer 2025.

Brimscombe Mill Community Spotlight

Brimscombe Mill Run Club

Mel, the Home Remedy Retail Manager set up Brimscombe Mill Run Club in the summer of 2024. Since then this amazing community filled run club has gone from strength to strength. Who better to tell us about it than Mel herself. Here's her run club story…

"I started the Brimscombe Mill community run club to create a space where people could connect and feel a sense of belonging, whilst looking after their physical and mental health. The priority of the club is to be as inclusive as possible; I wanted to create a club that didn't intimidate you with regards to paces or abilities, but welcome you and give you the opportunity.

It can be really scary making that first step into joining a club, I know I've been there before! We've now got this friendly small group of runners who have used their collective knowledge to create wonderful routes spanning the local area, share running tips, join races together and most of all have fun whilst doing it. We are a mix of ages, abilities and different personalities and would love to have even more people join.

A testimonial to the club - 'I wanted to say thank you to everyone - you've all been so welcoming over the past weeks, it's so much fun to run with you all 😁

Brimscombe Mill Community Spotlight

Mike's Bike

"My name is Mike, 6 years ago I found myself in a difficult situation, I was working full time and desperately trying to care for my father at the same time. Dad was having serious health problems and his mobility was deteriorating. I had no choice but to give up my job in able to support Dad.

I became his carer 24 hours a day. We managed but it was really difficult at times and slowly over the years his health improved but my mental health was affected.

However. gradually we managed to get him fit enough for a long awaited hip replacement operation which he had in January this year. The operation was a success and his life has become very positive. Incredibly Dad is now able to get about much more and look after himself in many ways although he still needs some support from me.

I began to think maybe I could get back into work, even if it was only part time to start with, however I had not realised how low my self esteem had become, I wanted to rejoin the world but struggled to believe I could. On my daily errands for Dad I would regularly see people who were aware of my situation and who always had words of encouragement for me to look after myself and to start thinking of myself and my future now that Dad was much improved. With their support and pushing months of self doubt aside I finally started applying for part time jobs.

After more months of applications and a couple of interviews I was delighted to get a job recently at Iceland in Stroud. It has boosted my confidence no end and the challenge now became what hours I could work that fitted in with public transport and Dads hospital and Doctors appointments.

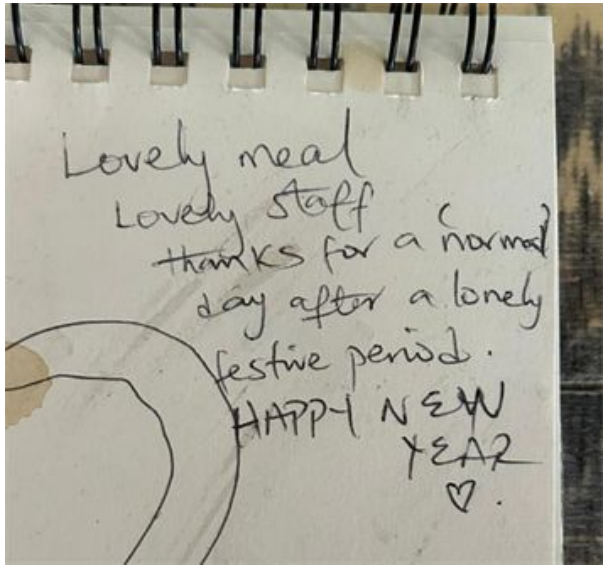
Then, I was gifted a bike by your project, AMAZING! what a difference this is going to make to my life, I can now easily work out when I can both work and work round Dads appointments without any problems. I cannot thank you enough.

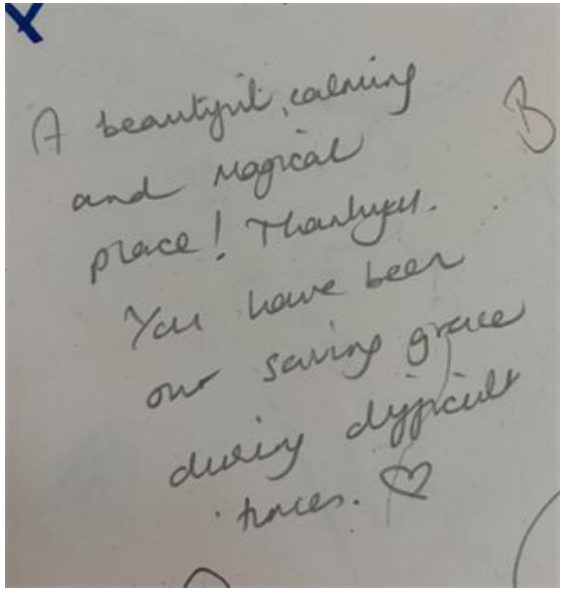
Thank you everyone, a special thanks to Jay who first heard about me and passed on my story to you. That he rode the bike home for me to pick up went above and beyond. I honestly cannot thank you all enough, you have changed my life, a million thanks.

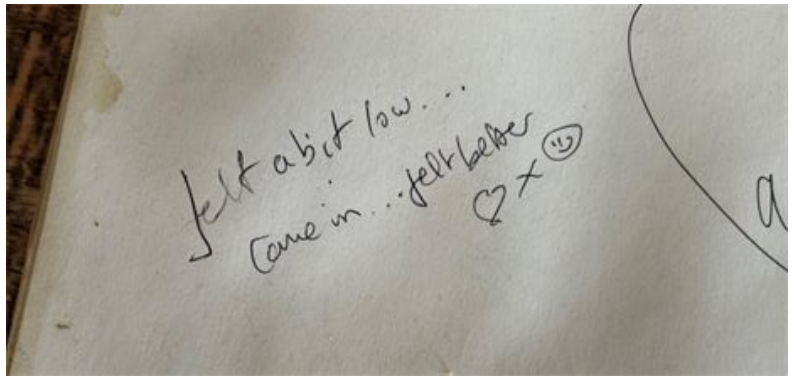
Mike"

Brimscombe Mill Customer Feedback

We have a customer comment book at Brimscombe Mill and here are a few of the comments that have been left.







Brimscombe Mill- part of the healthcare system

- It unlocked match funding neither party could've accessed alone—£350k from Barnwood Trust (loan and grant), £100k from Gloucestershire County Council, and £1.75m from the Diocese of Gloucester. That wouldn't have happened without the credibility your support gave us.

That NHS investment wasn't a grant. It was a vote of confidence in a new kind of system. And because of it, we were able to scale:

  - Cirencester Hub – now home to our pay-as-you-can restaurant, a children's reuse shop, refurbished bikes, and circular economy furniture.
  - Aston Down – a logistics hub powering services like The Great Plate (school meals with values), Kitchen Companions (meals + human contact), and Kick Off Stroud (wellbeing through sport).
  - And now, South Bristol—our first urban replication, inspired by your belief that what works in Stroud can work anywhere people matter.

- The relational model you've championed—taking time, building trust, staying human—has allowed us to go from "nice idea" to a resilient, region-wide ecosystem of care and enterprise.

- Your most recent £25k grant—just a few months ago—is now fuelling our vision for a Brimscombe Mill version of the Bromley by Bow Centre. A place where health, enterprise, social prescribing, food security, creativity, and employment sit under one roof. It's bold. But it's happening. It can now happen in Cirencester too.

One Gloucestershire
Transforming Care, Transforming Communities

VCSE partnership model co-development

ICB Board

May 2025

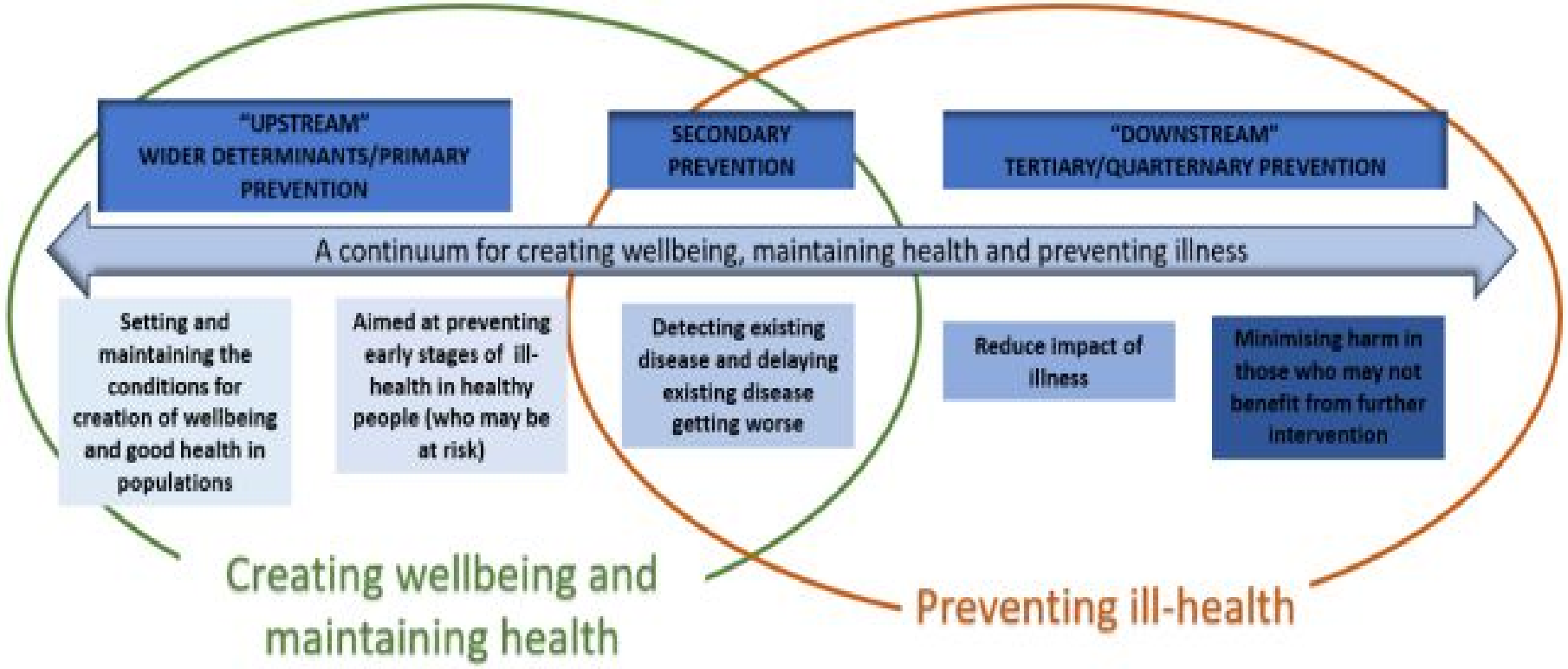
@One_Glos
www.onegloucestershire.net

One Gloucestershire Integrated Care System (ICS)

We need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in.

(Desmond Tutu)

One Gloucestershire
Transforming Care, Transforming Communities



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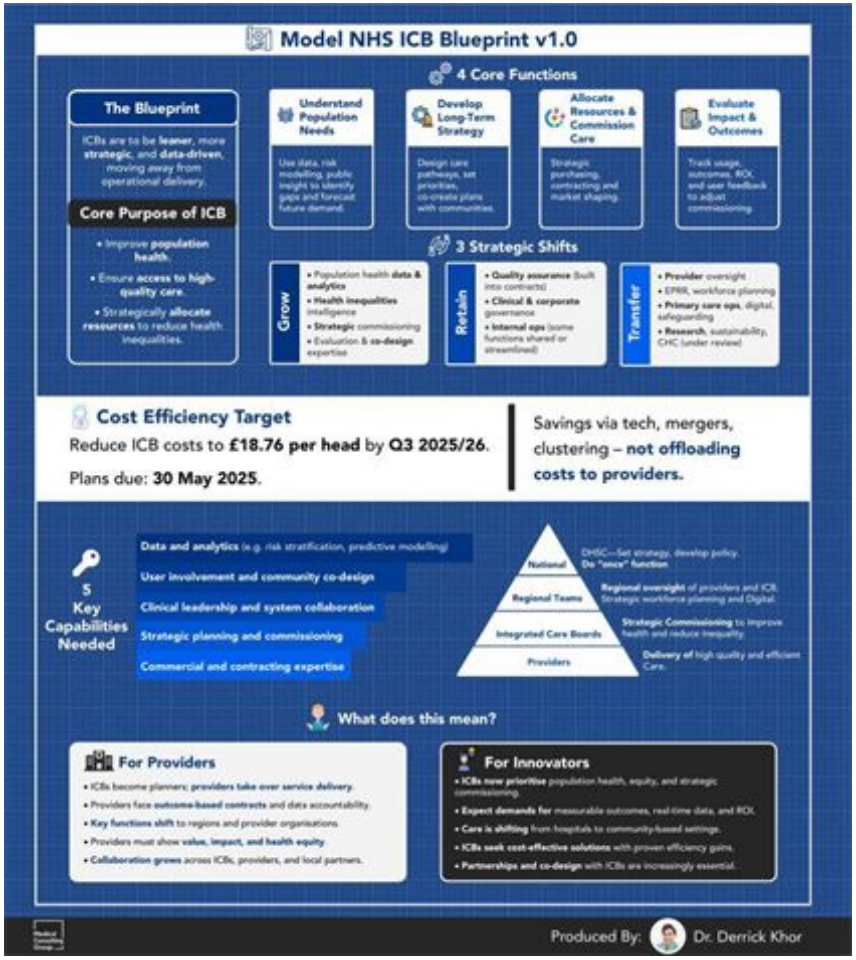
Vision

One Gloucestershire
Transforming Care, Transforming Communities



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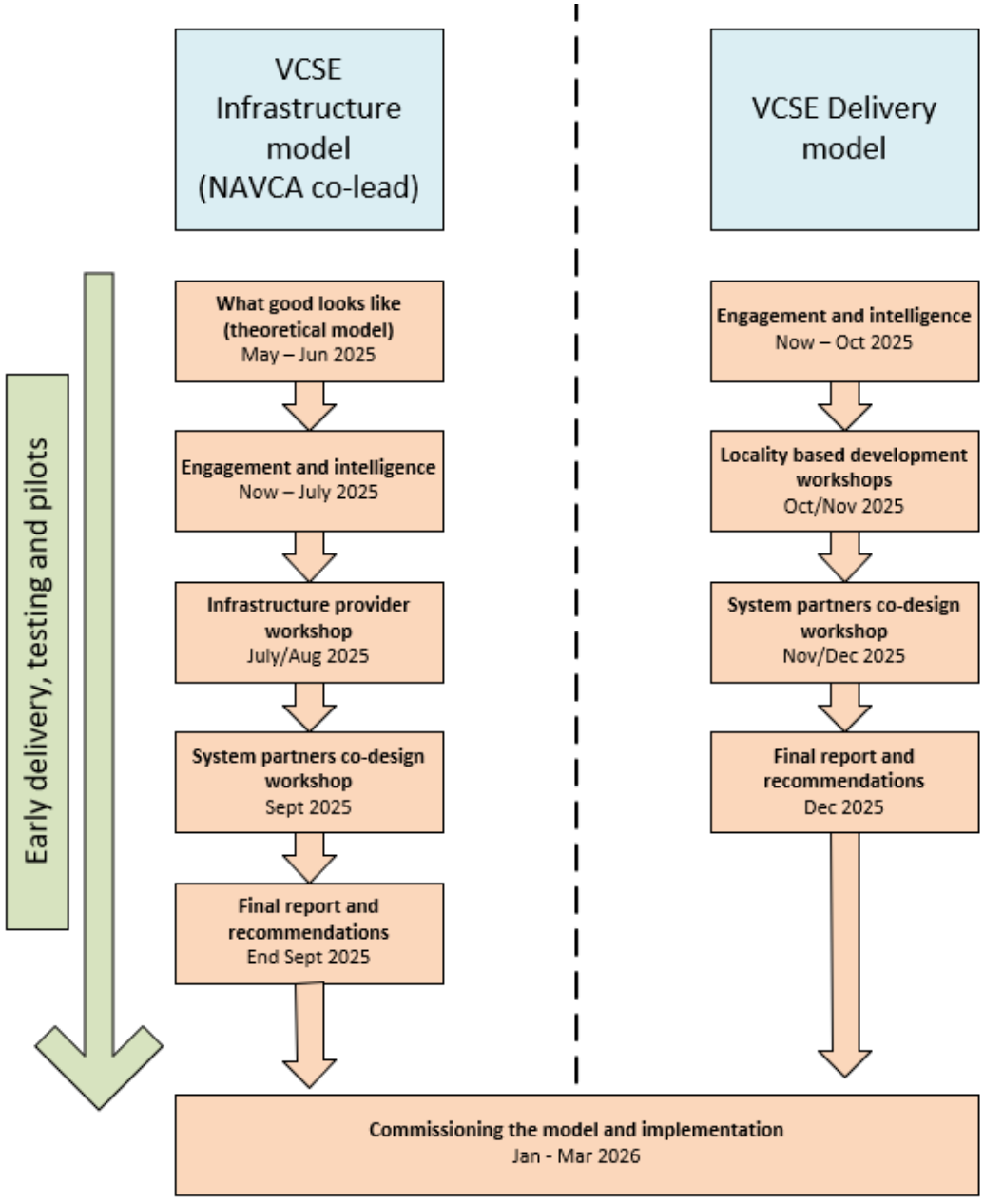
Transforming Care, Transforming Communities

Key milestones



One Gloucestershire
Transforming Care, Transforming Communities

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 28th May 2025

Report Title	**Chief Executive Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X				**X**		
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.						
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer.						
Key Issues to note	This report covers the following topics: • **ICB Reset** • **Six ICS Portfolis** • **Our partnership with Gloucestershire VCS Alliance** • **Public and Patient Engagement update – Supporting Community Groups with Health and Wellbeing** • **Public and Patient Engagement update report** • **Maternity Services Needs Assessment** • **Domestic Abuse Strategy**						
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 28th May 2025

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. ICB Reset

2.1 The Model ICB blueprint guidance has been published which is designed to give greater clarity on the purpose, roles and responsibilities of future ICBs as strategic commissioners. The document is clear that 'ICBs have a critical role to play - working to improve population health, reduce inequalities and improve access to more consistently high-quality care'. They are also described as central to realising the ambitions that will be set out in the 10 Year Health Plan.

2.2 The document is a blueprint, described as a first step and an indication of the future state. It is therefore relatively high level and not prescriptive on all functions and how they should be delivered. There is recognition that the detail and implementation will depend on multiple factors, including the parallel development of provider and regional models.

2.3 It is clear that ICBs will be required to work on larger footprints in the future to meet the strategic commissioning responsibilities set out in the Model ICB blueprint and the running cost reductions. At a meeting of southwest ICB and regional leaders on Wednesday May 7th, further discussions took place on the potential shape of ICBs for the future across the region, using a detailed design criteria to help ensure alignment with the Model ICB blueprint.

2.4 Following those discussions, the provisional view is for Gloucestershire to cluster with Bristol, North Somerset and South Gloucestershire Integrated Care Board. This provides the basis for discussions with staff, the Board and with our external stakeholders.

3. The six ICS Transformation Portfolios

3.1 As partners we approved the Joint Forward Plan 2025-2030 in March 2025, along with our 25/26 operational plan. We will be formally publishing online our Joint Forward Plan by the end of May 2025.

3.2 The commitments in these plans (performance, quality and financial) are being delivered through our 6 ICS Transformation Portfolios. These Portfolios are led with representatives from partner

organisations. This is an exciting development and will support us both in delivering the commitments for this year, but also over the longer-term. This includes delivery against the 3 Government shifts – sickness to prevention, hospital to community and analogue to digital.

3.3 The current priority for Portfolios is in ensuring that we have robust transformation plans to deliver on the commitments for this year – and ensuring that resourcing is aligned to support delivery. Monitoring of progress will take place during the year on progress with high level visibility through the Integrated Performance Report (and ICB System Resources Committee).

3.4 **Our 6 Transformation Portfolios**

Transformation Portfolio	Key Area of Focus
Prevention & Long Term Condition Physical Health	Proactive care in the community for people living with long-term conditions through early prevention as well as coordinated care through Neighbourhood Health and Care and Integrated Neighbourhood Teams.
All Age Mental Health, Neurodivergence, Learning Disabilities and Autism	Ensuring that we deliver effective care and support for people living with mental health problems and/or who are neurodivergent. This includes work to transform care in the community.
Urgent Care and Flow (Working as One)	Ensuring an effective response when people need urgent care - including responsive care closer to home, improved care in hospital and supporting people to independence through reablement and recovery.
Planned Care and Diagnostics	Providing timely and efficient diagnosis and treatment for people when they need it in Gloucestershire.
System Quality and Sustainability	Ensuring that the services we provide across Gloucestershire effective, sustainable, safe and provide a positive experience for people who provide and use them.
System Enablers	This brings together our enabling work to support delivery of the above priorities.

4.1 **Our partnership with Gloucestershire VCS Alliance**

4.1.1 Through our partnership with Gloucestershire VCS Alliance, we have been delivering infrastructure support to the local VCSE sector. Over the last year this has included the delivery of a successful and wide-ranging training and development programme, which has delivered nearly 3000 short course training places covering subjects such as AI, digital marketing, social media skills, IT security and much more. Alongside this our partnership has also delivered a Summer Management Programme to 170 delegates across 133 organisations and the Thrive Leadership Programme which has supported 18 leaders across 17 organisations.

4.1.2 Our partnership has also focussed on fundraising support to more than 80 micro and small VCSE organisations. Covering training workshops on fundraising, supporting tender bids, and identifying funding opportunities. This work has generated more than £300,000 for the sector.

4.2. **Community Health and Wellbeing Grants**

4.2.1 We have been able to invest in 32 Voluntary, Community and Social Enterprise (VCSE) organisations through an open grant round that we ran over winter 2024. Delivery started in January 2025 and we are starting to see the impact of these grants on the health and wellbeing of our population. One example is Wiggly Charity, which provides inclusive, accessible cookery courses to vulnerable, less advantaged or disabled adults and children. Our funding is being used to expand and solidify the Grow with Wiggly project in Gloucester and Cheltenham, which is a farm to fork project whereby they grow vegetables and herbs for the charity's cookery courses. These gardening and cookery projects to develop community capacity, build resilience, and reduce social isolation. Here are some highlights from Q1:

- Some food has been grown locally to be used in local cookery lessons
- 241kg of surplus food has been donated to other community and charitable organisations
- Over 150 volunteer hours have been taken up
- Provided 8 tailored cookery sessions for parents of children at Kingsholm Primary School
- Two 'waiting list' workshops have been run.
- 53 jars of social sauce made.

4.2.2 This is just a snapshot of one organisation that have been able to utilise this funding to create capacity within their organisation and the local community whilst providing support to people who are experiencing health inequalities in our county to create conditions to live healthy lives in a more connected community.

5.1 **Public and Patient Engagement update – Supporting Community Groups with Health and Wellbeing.**

5.1.1 Following ongoing conversations with underserved communities through the ICBs Insight Manager (ED&I) and visits, often with the Information Bus, to certain communities the following has been delivered:

- A breast cancer awareness session to the Jewish community who are 10 times more likely to carry a BRCA fault – this has initiated more conversations about what else the community could benefit from and we are now in talks to deliver diabetes and mental health sessions, whilst also capturing their hospital experiences.

- A cervical cancer/screening talk to the Explorers Group at the GL11 community hub. This is a group of people with learning disabilities. The session was greatly enjoyed and the learning disability nurse engaged very well with the group. He will be visiting in June to talk about bowel cancer.

- We continue to visit the Traveller community once a month and have had Healthy Living Service and mental health teams on the Bus. We are exploring other ways to further engage with the community including visiting at different times, partnering with other organisations to offer food during our visits and visiting other council run sites. At Filipino

Day, members of the community recognised the Bus and came on board to say hello, demonstrating that our approach to building a relationship with this group is working.

- The Bus attended Polish Heritage Day with the Smoking Sensation team from GHAC and the Liver Team from GHT and Bristol, who offered Hep C tests and liver scans for those eligible. The event was well attended and we spoke/tested many people. We hope to engage further with this community through the Polish Saturday School.

- New relationships have been built with Homeward Horizon, a Syrian Refugee community Group, and the Chinese Community in Cheltenham. Initial visits to the group have highlighted that both these communities are worried about diabetes, hypertension, dementia and mental health. We are working to engage with these communities on these topics, ensuring that the information shared is culturally relevant and tailored to their customs e.g. specific dietary information for diabetes.

- The Outreach Vaccination Team continue to visit the Ebony Carers Group, a Black Elders group, at the All Nations Community Centre in Gloucester City. Regular visits to this group also highlighted that they were worried about falls, so the Strong and Steady team have visited, sharing information on services across the county and offering demonstrations on how to get up following a fall etc. They are due to return to reinforce some of the key messages and run Functional Fitness MOTs.

- Visits to the Syrian Refugee community and Explorers Group has helped identify barriers to accessing the National Diabetes Prevention Programme. We are working with the provider to help address these. Visits to a South Asian ladies group has also identified barriers to accessing mental health support and poor experiences of using 111. Conversations with this group during Dying Matters week also helped increase understanding of what matters in these cultures regarding dying, death and grieving.

6.2. **Public and Patient Engagement update report:**

- The Bus is going to the Telegu Association June Picnic, Prescott Biker Festival and Jamaica Day with various teams including Rethink, Managing Memory, Outreach Vaccination Team, Dying Matters and the liver team.

- Information Bus – Visits have focussed recently on: cardiac rehabilitation, MECC, the new cancer build at CGH, blood born viruses, bowel cancer awareness, Carers Hub, CDC Strengthening Communities, Cinderford Community Catalysts, Maternal Mental Health. At the Livestock Market in April, 16 new people visited the Health Check Team on the Bus, 10 of whom required a referral to their GP.

- One Gloucestershire People's Panel – Panellists (1118 local residents) have provided feedback on weight management support. The survey has also been sent to GIG Members and the general public. All feedback is being used to inform a series of service redesign workshops taking place in May and June 2025.

- Countywide Patient Participation Group Network – The April 2025 meeting of the Countywide Patient Participation Group (PPG) Network focussed on: Supervised toothbrushing; Fundraising for Gloucestershire Hospitals Oncology Big Build; Update on future ICB Changes; Recruiting PPG Members. One PPG Member shared details of a new Asthma Lung UK new support group in Gloucester. The May meeting will focus on a GMS Contract update, the July meeting will focus on the results of the national GP Patient Survey.

- Shared Care - GP's receptiveness to take on Shared Care is a live issue for PALS, the ICB Engagement Team and the Primary Care Commissioning Team. Currently we are aware of particular challenges for people who identify as Transgender in accessing medications such as HRT (often this is repeat prescriptions, rather than 'new' requests). In response to issues raised by patients, primary care clinicians, the LMC, and the ICB are working in partnership to develop an interim specification for Shared Care for Adult Transgender Patients. The ICB Engagement Team have met with the LGBTQ+ Partnership and individual patients to support the development of the specification.

7. Maternity Services Health Needs Assessment

7.1 NHS Gloucestershire are undertaking a full health needs assessment for maternity services for a number of reasons.

- Changes in national guidance, such as when people are induced
- Changes in national trends such as an increasing age of women giving birth leading to more complexity
- Changes in lifestyle choices, such as increasing obesity and working patterns for women
- Changes in technology, such as improving IVF outcomes

7.2 A full needs assessment includes nationally available data which looks at trend over time, reviews the evidence base regarding what works and includes the views of women, their families, wider communities and staff. We regularly gather insight from women living in Gloucestershire but we are keen to increase the diversity of the voices that we heard and number of people involved. We want to understand what works well and what could be better.

7.3 In order support the development of our needs assessment, we plan to conduct a survey to help us understand what matters most to women and their families. Providing them an opportunity to share their thoughts about what is important for the future.

8. Domestic Abuse Strategy

8.1 The Gloucestershire Domestic Abuse Strategy for 2025-2028 has been created following completion of the county DA needs assessment, survivor consultation, and workshops and engagement with the DA Local Partnership Board, which includes representation from key partners including the ICB, district councils, police, OPCC etc. .

8.2 The new strategy retains the same vision and priorities as the previous strategy, but introduces new objectives under each priority, and an overarching ambition to end domestic abuse across

the county. The strategy also introduces cross-cutting objectives which have been included to reflect that areas of work such as consultation activity and communications/engagement should be conducted across all priorities and objectives. This also introduces the proposal for thematic responses to the strategy to be developed, encouraging as an example, that a health sub-group be formed to develop a plan to implement the strategy from that perspective, covering each of the priorities

8.3 The strategy is currently out for consultation, and we're asking for any for feedback by the end of May, and there is a public survey asking for feedback on the overall strategy (Draft Domestic Abuse Strategy (2025 – 28) | Have Your Say Gloucestershire) which closes 16 June. Once the content is agreed, it will then be taken for formal approval/adoption by the county council's cabinet and the ICB's Exec Board in July, and it will be designed into an official accessible format before publication on the county council's website.

9. Recommendation

9.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 28th May 2025

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	20/05/2025					
Executive Summary	The BAF was refreshed last 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 BAF and the CRR were reviewed at the Audit Committee meeting that was held on 6th March and requests were made to update and refresh the BAF particularly around UEC and Mental Health.						
Key issues	The BAF has been reviewed this March and the changes made to the BAF are marked in RED. The key changes for the BAF report are as follows: There are 14 strategic risks on the BAF including a new risk on the ICB reset (BAF 13). • 11 Red rated risks (an increase from last reported in March where there were 9) • 3 Amber rated risks. The following changes have been made:						

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- BAF 1 Health Inequalities risk has been reviewed, significant updates have been made to both the actions / mitigations and the Director's report.
- BAF2 community and locality focused approach to the delivery of care. Significant updates given on the controls, assurances, gaps in controls and assurance, actions and Director's update.
- BAF 3a workforce risk has been reviewed, the controls, actions and Director's report have been updated. The risk score has been changed with impact now rated at 4 rather than 5 to ensure consistency with other risks. The risk score is now 16 RED.
- BAF 3b Equality, Diversity, and Inclusion has been reviewed actions and Director's Report updated.
- BAF 4 Quality risk has been reviewed and the Director's report updated with changes made to the controls and Director's update.
- BAF 5. UEC risk has been reviewed and significant updates have been made to the controls, assurances, actions and the Director's update.
- BAF 6 Risk, significant updates have been provided on the impact, controls, assurance, actions and Director's update.
- BAF 7 Recovery and Productivity risk has been reviewed, significant updates provided for the impact, actions and Director's update.
- BAF 8. Mental Health Transformation risk has been reviewed and an update has been given on the actions / mitigations and Director's update. It should be noted that the risk has been transferred to the Chief Nursing Officer as Mental Health now sits within the Quality Directorate, following changes to the Integration Team.
- BAF 9 Financial Sustainability: Financial Sustainability: this risk has been reviewed and updated including alignment of risks with system partners, controls, actions and Director's update.
- BAF 10 Estates Infrastructure: There are updates to the impact, as well as controls, actions and Director's update.
- BAF 11 Emergency Planning Resilience and Response (EPRR) Risk reviewed and due to capacity issues within the EPRR team the risk has been increased from 12 to 16. Actions and the Director's report has been updated.
- BAF 12 Risk has been reviewed against GHFT risk as shared IT service/systems and there are no changes to report for this iteration of the BAF.
- BAF 13 ICB Reset is a new risk that has been included on the BAF and is currently rated as RED 16.

</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>
</table>

Financial Impact	Risk around finance have been included within this report.		
Regulatory and Legal Issues (including NHS Constitution)	The ICB Constitution requires the ICB to have appropriate arrangements for the management of risk.		
Impact on Health Inequalities	There is a risk pertaining to health inequalities within the BAF see BAF 1.		
Impact on Equality and Diversity	An Equality Impact Assessment is included in the Risk Management Framework and Strategy		
Impact on Sustainable Development	No specific risks relating to sustainable development included in the BAF		
Patient and Public Involvement	There are no risks included in the BAF on Patient and Public Involvement		
Recommendation	The Board is asked to; • discuss the system wide strategic risks contained in the BAF • note the report		
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**		

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

Strategic Risks – Board Assurance Framework

May 2025 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.	19/05/2025	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.	16/05/2025	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.	14/05/2025	Director of People, Culture & Engagement	**16** (4x4)	**16** (4x4)	**4** (4x1)	People	*Score has been changed reduced impact now 16 from 20*
	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.	14/05/2025	Director of People, Culture & Engagement	**12** (4x3)	**15** (5x3)	**4** (4x1)	People	*Current score unchanged. And was agreed at the People Committee*
	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.	14/05/2025	CNO & CMO	**15** (5x3)	**16** (4x4)	**4** (4x1)	System Quality	Current score unchanged
	Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*									

3: Improving health and care services today	**BAF 5**	13/11/23	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.	**13/05/2025**	Interim Chief Delivery and Transformation Office	**20** (5x4)	**16** (4x4)	**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.	**16/05/2025**	Director of Primary Care & Place	**16** (4x4)	**15** (5x3)	**5** (5x1)	PCDC	*Scored reduced from 20 to 15*
	BAF 7	01/11/22	Failing to deliver increased productivity requirements to meet both backlogs and growing demand.	**19/05/2025**	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.	**21/05/2025**	Chief Nursing Officer	**12** (4x3)	**12** (4x3)	**4** (4x1)	People System Quality	*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.	**13/05/2025**	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.	**13/05/2025**	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.	**20/05/2025**	Chief Nursing Officer (CNO)	**12** (4x3)	**16** (4x4)	**4** (4x1)	System Quality Audit	*Increase in score from 12 to 16*
	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.	**20/05/2025**	Chief Clinical Information Officer	**20** (5x4)	**15** (5x3)	**10** (5x2)	Audit	*Current score unchanged.*
	BAF 13 (NEW)	09/05/25	Risk of failure to meet statutory duties, regulatory and legal requirements during ICB transition and beyond. Risk of not being able to meet the new organisational cost envelope of £18.76	**19/05/2025**	Director of People / Director of Op Planning	**16 (4x4)**	**16 (4x4)**	**8 (4x2)**	Transition committee	Current score

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

Key Changes since March 2025

1	Significant new and edited content added to Actions to Mitigate and Directors' Update.
2	Risk reviewed. Current content updated in Controls, Assurances, and Known Gaps in Assurances sections.

3A	Controls, Actions to Mitigate and Directors' Update content added.
3B	Update to Actions to Mitigate and Directors' Update content.
4	Risk reviewed. System Mortality content edited. No other changes.
5	Risk being reviewed regularly. Updates to all sections within the risk provided.
6	Scored reduced to a 15 for May. Updates to risk provided.
7	Significant new and edited content added to Actions to Mitigate and Directors' Update.
8	Risk has been reviewed mitigation actions and director's report updated.
9	Risk reviewed. Aligned with new F&BI ICB risk. Actions to Mitigate and Directors Update content updated.
10	'Due to,' Impact and Known Gaps in Assurances sections updated. Actions to Mitigate and Directors Update content added.
11	Risk has been reviewed and the risk score increased from 12 to 16 to take account of loss of capacity in the EPRR team, mitigation actions have been included.
12	This risk has been reviewed but there are no changes at this point in time. The risk score remains the same.
13	New risk added to the BAF about the ICB reset..

**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:**	**19/05/2025**
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 25/26: *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 as well as other inclusion health groups ("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

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. Six-monthly updates on health inequalities objectives by system organisations and partnerships to ICB Board.
3. Updates on health inequalities objectives by system organisations and partnerships to ICB Board.
4. Regular reporting to System Resources Committee & Strategic Executive.
5. Quarterly activity reporting to NHSE.
6. Oversight by SROs.

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.

application of Equality and Engagement Impact Assessments. **7.** Health Inequalities annual statement – reviewing the status of specified metrics as defined by NHSE. **8.** Gloucestershire Health Inequalities Framework launched. **9.** Organisational level health inequalities objective-setting tool. **10.** ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery. **11.** Commitment to patient participation in all workstreams.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. 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. Collaboration with GCC on roll out of system Health Inequalities dashboard (throughout 2025). Internal ICB PowerBI dashboard has been launched covering the majority of indicators required for the national statement on health inequalities. Work is ongoing to develop the dashboard further.	**1.** The returns on the Health Inequalities Framework for the ICS have been completed by system partners and key themes are being identified. Review of these has demonstrated some issues with the HI framework which will be addressed by the project group, including consideration of effectiveness/impact measurement and reporting. Full update went to Board in January 2025 and Health & Wellbeing Partnership in March 2025.
2. 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.	**2.** A workshop was undertaken with health inequalities "champions" from system organisations and partnerships and ILP leads with the aim of reviewing the HI Framework and develop a set of shared objectives, priority outcomes and metrics for addressing health inequalities across the system, aligned to the Health Inequalities Framework. A revised version of the Framework and reporting process will be shared with health inequalities SROs and champions for feedback.
3. NHS Gloucestershire ICB was 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 was launched on 12th February, and we are working with SROs to implement the framework within the system during 2025/26.	**3.** The Gloucestershire Statement on Health Inequalities has been presented at several system and internal meetings to raise awareness, a development group has met to steer the focus for additional reporting and analysis for the 2025 statement and we have agreed a cross-system approach to align the ICB and provider statements, with particular emphasis on the exemplar themes identified in Gloucestershire.
4. Health inequality reporting to be scoped and developed as a regular standing item to System Resources Committee who are taking on the delegated assurance responsibility from the ICB board around progress to reduce health inequality in the Gloucestershire system.	**4.** The second annual Gloucestershire Health Inequalities Information report is in development and an overview was presented to System Resources Committee. The completed report will be shared with health inequalities SROs, System Resources Committee and Audit Committee before being published alongside the ICB Annual Report in July.
5. Equality Impact Assessments are required to be completed and submitted with business cases being considered under the priorities process.	**5.** Lung scanning under the Targeted Lung Health checks scheme has been completed in Gloucester Inner City PCN and will now be rolled out in other PCNs that cover areas of high deprivation. 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
6. A One Gloucestershire health inequalities community of practice is being developed to ensure that we have a shared understanding and are taking a systematic approach to addressing health inequalities.	**6.** We completed our testing of the ICS Engagement Framework in mid-November and fed-back on our observations and experiences of using the Framework at a number of action learning meetings. The Framework has been amended based on the feedback received from the test sites and was launched at an event on the 12th February. We were involved in filming a promotional video about the Framework. which was shown at the event. We have been invited to join a speaker panel at the NHS Confed Expo in June, which introduces the framework to a wider audience.

	7. The Research Engagement Network project team applied for additional funding to continue activities to improve engagement in research with underserved communities and this was successful. 8. Information on health inequalities and tools to support the design, delivery, and evaluation of initiatives to improve health equity has been built into the ICB Project Management training.

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:	**14/11/2023**	**Last updated:**	**16/05/2025**
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 25/26: *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, coupled 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 delivered in 25/26.	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. Provider-led INT Delivery Group in place to drive the development of INTs in a systematised way across the county and to ensure INTs deliver care as per the national INT definition. A new INT Oversight Group will report to ICB Board. 2. Board agreement to focus initially on cohorts of people living with moderate to severe frailty and health inequalities. Working with BI colleagues to further understand our cohorts and baseline. 3. Supported by 25/26 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.	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 time limit required. 3. Permission & time for operational staff to actively engage.	1. Reporting through the INT Delivery Group and INT Oversight Group and onwards to ICB Board. 2. Ongoing monitoring supported by clear baselining and outcomes measures. 3. Delivery supported by enabling subgroups with clear reporting function; digital, PHM and Business Intelligence, Organisational Development and Quality Improvement and Estates.	1. Further development of the performance and benefits realisation trajectories required in order to systematise approach and evaluation.

4. All PCNs/Neighbourhoods included within the programme. **5.** PCN QI funding focussed on Frailty (moderate to severe) and health inequalities to standardise evidence based good practice and support consistency of outcomes.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. All PCNs/Neighbourhoods included within the programme (rather than the initial three pilot areas). **2.** Bi-annual update to ICB Board scheduled for June 2025 including INT implementation progress and anticipated outcomes, as well as consideration of local approach to wider Neighbourhood Health	**1.** System partners collaborating to deliver local and national direction for INTs/ Neighbourhood MDTs as one of six Core Components of Neighbourhood Health Guidelines and supporting the 'three shifts' (specifically hospital to community and treatment to prevention) and the upcoming 10 year plan. Locally this is an opportunity for building on partnership working for greater integration of teams of teams and joined up care. The importance of equal input from all system partners to ensure fair and effective collaboration going forwards has been emphasised to stakeholders. **2.** Baselining exercise across providers to support ongoing evaluation and systematisation of Neighbourhood MDTs has continued. Clear alignment has been made to strategic approaches such as the Older Adults Prevention Strategy from GCC Adult Social Care. Clarity of membership of Neighbourhood MDTs across all partners will now need to be agreed. **3.** Continued system support to align resources to move from pilot projects to a cohesive, system-wide approach which is necessary for transformational change; to systematise INTs as our way of working at neighbourhood.

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:**	**14/05/2025**
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 (Culture & Retention)* ***(Risk rating 20, March 25)*** **GHFT SR17:** *Inability to attract and recruit a compassionate, skilful, and sustainable workforce (Recruitment & Attraction)* ***(Risk rating 20, March 25)*** **GHC ID3:** *There is a risk that we fail to recruit, retain, and plan for a sustainable workforce to deliver services in line with our strategic objectives* ***(Risk Rating 16, Nov 24)*** **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 16, Nov 24).***		

Pillar 2: *Transforming what we do.*

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

Key Priorities 25/26: *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:** *Inadequate Workforce Supply* **PCE:** *Workforce Infrastructure Funding for 2025/26* ~~PCE: Uncertainty of strategic workforce planning function as part of future model blueprint for Model ICB and Region.~~ Removed. **(Risks 15 and above)**

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
16 (4x4)	**16** (4x4)	**4** (4x1)	**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. Both Trusts have staff experience improvement programmes	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, options for future being explored in context of limited investment opportunities)	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 and impact of operating planning guidance for 2025/26. 2. Reduced funding for workforce transformation in 2024/25 and in 2025/26. 3. Awaiting details of strategic workforce planning assumptions in response to 10-year plan.

4. Refresh of system level delivery plan for 2025/26 and refresh of people governance arrangements. 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. Continued focus on agency and temporary staffing spends in response to revised 2.3% target for 2025/26. 4. On-going recruitment activities at organisational level e.g. GHFT's Workforce Sustainability programme aimed at transforming its recruitment process. Roll out of system wide recruitment promotion campaign 'Be in Gloucestershire.' 5. H&WB review complete with a series of system recommendations being taken forward. 6. Continued but reduced focus on System Leadership in 25/26 due to limitation of resources.	1. Peoples Promise Manager extension in GHFT to 18 months. New starter packs to be implemented for staff. Continued progress on areas where a system approach would be beneficial e.g. pension awareness and menopause policy and resources. 2. System wide EDI conference planned for 3rd July 2025 and collective review of 2025 staff survey results took place at April People Committee. Provider level plans e.g. GHFT Board development programme and GHC Leadership & Culture Programme. 3. Agency spend remains within agreed cap of 3.2% for 2024/25. 4. Recruitment: We Want You project team continues to develop service offer including coaching and work placements. Be a GP in Glos Campaign now scheduled for launch May 25. 5. Regional conversations to establish housing hub have been paused. Housing Officer came into post November 24. Housing needs survey launched. 6. OD Delivery Group to confirm leadership offers for 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:**	**14/05/2025**
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, March 25)** **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 16, Nov 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:** Lack of Progress on ED&I – system partners do not make sufficient progress on ED&I priorities and against our commitment to creating a fully inclusive, diverse, and engaging culture for our workforce. (Rated 16)

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

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.** Continued Board and People Committee focus.	**1.** EDS2 briefing and position statement submitted to March Board, followed by publication on ICB website. **2.** Individual organisational level action plans progressing focusing on anti-discrimination approaches and reporting of incidents and inclusive recruitment. **3.** SW EDI Regional workshop on 10th April 2025. **4.** EDI dashboard at provider and system level developed with a focus on priority metrics – shared with providers for internal use and advice on further development. **5.** System wide EDI conference on 2nd July 2025 aimed at middle managers. **6.** Review at April People Committee of 2024 staff survey results. Providers publications of gender, disability and ethnicity pay gap reports.

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:**	**14/05/2025**
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 25/26: *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 37: *Reputational damage to the ICB and Childrens Continuing Care team of transferring long term complex packages of care to a new provider.*

Integration 39: *Lack of clinical oversight for Local Authority led joint packages of care and direct payments*

Integration 43: *CCC team in relation to governance and challenge due to key policies and procedures not being in place*

Safeguarding 6: *Child Protection Medical Assessments Not Being Undertaken For All Types Of Abuse By GHFT*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
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	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	1. Reporting to the System Quality Committee. 2. Quality Assurance discussions.	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,

2. Reporting from and attendance at Provider Quality Committee. 3. Learning from Case Reviews. 4. System Quality Group. 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. 11. 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.	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. 4. Triangulation of data across the system through quality dashboards not in place currently.	3. Intelligence gathering through data relating to all aspects of quality. 4. Contract Management Boards. 5. Regulatory reviews.	Effectiveness and Experience groups) are working.

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; working with providers to develop their plans. 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. 3. **System Mortality**: The national NHSE data tool shows that the Summary Hospital-Level Mortality Indicator (SHMI) for Gloucestershire Hospitals has reduced to 1.13. This is a 12-month rolling average covering the previous 12 months up to December 2024. This has remained within expected limits.. The CGH out of hospital also now back to normal. The system mortality QIG (with support from regional colleagues and external support from a colleague in another ICB) meets monthly. A regional mortality insights visit has been planned in July 2025 . The ICB is overseeing a number of actions looking at improving quality of depth of coding and improving clinical pathways. ICB oversight is through the System Quality processes and mortality remains on the Board assurance framework risk register. 4. Quality Improvement Group (QIG) remains in place for maternity services and currently subject to enhanced surveillance owing to Section 31 notice. Following maternity reset meeting by the national MSSP team, enhanced oversight will focus on the 6 areas needing further attention. National team to assess progress formally in 4 months. 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:**	13/05/25
Owner:	**Gemma Artz, Interim Chief Delivery and Transformation Officer**		
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	Increase 12 (4x3) to 16 (4x4)
20 (5x4)	**16** (4x4)	**8** (4x2)	**Appetite**	**Zero/Minimal**

Due to:	Impact:
Ongoing performance challenges, despite improvement and some recovery from high demand levels we remain behind trajectory for a number of key metrics.	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 and the High Impact Interventions via the Patient Flow Delivery Board. .	1. Further development of the performance and benefits realisation trajectories required for some measures, with a focus on quality and outcome measures.
2. Strong governance through Patient Flow Delivery Board and contractual oversight for all health provider	2. Clarity on the improvement resource whilst also delivering the recurrent £4m savings target for the portfolio	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 Portfolio.
3. New 'Working as One' Portfolio structure agreed with dual Provider COO SROs. The Portfolio will be governed by a Portfolio Oversight Board with three Programme Boards reporting to it, covering the entire UEC pathway. These boards are now established with clear system-wide leadership.	3. There is a gap in transformation resource – when compared to previous year - allocation of leadership across the system underway.	3. NHSEI Reporting.	3. Impact of planning round combined with system pressures on staff capacity to deliver
4. Agreed reporting on priority improvements in place.		4. High level metrics for Working as One Portfolio in place.	
		5. Portfolio for UEC set up to ensure safe transition from working as one to new system working approach to ensure system oversight and grip	
		6. New governance set up for intermediate care oversight (intermediate care board) and 'front door'	

5. Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver within UEC system flow. 6. Full alignment between strategic priorities and operational plan for 25/26 7. Annual Resilience (Winter Plan) to be developed and in place to communicate to patients about where to access services during winter.		oversight (community urgent care board) to ensure focus on improvement is maintained.	

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Oversight of sustainability of the trials and impact from Working as One in place 2. Three Clear priorities for the Working as One (UEC) Portfolio: Care Co-ordination (Integrated Working), Community Based Urgent Care and Community Based Intermediate Care model. 3. Portfolio and Programme metrics in place. 4. Focus on system actions to deliver operational plan commitments including finance, projects identified, system leadership in place. System timeline being refined. 5. Clear opportunity plan by end May 2025, with quantified implementation plan by end June 2025 6. Communication and Engagement plan being refreshed. Portfolio workshop day held on 2nd May 2025, with further sessions planned	1. Portfolio in place with agreed leadership, priorities identified and governance in place/implementing in May 2025.Portfolio and Programme metrics for Working as One are in place (Transitioned metrics from 2024/25 with additional targets and reset baselines for 25/26). Workstream measures have been developed, to be refreshed in line with priorities. Action remains open whilst quality and outcome measures are refined, alongside automated reporting. Automated reporting has been developed as a system visibility tool, under review prior to wider roll out across the system alongside development of automated metric dashboard. 2. A Working as One Workshop was held on 2nd May, focused on empowering system leaders to prioritise and lead improvements. Agreed actions being taken forwards with a focus on understanding the impact on quality, performance, and finance. Impact of shift from integrated to aligned commissioning to be understood, including focus on ambitions for Intermediate Care (which is critical to delivering eth financial plan and discharge ready trajectory)

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:**	**20/05/2025**
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 10:** *Primary Care Sustainability* **PC&P 13***: Primary Care & Secondary Care Interface* **PC&P 14:** *Collective Action* **PC&P 18***: Special Allocation Scheme~~t~~* *PC&P : Potential National Community Pharmacy Collective Action* **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)	**15** (5x3)	**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 25/26: *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, 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.

The general practice national collective action, which commenced on the 1st of August 2024, following the BMA ballot results to proceed with a gradual introduction of a possible 10 BMA Actions to move primary care to a new normal has been nationally 'paused' after the release of the new General Practice Contract for 2025/26 following national negotiation. The GPC have also now received written confirmation that a whole new contract will be agreed within this governments parliamentary term. Elements of collective action such as safe working limits and resolution of unfunded work is expected to remain.

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 Collective Action took place on the 16th September 2024. The National Pharmacy Association undertook a ballot which received near a unanimous vote in favour of national Community Pharmacy Collective Action, the possibility of this still remains even though the new Community Pharmacy Contractual Framework has been released and additional funding has been provided it has been recognised nationally that there is still a shortfall in funding. The National Pharmacy Association has confirmed some pharmacies will undertake reduced hours unless confirmation received on a new contract and sufficient funding.

Impact:

It is still unclear what financial hardships practices will experience (including the impact of national insurance changes) and therefore remains the potential that this could result in 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 patients and to wider system, particularly GP providers. Potential risk of pharmacy closures and impact to patients and practices nearby.

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) taking place when required. 3. A Standard Operating Procedure (SOP) for practices requiring financial assistance and support is in place to ensure a fair and consistent approach with good governance. 4. Finance Training Package procured and cohorts complete. 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. A Primary Care Strategy is in place with associated plans. 11. Producing a Primary Care Action Plan for regional submission, as part of Operational Planning. 12. Undertaking a General Practice Commissioning & Transformation Support Tool review for regional submission to provide robust assurance. 13. A Secondary Care/Primary Care Interface Group (senior leads level) in place and reviewing delivery of the national 4 key areas of focus.	Details on the level of Collective Action – for Community Pharmacy - to determine which areas of work/system this will impact. However we know some pharmacies will reduce their hours if this goes ahead. 2. The level of action general practice will follow post the new GP contract and national 'pause' of collective action, especially around unfunded work. 3. National Insurance bill rejected by the House of Commons, following the House of Lords support.	1. The Primary Care Operational Group receives regular reports on practice resilience and the schemes and initiatives to support practices including workforce reports. 2. The Primary Care and Direct Commissioning Committee receives those reports from PCOG and provides oversight and scrutiny 3. The Primary Care Resilience and Sustainability subgroup has been established to further develop the ICB response to struggling practices 4. Working with the LPC to understand Community Pharmacy issues and a number of community pharmacy events held to date to support the community pharmacy voice within primary care across the system	1. Volume of shared care and additional 'discretionary' activity, are both unknown.

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. Working with the LPC to understand Community Pharmacy issues and successful Community Pharmacy Events held in November 2024 & February 2025 to support the community pharmacy voice within primary care across the system 6. Community Pharmacy Strategy Group and Dental Strategy Group in place with LPC & LDC attendance.	1. Newly qualified GPs now claimable via ARRs with additional funding. 2. Working closely with the LMC to understand the potential impact to general practice capacity, due to the sustainability challenges. 3. Regularly surveying practices to understand impact to capacity, particularly urgent on the day care. 4. Resilience and Sustainability Sub - focussed on understanding the impact on general practice and ensuring we are developing action plans to support mitigations. 5. Financial Awareness Training undertaken for all partners and practice managers. 6. A meeting for all four contractor group committees with the ICB has taken place to discuss constraints and opportunities to delivering primary care in the county and further meetings are being set up. 7. New GP Contract for 2025/26 nationally agreed and in place. 8. National Collective Action has been put on 'Pause' and GPC have received written confirmation that a whole new contract will be agreed within this governments parliamentary term. Local Collective Action Task & Finish Group now stood down but understand elements of collective action such as safe working limits and resolution of unfunded work is expected to remain and will be picked up by the Primary Care Team. 9. New Community Pharmacy Contractual Framework for 25/26 released alongside additional national funding which has seen a 19.7% increase on 23/24 funding, as well as a national write off of historic margin overspend (noting there is still an identified shortfall in funding to community pharmacy). ~~contract for 25/26, due to be announced by~~ 10. Producing a Primary Care Action Plan for regional submission, as part of Operational Planning. 11. Undertaking a General Practice Commissioning & Transformation Support Tool review for regional submission to provide robust assurance. 12. Identifying practices which may require support, through local intelligence and triangulation of data, to have targeted conversations. Practice level support offer being worked up.

	13. Peer Ambassador in place.

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:**	**19/05/2025**
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 25/26: *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	Unchanged
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 and Urology which has diverted elective capacity towards seeing and treating them at the expense of routine patients.

Impact:

Some elective specialties have a level of long waiters >52 weeks but there are specific specialties with most numbers e.g. ENT, T&O and OMF. The total waiting list size is also 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 technical and administrative validation and prioritisation of system waiting lists plus regular proactive contact with patients to notify them of delays and what to do if clinical condition changes. Elective waiting list prioritised with P codes to ensure patients are booked in priority order.
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. Monthly elective care 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. System interface group established to oversee improvements in the interface between primary and secondary care.
8. Operational and transformational delivery monitored by system Planned Care Delivery Board. Reallocation of ERF slippage undertaken here.
9. 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.
10. Clinical harm reviews undertaken for all long waits.
11. Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.
12. New payment models introduced at GHFT to support willingness of staff to undertake additional weekend activity.

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

4. Reporting to NHSE/I on forecast month end long-waiters weekly. 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. Visibility of waiting times through WLMDS returns.

Actions to Mitigate Risk & Implementation Dates

1. Operational plans for 25/26 submitted. Delivery underway and being monitored.
2. Specific additional capacity investments agreed and being implemented.
3. Elective and diagnostic portfolio plan in place with associated savings plan.
4. Independent sector budgets and activity plans agreed which support delivery of waiting times and contribute to system breakeven financial position.
5. Patient Engagement Portal phased implementation underway.
6. Roll out of FDP within GHFT to improve productivity and efficiency.
7. Use of robotic automation in booking processes identified and due for implementation by April 2025.
8. Elective and Diagnostic Portfolio developed to support delivery of transformation programmes including IP/DC/theatres, outpatients, waiting list management, referral optimisation and diagnostics.
9. 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 achievement at M12 position was 119.5% against a target of 118%, providing additional income to the system financial position.
2. Priority schemes identified in long wait specialties, including ENT, OMF, Orthopaedics, Spines, Endoscopy and Angiography to support waiting time achievement through 25/26. Transfers underway to IS for longest waiters in ENT and Orthopaedics.
3. Capped theatre utilisation at GHFT was 81% in March. Daycase rate was at 84.6% against the national target of 85%. GHFT have recently joined the national GIRFT programme to reduce short notice theatre cancellations and late starts, although currently upper quartile for late starts and early finishes. All of this has culminated in the Trust delivering on average an additional 153 cases per month.
4. Baseline assessment of community hospital theatre activity completed and to be presented to the T&F group this week. GHFT to present their options appraisal as to the best use of community theatres by creating centres of excellence. Recommendations to be put to Execs thereafter for consideration.
5. The ICB has accredited two more elective care providers in the last month and received one more application from and Ophthalmology provider. There are still three other providers going through the accreditation process. Whilst good for choice and capacity, these new providers pose a significant risk to our financial position. Activity plans will be set after 3 months to try and contain expenditure.

	6. GHFT primary care liaison role is working well and hugely appreciated by GP practices. Numerous interface and pathway issues have been resolved (or have plans to). Number of complaints and issues have reduced as a result. Interface workshop run with ISPs to engage them in improving their interface with primary care.

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	RTT performance

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:**	**21/05/2025**
Owner:	**Marie Crofts, Chief Nursing Officer**		
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 25/26: *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. All age MH LDA Board established as part of the portfolio approach to prioritising programmes of work and transformation. **2.** Eating Disorder Programme including system wide prevention through to crisis workstreams established. **3.** CAMHS recovery plan including within service provision and system wide to support improvements. **4.** Neurodevelopmental business case and plan in place. Project team established to oversee recommissioning of ADHD/ASC pathway. **5.** 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	**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.

transformational changes. 6-month extension to programme management agreed. ICB PM resources released to support UEC MH programme/Right Care Right Person.	5. CYP MH Lead for ICB currently away. Programmes that sat with her (Eating Disorders) have been transferred to Adult MH commissioning but from end of Feb 25 there will be limited capacity in team to support programme. 6. 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. Regular reporting to the Children's Mental Health Board and Adult Mental Health Board. 3. SEND inspection complete and ICB SEND programme board established. 4. 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. SEND Strategy approved by GCC and ICB Board in March 2025 2. Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy. Update with timeline 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. A newly established all age Mental Health, Learning Disability, Neurodivergent Board – system level, with an Executive Chair ICB CNO. 5. Agreed portfolios in Mental Health, Learning Disability and Neurodivergence, agreed work priorities ensuring that the portfolios are appropriate resourced and monitored. 6. 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:**	**13/05/2025**
Owner:	**Cath Leech, Chief Finance Officer**		
Committee	**Audit, Resources**		
Aligned with System Partner Risk(s):	**GHC: 6** *There is a risk that funding constraints impact the ability of commissioners to commit to long term transformation of services to meet the needs of the population (Risk Rating 12)* **GHFT: SR9** *Failure to deliver recurrent financial sustainability* (Risk rating 20)		
Aligned with ICB Risk(s):	**F&BI X -** *The ICB does not meet its breakeven control total in 2054/26 (noted that these risks are to be updated on ICB risk management system).* **F&BI X -** *The ICS does not meet its breakeven financial duty in 2025/26* **F&BI X** *- The ICS is not able to develop a breakeven plan for 2025/26 and is unable to deliver its control total in 2025/26*		

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 25/26: *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. - Publication of new NICE TAs with significant resource implications and benefits being seen in the longer term. - 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 - The impact of staffing reductions within the system and the impact of organisational changes.	- Underlying revenue deficit position within the system as a whole 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.	**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 leading to cashable benefits not in place.	**1.** Reporting into Board of the ICB and relevant Committee for each organisation including Strategic Executives. **2.** Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position.	**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.

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. 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.	3. Uncertainty around future organisational form and structure with loss of clarity on roles and responsibilities. 4. 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. 5. Monitoring of workforce numbers is incomplete currently across the system.	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. 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. Portfolio governance developed and in place with prioritisation of key programmes of work focussed on the delivery of benefits with significant focus on trajectories and the actions required to enable recurrent cashable savings in addition to the quality and operational benefits. Support from the PMO on overall approach in place. Portfolio reporting to Strategic Executives on a rolling basis.	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. Portfolio governance developed and in place, support from the PMO working with programmes to identify gaps in project management resource to delivery prioritised programmes. 3. Work on the medium-term plan including financial plan underway. 4. 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. 5. Bi-weekly meetings with CEOs and DoFs to monitor progress of plans and progress for 2025/26 and 2024/25 financial position.

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:**	**13/05/2025**
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):	**N/A**		

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 25/26: *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. - High level of backlog maintenance within GHFT (c£72m) and ageing estate leading to increases in maintenance work both planned and unplanned. - Additional capital allocations are not always cash backed leading to an impact on the cash position for the system and a potentially reduced ability to take full advantage of additional allocations. - Revenue costs of primary care rents increasing significantly leading to a slowdown in the development of replacement premises for surgeries which have estate issues or where the population served has increased significantly. - Compliance issues relating to fire, water, and electrical safety within the GHFT estate.	- 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. - Inability to progress with primary care estate developments leading to GP surgeries with insufficient space to accommodate staff required to deal with increased numbers of patients and/or GP surgeries with estates issues that impact on operational performance. - Operational performance within the Gloucester Royal and Cheltenham sites impacted due to both unplanned estates issues and significant planned estates work.

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.	**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	**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. **2.** System review of risks relating to estates to provide a forward look to enable better

4. Capital and Estates Infrastructure meeting in place and taking forward actions from the draft infrastructure strategy. **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.** Revised primary care infrastructure plan developed. **8.** This risk will form part of the ICB infrastructure plan.		the capital resource limit across the system.	planning to manage estates issues and risks.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. ICS Health Infrastructure Plan (HIP) close to completion and due to go to ICB Board 31/5/25. **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.** 2025/26 capital programme agreed including bids in progress to national team for critical infrastructure and constitutional standards improvement 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) due to ICB Board on the 31/15/25.

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:**	21/05/2025
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* **(Risk Rating 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* **(Risk Rating 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, the ICB being rated as 'partially compliant' and new resource in the EPRR team taking time to embed.	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):*	Known Gaps in Controls	Current Assurances *(of controls effectivity):*	Known Gaps in Assurances
1. EPRR on-call manager training. 2. EPRR exercises. 3. Oversight of EPRR through the Local Health Resilience Partnership. 4. ICB EPRR Policy and Business Continuity Policy 5. ICB EPRR Training Needs Analysis	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. Lack of take up of strategic training offered and lack of attendance and representation at local and regional exercises. 4. Band 7 EPRR T&E Manager Has left the organisation and with the current recruitment freeze across the organisation we are unable to recruit to the post at present. This means the training needs analysis is not updated as regularly and training events for staff are less frequent. 5. Loss of on-call staff as a result of natural churn or impending organisational change will significantly affect the ICB's ability to respond to an incident.	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. 4. Peer review and sharing good practice through the new SW EPRR Collaborative group	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). NHS System Assurance 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. The ICB itself has seen its overall rating remain static and again whilst a self-assessment of "fully compliant" was submitted, we have been rated as "partially assured" by NHSE).

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Sign off of the ICB T&E Strategy through Ops Exec and then System Quality Committee – mid April 2025 **2.** Full roll out and further testing of the new mass notifications system for incident alerts – end of March 2025 **3.** Recruit to the post of EPRR T&E Coordinator (which will become vacant 3rd April) – May 2025 **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. **5.** Additional support with administration and training exercises has been made available via the Governance Team **6.** As BNSSG and Gloucestershire ICBs cluster there will be opportunities to share resources	**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. **3.** Board Development Session is planned for later in the year to reiterate Cat 1 responder duties and responsibilities and update. **4.** A new Business Continuity Policy has been developed and signed off at System Quality Committee in February. This includes enhanced steps for monitoring and evaluating BCPs across the organisation. In addition, the EPRR Manager has met with some departmental leads re BCPs and updated the departmental leads list. The ICB EPRR Policy has also been reviewed and signed off by System Quality Committee. **5.** A new ICB Training and Exercise Strategy has been produced and is due to be approved by System Quality Committee in April. The policy contains a detailed training prospectus for all incident response and EPRR functions across the organisation and commits the organisation to running and participating in a certain number of exercises per year. **6.** EPRR team now attend Cyber Ops meetings and have been working with the Digital team in terms of delivering a cyber workshop and exercise event in June 2025. **7.** Significant work has been underway to capture lessons identified in the January System Critical Incident response. The learning will be embedded in the review of the ICB Incident Response Plan and Health Community Response Plans. A report on the CI incident will go to Ops Exec and then Patient Delivery Board. **8.** With admin support in the team, the EPRR team have already created a folder structure to collate evidence for this year's NHSE EPRR Core Standards assurance and evidence is being uploaded through the year to meet the September deadline. **9.** The loss of the T&E Manager in the EPRR team affects our ability to appropriately train and develop staff with a response role. In addition, our contribution to the multi-agency planning for Ex Pegasus and other system exercise events is significantly hampered.

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:**	**17/03/2025**
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 Amber 15)** *Key threats include malware, phishing, and potential physical breaches, with the National Cyber Security Centre emphasising the increasing sophistication of cyber-attacks on the NHS. (14th November 2024)* **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 28 November2024**)*		

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
20 (5x4)	**15** (5x3)	**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 25/26: *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 via 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. Disaster recovery planning around support systems (out of IT control) not consistently in place. 3. Operating model of cyber-technical & cyber-governance currently not optimal. 4. Volume of cyber-security issues requiring resolution. 5. 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. Annual ICB board cyber development completed at February 2025 session and associated online training to follow. 5. GHFT reduced their BAF risk score from 20 to 15 to reflect work undertaken to mitigate cyber risk.	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.** Progress continues to be made towards protecting from cyber-attack however the external environment means the threat continues to evolve and is likely to remain. Gloucestershire's cyber security strategy has been through organisation reviews and due for approval at ICB board in March. Good progress continues to be reported by our NHS ICS cyber service on removal of end-of-life software and hardware, building our asset registers and monitoring. **2.** GHFT have reduced their BAF score to 15. As hosts of our NHS ICS cyber service this is positive news.

Relevant Key Performance Indicators
N/A

BAF 13	**Risk of failure to meet statutory duties, regulatory and legal requirements during ICB transition and beyond.** **Risk of not being able to meet the new organisational cost envelope of £18.76**

Entry date:	**19/05/25**	**Last updated:**	**19/05/25**
Owner:	**TBC**		
Committee	**Op Exec**		
Aligned with System Partner Risk(s):	**Unknown**		
Aligned with ICB Risk(s):	**N/A**		

Pillar 1: **Improving health and care services today**

Strategic Objective: **Improving health and care services today**

Key Priorities 25/26: ***Creating a financially sustainable health and care system***

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Risk Appetite
(16) **4 x 4**	**(16)** **4 x 4**	**(8)** **4 x 2**		**Seek**

Due to:

- Delays in national guidance, views, and schemes e.g. VR and MARS.
- Pace of change does not allow enough time for due consideration to employment law.
- Delays in national, regional, and local change to unlock the transfer of some services out of ICBs negatively impacts the deliverability of the savings required.
- Receiving organisations lack the capacity, maturity, or desire for transferred services.
- Pace required for transfer doesn't allow sufficient time to develop appropriate service specifications and/or comply with procurement regulations.
- Greater clarity is needed on how joint arrangements under s 65Z5-65Z7 – 2006 Act will operate to allow for arrangements for delegation and joint exercise of statutory functions that can take place within clustered ICBs.
- Current NHSE guidance requires that local authority partners must support mergers which may delay merger of ICBs until local government changes are enacted.

The requirements force suboptimal decision making that increases the overall cost of delivering healthcare.

Impact:

- Delay to the deliverability of the cluster, prior to merger
- Ability to meet the savings required within the agreed timescales is challenging and will be difficult to attain
- There is a negative impact on the patient care as the organisation find it challenging to meet performance and service requirements while simultaneously delivering the changes required nationally
- Reduced self-determination
- Staff morale, motivation and productivity is negatively affected
- Experienced and well qualified staff may choose to opt for redundancy or leave the organisation meaning that some of the organisational history and expertise is lost

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
12. RET/CEO/Chairs meeting **13.** Weekly executive ICB transition meetings **14.** Gloucestershire and BNSSG Transition Working Group established. **15.** Lead seconded into Transition programme **16.** Sharing HR and Governance in Glos ICB and BNSSG resources to manage the change process	**6.** No national MARS/VR/CR scheme details as of yet **7.** No regional or national Blueprint **8.** National agreement on Cluster arrangements not yet received.	1. Positive feedback from NHS on initial draft of preferred options	**5.** Formal Transition Committee not yet in place (planned for June 2025)

Actions to Mitigate Risk & Implementation Dates	**Directors Updates on Actions to Date (Updated Quarterly)**
1. Joint transition working Group in place. 2. Development of a Glos/BNSSG joint Transition Committee due to be established in June 2025 to include non-executive directors.	**9.** New BAF Risk.

Relevant Key Performance Indicators
% of savings to be made by Q3/4

Risk scoring:

Impact	Likelihood				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

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

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

Agenda Item 10

NHS Gloucestershire ICB Board, Public Session

Wednesday 28th May 2025

Report Title	**Integrated Performance Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	N/A						
	ICB Internal	**Date**	**System Partner**	**Date**			
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for May 2025. 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) • Quality Please note: there is no finance report for M1. 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	None.			
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	**PMO:** **Jess Yeates** **Performance:** **Kat Doherty** **Workforce:** **Tracey Cox** **Quality:** **Rob Mauler**	**Role Title**	ICS PMO Coordinator Senior Performance Management Lead Director for People, Culture & Engagement Senior Manager, Quality & Commissioning	
Sponsoring Director (if not author)	**Performance:** **Mark Walkingshaw** **Workforce:** **Tracey Cox** **Quality:** **Marie Crofts**	**Role Title**	Director of Operational Planning & Performance Director for People, Culture & Engagement 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

May 2025

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Detail of Key Achievements & Areas of Focus	
11 - 23	Performance: Improving Services & Delivering Outcomes *(Including ICP Dashboard, pages 12-17)*
24 - 27	Workforce: Our People
28 - 33	Quality: Safety, Experience and Effectiveness
Please note there is no finance report for Month 1 of 2025/26	
Supporting Performance and Workforce Metrics – see supporting document here.	

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

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Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Feedback from Committees

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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	1st May 2025

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
25/26 Plan Delivery	**LIMITED**	Committee received an update on delivery of the 25/26 Plan – including performance and savings plans. System savings and performance objectives had been mapped to the 6 Transformation portfolios for delivery with an update received on reporting arrangements.	Performance team to review and work with system teams to develop the report, incorporating the suggested changes.	May 2025
Investments and Benefits Review	**LIMITED**	The Committee heard an update on work underway on a review of recurrent investments being made by the Transformation Portfolios. A list of these investments was shared (over £250k). Initial work had been undertaken to prioritise this for review.	Work with the Transformation Portfolios to identify the small set of investments that will be subject to evaluation and review over the summer with recommendations made on next steps in the Autumn.	June 2025
Performance	**LIMITED**	Update received on performance with a specific focus on cancer, elective performance and urgent care and flow.	No further actions at this stage but continue to monitor delivery in year through the Committee.	Ongoing
Finance	**LIMITED**	Update provided on financial performance noting positive position for ending the year in 24/25. There is a challenge to delivery in 25/26 with significant savings requirements in the plan for this year (over £90m savings requirements) and a number of risks to delivery.	Continue to monitor delivery in year through the Committee. This included reviewing progress being delivered through the Transformation Portfolios in delivering the system savings requirements for 25/26.	Ongoing

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

Issues referred to another committee

Topic	Committee
None	None

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People Committee

Accountable Non-Executive Director	Karen Clements
Meeting Date	17 April 2025

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Staff Survey results	**SIGNIFICANT**	The committee received staff survey reports from GHFT, GHC, ICB, GCC and General Practices. Organisations have robust action plans and processes to address issues that have been raised through the surveys.	Organisations to progress with their actions plans and identify areas for system-wide potential collaboration	March 2026
Revised Governance Arrangements for People Committee	**SIGNIFICANT**	The committee received draft proposals for a streamlined workforce governance model, removing a layer (steering groups). These were approved by the committee.	Implement new governance model (remove Steering Groups) Review ToRs, and particularly membership, for the People Programme Board and the People Committee	April 2025 End Q1 25/26
Risk register	**LIMITED**	The committee reviewed the risks and discussed a potential new risk in relation to NHS organisational change and the impact of that on work programmes and long-term workforce planning.	Receive model ICB and assessing details of local impact	Q1 to Q3 25/26

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	

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	23 April 2025

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
HBA1C testing	**LIMITED**	The numbers affected were smaller than initially thought. Assurances had been given that the GHFT team is working with clinical colleagues and GPs to address the issues and retest affected patients.	The CMO is keeping a watching brief.	Update in June
Pharmacy Manufacturing Unit	**LIMITED**	The GHFT Pharmacy Manufacturing Unit is currently closed due to water contamination issues identified during routine surveillance. The team was working on an action plan to address these issues and collaborating with the hospital IPC team to address the situation. An Action Plan had been submitted to the inspectors and GHFT senior management for review.	GHFT is working on mitigating the impact by seeking mutual aid from Bristol. Chemotherapy re-bookings were a high priority and longer-term, the team would be considering the possibility of relocating the unit to a modular facility, to address the issues which related to the old and ageing estate.	Update in June
Delay related harm	**LIMITED**	The committee received information on potential harm caused by delays to admission when certain cohorts of patients presented in the Emergency Department (ED). This was part of a broader effort to address rising Summary Hospital-level Mortality Indicator (SHMI) rates over the past two years.	**12-Month Rolling Data**: Moving to a 12-month rolling model for better data interpretation. **Clinical Deep Dive**: A clinical deep dive into the December 2024 data, to better understand the patient cohort and their needs. **Focus on Frail Elderly**: Emphasis on reducing ED attendance for frail elderly patients, who often did not benefit from hospital admission.	Ongoing. Update in June.

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

Topic	Committee
None	

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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

- Following seasonal pressure and pathology capacity issues, the Faster Diagnosis cancer target was achieved in February and March. 81.1% of patients referred on a cancer pathway received their diagnosis or all clear within 28 days of referral. 62-day treatment performance has also improved, with February performance at 75.2% - meeting the national interim recovery target for 2024/25. Plans are in place for resolving constraints on timed cancer pathway performance – particularly diagnostic capacity and turn around times, as well as reviewing surgical capacity and additional locum support where required.
- We have continued to see good progress in the reduction of long elective waits with 274 reported for Gloucestershire patients in March. GHFT are among the top performers in the country for eliminating long waits, with a final year end position of 116 for 2024/25 (down from 1917 in March 2024). The system is currently working on the elective plan for 2025/26 to maintain this good performance and address any capacity issues arising as we continue to reduce the waiting list. Elective recovery fund performance in 2024/25 is forecast to meet the local ambition to recover to 118% of cost-weighted activity compared to the 2019/20 position.

Areas of Focus

- Urgent and Emergency care performance is stable overall at the beginning of 2025/26. However, it continues to be a daily challenge and focus for the system to improve performance against the key standards. There have been notable improvements in ambulance handover response times and Category 2 response times at the end of 2024/25 which have been sustained into April 2025. The focus for the system is on the patients with the longest acute hospital stays to reduce the length of time between patients being ready to return home and their discharge. This is work taking place across the whole patient pathway, to optimise each step of their journey, and ensure that we keep people in a position to be able to return home rather than deconditioning during their admission.
- Diagnostic waiting lists have risen at the end of 2024/25 despite seeing record levels of tests carried out during the year. Particular modalities with increased waiting lists are MRI and cystoscopy, alongside ongoing pressure on echocardiography and waiting times for this test. Review of diagnostic pathways to refine the referral process and ensure the right patients get the right test in the right place in the timeliest way is underway across the system led by the diagnostic programme board and Planned Care and Diagnostic portfolio.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Strategy & Planning
- 25/26 annual operational planning final submission completed and submitted on 27th March.
- Workforce workstream governance structure has been streamlined.
- Series of nursing focused optioneering sessions run end March by NHSE within GHFT. GHC have session booked in.

Education & Training
- ICS Universal Family (care leavers) conference day held Monday 12th May.
- Collaboratively worked with system partners and NHSE on platform contents for the SW Virtual Careers day on 21st May 2025
- Cohort 1 of the ICS apprenticeship cohort for project management successfully commenced (x 7 apprentices). Cohort 2 being advertised and promoted across the system for July start

Retention
- Pilot Legacy Mentor evaluation analysis completed.

System-wide Development Programmes
- Date agreed for the next ICS leadership conference, as 2nd July, the focus of which will be anti-racism with external speaker/facilitator Tracie Jolliff.

EDI
- Draft EDI dashboard shared with HRDs, now being shared in Trust EDI forums for feedback prior to finalising.

International Recruitment & Pastoral Support
- Social care providers requested funding for 56 social care recruits since January 2024 to March 2025, of which 36 were eligible and funded. This leaves a target of 14 more to fund by December 2025.

Health & Wellbeing
- The Health & Wellbeing review feedback has been processed and discussions underway as to how to implement recommendations.

Areas of Focus

Strategy & Planning
- System wide redeployment draft MOU to be reviewed alongside new regional redeployment policy and process. Feedback from partner organisations due mid-May.
- Scaling People services being scoped.
- Reviewing priority work areas against JFP, ICB revised transition priorities in light of recently published model ICB.
- Focus on delivery with partners on 25/26 ops plan targets.
- Transition of Advance Practice and AHP system lead work into team/providers.

Education & Training
- Mobilising system-wide cohorts for AI apprenticeships and L3 team leader, L5 Department Manager apprenticeships
- Co-producing a workshop with graduating students/T-Level students and new employees in conjunction with Wellbeing line to support transition into employment

Retention
- Pilot Legacy Mentor full evaluation to be finalised and shared with Trusts.
- Health and Social Care Support Worker appreciation event(s) being planned for existing staff in Sept/Oct 25.
- Stay & Thrive event being planned to support existing international educated staff in Sept/Oct 25.

System-wide Development Programmes
- Progress the practical delivery of the ICS first-time line-managers programme in 25/26.

Health & Wellbeing
- Rescheduled workshop to be arranged to agree implementation plan and timescales.

Quality – Safety, Experience and Effectiveness

Please note: The Quality report is updated bimonthly.

Quality

Key Achievements

- **Standardised Hospital - Level Mortality Indicator:** The SHMI has now returned to within control limits, with local forecast data showing that the improvements are being sustained.
- **Information Bus:** Visits have focussed on: cardiac rehabilitation, MECC, the new cancer build at CGH, blood born viruses, bowel cancer awareness, Carers Hub, CDC Strengthening Communities, Cinderford Community Catalysts, Maternal Mental Health. At the Livestock Market in April 2025, 16 new people visited the Health Check Team on the Bus, 10 of whom required a referral to their GP.
- **One Gloucestershire People's Panel:** Panellists (1118 local residents) are currently providing feedback on weight management support. The survey has also been sent to GIG Members and the general public. All feedback will inform a series of service redesign workshops taking place in May and June 2025.
- **Patient Safety Incident Response Framework:** The ICB has updated in PSIRF policy, including a section on cross system learning responses.

Areas of Focus

- **Shared Care** - GPs receptiveness to take on Shared Care is a live issue for PALS, ICB Engagement Team and Primary Care Commissioning Team. Currently there are particular challenges for people who identify as Transgender in accessing medications such as HRT (often this is repeat prescriptions, rather than 'new' requests). In response to issues raised by patients, primary care clinicians, the LMC, and the ICB are working in partnership to develop an interim specification for Shared Care for Adult Transgender Patients. The ICB Engagement Team have met with the LGBTQ+ Partnership and individual patients to discuss the development of a specification.
- **Mortality Insights Visit –** We are currently arranging a mortality insight visit (with representation from NHS England, the ICB and GHFT, along with ICB Non-Executive directors) to look at the past issues with SHMI and the improvements made, in order to secure assurance on the sustainability of the solutions.
- **Delay Related Harm** – This links with SHMI work and looks at delays in ED. GHFT will be moving to a 12-month rolling model to enable better data interpretation, as well as planning clinical deep dives and a focus on the frail elderly population.

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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)	79.7	81.4	79.3	77.9	81.0	81.1	80.0
	0.2	Life Expectancy	Life expectancy at birth (female)	84.1	84.6	83.6	81.8	83.9	84.6	83.8
	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	2.8	2.4	4.5	4.9	3.3	3.8	3.7
Pillar 1: Health and Wellbeing Board	1.1*	Physical Activity	% of physically inactive adults	17.0	19.3	19.3	18.8	14.1	19.1	17.8
	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	67.8	103.4	75.7	127.2	87.7	85.6	92.2
	1.4	Social Isolation & loneliness	% of adults who feel lonely often/always	N/A	N/A	N/A	N/A	N/A	N/A	6.3
	1.5	Healthy Weight	% Year 6: Prevalence of obesity (including severe obesity),	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	2.8	2.4	4.5	4.9	3.3	3.8	3.7
	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

Updated metrics indicated with *

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)	11.3	1.4	5.4	11.8	4.1	7.6	8.2
	2.2*	Health equity	Inequality in life expectancy at birth (female)	9.6	1.7	2.8	8.1	4.1	5.9	6.6
	2.3	Health equity	Excess under 75 mortality rate in adults with severe mental illness	N/A	N/A	N/A	N/A	N/A	N/A	538.2
	2.4	Health equity	% School Readiness	69.1	73.3	69.0	65.6	67.2	71.7	68.2
	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	16.7	15.4	24.7	17.0	17.1	13.2	16.7
	2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+) - % (three year average)	12.7	7.3	12.9	14.3	11.9	9.5	11.7
	2.9	Blood pressure exemplar theme	% of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	64.6	66.3	64.0	59.9	68.0	62.3	64.1
	2.10	Blood pressure exemplar theme	% patients with no GP recorded CVD and a QRISK score of 20% or more currently treated with lipid lowering therapy.	56.2	59.1	58.6	62.1	58.9	56.4	58.9

Updated metrics indicated with *

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	96.4	102.5	116.4	98.6	95.2	95.6	99.9
	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	24.1	13.6	14.8	26.0	14.5	18.2	20.1
	3.5*	Support Improvements in delivery of UEC	Emergency admissions – rate per 1000	10.2	9.1	10.1	11.1	9.0	9.6	10.0
	3.6*	Support Improvements in delivery of UEC	Long lengths hospital stay (proxy of availability of out of hospital support – rate per 1000).	0.62	0.67	0.51	0.48	0.59	0.78	0.58
	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

Updated metrics indicated with *

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 – narrative

1.1 Percentage of physically inactive adults

- Gloucestershire's percentage of physically inactive adults has been significantly better than the England average since at least 2015-2016 (when comparable data became available). The latest data for 2023-2024 shows there has been **no significant change** at a Gloucestershire level since the previous period (2022-2023).
- There are no significant differences between the percentage of physically inactive adults at a county level and across all districts. This marks a change from the previous year when the percentage of physically inactive adults in the Forest of Dean was significantly higher than the county average.

2.1 Inequality in life expectancy at birth (male)

- Gloucestershire's inequality in life expectancy at birth for males can not be directly compared to the national average. This is because the measure for England takes account of the full range of deprivation and mortality across the whole country. This does not therefore provide a suitable benchmark with which to compare local authority results, which take into account the range of deprivation and mortality within much smaller geographies.
- Looking at change over time, the data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).
- At district level Cheltenham and Gloucester have a significantly greater inequality in life expectancy at birth than the county average, while Cotswold and Stroud have a significantly lower inequality in life expectancy at birth than the county average.

2.1 Inequality in life expectancy at birth (female)

- Gloucestershire's inequality in life expectancy at birth for females can not be directly compared to the national average. This is because the measure for England takes account of the full range of deprivation and mortality across the whole country. This does not therefore provide a suitable benchmark with which to compare local authority results, which take into account the range of deprivation and mortality within much smaller geographies.
- Look at change over time, the data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).
- At district level Cheltenham has a significantly greater inequality in life expectancy at birth for females than the county average, while Cotswold and the Forest of Dean have a significantly lower inequality in life expectancy at birth than the county average.

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)	2021-2023
0.2	Life Expectancy	Life expectancy at birth (female)	2021-2023
0.3	Premature mortality	Under 75 mortality rate from all causes	2021-2023
0.4	Infant mortality	Infant mortality rate	2021-2023
1.1*	Physical Activity	Percentage of physically inactive adults	2023/2024
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)	2023/2024
1.4	Social Isolation & loneliness	Percentage of adults who feel lonely often/always	2021/2-2022/23
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), 2021-2023	2021-2023
2.2	Health equity*	Inequality in life expectancy at birth (female), 2021-2022	2021-2023
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,	2023/2024
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	2024
2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+) (three year average)	2021-2023
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.	Dec-24
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	Dec-24

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).	April 2025
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	January 2025
3.5*	Support Improvements in delivery of Urgent and Emergency Care	Emergency admissions - Rate per 1000 population	January 2025
3.6*	Support Improvements in delivery of Urgent and Emergency Care	Long lengths of hospital stay over 21 days rate per 1000 population	January 2025
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	2020

ICP notes and caveats

In Gloucestershire, the preferred method of determining whether something is significantly better/worse than the national/county average is overlapping confidence intervals. This gives us 95% confidence that the difference is not due to chance.

OHID's fingertips tool generally uses the method of confidence intervals overlapping the reference value. This difference in methodology means the colour coding used in this pack may not correspond with that presented in OHID's fingertips tool.

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- Long waits in the acute Emergency Departments (ED) have been reducing, with 10.7% of type 1 ED attendances in March 2025 waiting in the department for over 12 hours. This is the lowest proportion of 12-hour waits since the national reporting of this metric began in February 2023. Gloucestershire has improved from a position of significantly higher 12-hour waits than the national average to being similar to the national average throughout Q4 of 24/25. The position in April 2025 has slightly deteriorated, in line with the national performance trend, to 11.1%.
- The system has submitted a compliant plan against national operational planning targets for UEC, including the expectation around 4-hour performance – with cross partner work identifying areas to support the overall metrics, for example commitment to LOS across community settings to support system flow. April Type 1 performance was 60.8% against a target of 62.6%, however system performance was 75.8% against a target of 75.4% - with the impact of significantly above plan Type 3 activity contributing to the overall performance lift (Type 3 performance was 98.2% in April). The system ranked 17/41 systems in terms of 4-hour performance.
- Ambulance response time performance has improved in April, with a 36.8 minute average Category 2 response time for the month (compared to a 45.2-minute average throughout 23/24). Category 1 performance remained stable, with a 9.6 minute average response time in April (against a target of 7 minutes).
- Average handover time per patient was at its lowest in March for the whole of 2024/25, with a 44.2 minute average handover time compared to a full year average of 61.8 minutes. April performance has slipped slightly, with average handover time at 49 minutes, however is 30 seconds above the improvement trajectory for 25/26 and is 28 minutes quicker than the average for April 2024. To support improved patient experience and ambulance response times, Gloucestershire has committed to reducing handover times in 2025/26 to under 30 minutes by March 2026. This will be supported by whole system working, for example by reducing conveyance with use of alternative services and increasing Hear and Treat, as well as improved processes at the main acute hospital to improve timely handover.
- The “Call before convey” pilot has now been completed (where paramedics responding to calls in nursing or residential care homes for patients with new confusion or delirium will call the Single Point of Clinical Access before conveying the patient to hospital to maximise admission avoidance opportunities where not in the patient’s best interest). Full evaluation is underway but initial feedback from paramedics and clinicians from GHFT has been positive.
- System review of the “Right care, Right time” report which reviews the interface between community, acute, and SWAST care settings is now set up as a regular process, with and outputs coming through to the patient flow delivery board to determine next steps.
- There has been continued good performance by IUCS for NHS111 call answering times – with 2.6% calls abandoned in March 2025 and an average speed of call answer at 39 seconds – next data available end of May (for April 2025).

Improving Services & Delivering Outcomes

Elective Care

- There has been significant progress in reducing the longest waits for treatment with the number of people waiting more than 52 weeks cut by almost two thirds in the last twelve months from 3,000 in March 2024 to 274 in March 2025. There were 10 over 65 week waits for Gloucestershire patients in March – GHFT accounted for 4 of the total 65 week waits – two in Trauma and Orthopaedics and two in Ophthalmology. In February (latest national data for comparison) those waiting over 52 weeks in Gloucestershire make up 1.4% of the total waiting list – half that of those waiting nationally (2.8% of total waiters). In March this dropped to 0.4% for Gloucestershire – significantly below the planned trajectory of 546 at the year end.
- System performance against the RTT target is 69.8% in March. The total size of the waiting list is now at just under 75,292, reduced by 5,700 from its highest levels in 2023.
- The operational plan ask for Gloucestershire is to achieve 72.1% as an interim RTT recovery target by March 2026. This is in line with the national expectation of a 5% improvement in RTT throughout 2025/26. Additionally, the operational plans sets out expectations around the time patients wait for their first appointment – current performance is that 68.1% of patients are waiting under 18 weeks for their first appointment, and the expectation is that this will improve to 73.1% by March 2026. The national recovery plan for elective care sets out the longer-term ambition to meet the 92% RTT standard by March 2029.
- Actions to support performance are focussed on patients with the longest waits – during 24/25 use of additional capacity has supported ENT from the independent sector which has reduced their long waits significantly. There is a general focus on booking all patients with waits of over 52 weeks to ensure none reach 65 weeks and proactive work by GHFT to identify capacity and demand mismatch to ensure 52-week waits are avoided wherever possible. Delayed follow up lists have remained stable, which is an area of focus for GHFT, with the elective care hub validating overdue follow ups to ensure resource is used appropriately. Waiting list validation has been a national priority to ensure that the waiting list reflects true demand and that duplication of referrals or patients no longer requiring treatment are removed – GHFT have been carrying out waiting list validation in line with this ask, however have not seen large reductions in the waiting list size, implying good data quality for the waiting list locally.
- Elective Recovery Fund performance as at March (FLEX position) is 105.3%, giving a year-to-date position of 118.4% against our local ambition of 118%, with a further potential of £1.78m income if uncoded activity is included. Including uncoded activity increases the March position to 114.4% and the year-to-date position to 119.5%. All areas are delivering activity above 19/20 levels, with the independent sector in particular performance well above plan.

Improving Services & Delivering Outcomes

Cancer

- 31-day treatment performance remained stable in March 2025, compared to the February position at 93.2% - surgical capacity in Urology and Gynaecology, and a lack of specialist equipment for some surgery in Lower GI driving most breaches.
- 62 day combined performance for the ICB improved in March up to 75.2% from 72.0% in February, missing the 85% target but meeting the national recovery ambition for March 2025 of 70%. There were 81 breaches in March, the majority being in Urological (Prostate) and Skin. 104 day waits have decreased in March to 8 from 12 in February. The highest number of waits over 104 days are for Prostate cancer treatment, accounting for 5/8 of the breaches.
- Faster Diagnosis Standard (FDS) (people receiving a diagnosis or all clear following a cancer referral within 28 days of the referral being made) performance has improved significantly since the dip to 70.4% in January 2025. Latest performance for March 2025 is 81.1% - meeting the new ambition for 80% to be the standard by March 2026.
- We have continued to see excellent compliance with the Faecal Immunoprecipitation Test (FIT) target for Lower GI referrals – across the county latest performance shows over 84% of referrals are accompanied by a valid FIT result, ensuring we are prioritising urgent cases appropriately. Where performance drops the cancer team work with PCNs to implement quality improvement measures to support continued delivery which has been successful in sustaining the overall county performance.
- Delays in pathology and radiology reporting turn around times have both been impacting performance for several months, driven by multiple factors including staffing capacity and capital equipment issues. Efforts are being made to improve this in the short time by increasing outsourcing and implementing new processes. Longer term solutions will include procurement of new equipment and additional recruitment.
- To address the impact of surgical capacity on performance a locum consultant remains in place within the Urology specialty until June 2025, increasing capacity by an additional three lists per week. In Head and Neck, two waiting list initiatives have been scoped, and additional Skin specialty lists have also been agreed to reduce the backlog of patients waiting – this is already having an impact, skin treatment performance times are significantly improved looking at unvalidated data for the start of the 2025/26 year.
- Specific equipment issues in Lower GI are also being addressed, with additional surgical kit for Transanal Endoscopic Microsurgery (TEMs) being purchased.

Improving Services & Delivering Outcomes

Primary Care

- 406,052 appointments were delivered in general practice in Gloucestershire in March 2025. Same day appointments made up 42.0%. Rates of delivered appointments benchmark highly compared to the national average, with Gloucestershire ranking 5/42 systems across 24/25. Total volume of general practice appointments delivered in 2024/25 was 17.3% above plan.
- The Pharmacy First offer has helped over 35,000 local people to access assessment, advice and medications (where appropriate) for the seven conditions and other minor illnesses covered by the scheme in the first 12 months since its launch. The most common presenting illnesses for adults have been sore throat and uncomplicated urinary tract infection, and for younger people, earache and impetigo. The service is continuing to expand as more and more local people are choosing their local pharmacy as their first point of contact.

Dental

- Dental Market Engagements - The ICB has carried out a series of market engagements in March 2025, which is part of the development of the Gloucester City based Centre of Dental Excellence with the aim of increasing NHS access for patients in more deprived neighbourhoods as well as developing dental clinical staff and increasing training in dentistry. This will be a bespoke primary care service in a fit for purpose environment. A new local dental workforce strategy will underpin future developments of increasing dental workforce training and qualifications.
- The ICB are working in conjunction with Gloucestershire County Council to enhance the Oral Health Promotion programme across Gloucestershire with the aim to increase preventative care and oral health education across all health and social care providers supporting patients to manage their dental health throughout their life course.
- A regional plan is being developed to deliver additional urgent dental appointments in line with national commitments for 25/26 – Gloucestershire will deliver an additional 11,464 appointments throughout the year to support this ambition.

Improving Services & Delivering Outcomes

Diagnostics

- Throughout 2024/25, diagnostic performance overall has remained relatively stable, with latest data showing 16% of patients were waiting over 6 weeks for a test at the end of March. GHFT performance was 17%. The waiting list has also remained at relatively consistent levels during the year, however has seen signs of growth in the 2025 calendar year, with the March 2025 position at 16,797 people waiting, 2000 more than in March 2024. This is despite higher activity levels throughout 2024/25, with more than 38,000 additional tests being delivered throughout 2024/25 compared to 2023/24.
- Modalities driving the increases seen in the waiting list size are MRI which has seen steady growth to the waiting list throughout 24/25 from a monthly average of 1750 to 3250. Cystoscopy has also seen a surge in demand over the last three months, with latest waiting levels at the end of March at 400 people compared to an average of 250 earlier in the year.
- While overall waiting list numbers have grown, longer waits have been reduced, with 667 people waiting over 13 weeks for a test at the end of March. 404 of these were waiting for Echocardiography (and over a third of all 6-week breaches are for echocardiography), and 93 for MRI. Peripheral neurophys performance remains challenging but long waits over 13 weeks have now been almost eliminated. Additional capacity in Echocardiography will be rolled out through the CDC in 2025/26 which will help to improve performance.
- For Endoscopy, a business case has been approved to support delivery of an additional 2500 endoscopy procedures throughout 2025/26 – this will help to further improve performance and reduce the backlog of patients waiting for these diagnostic tests, building on the consistent reduction in the waiting list seen throughout 2024/25 to date. While there have been improvements across all three modalities, gastroscopy performance has been particularly successful, with the waiting list now at a sustainable level, and performance in February at 12.8% - the best performance seen in the last two years.
- CDC activity continues to deliver at expected levels, with no concerns for 24/25. The CDC benchmarks well against other sites, particularly for imaging activity levels where activity is delivered 12 hours a day, seven days a week. GHT CDC accounts for 18.3% of diagnostic activity at the trust.
- Review of diagnostic pathways to refine the referral process and ensure the right patients get the right test in the right place in the timeliest way is underway across the system – including scoping increasing opportunities for direct access.

Improving Services & Delivering Outcomes

Mental Health

- CYP access continues to be strong across all providers, with latest national data showing access exceeded our target (9230 against the 7340 target in February 2025). Compliance with the 4-week waiting time target improved in February 2025, with 85% of referrals receiving their initial appointment within 4 weeks (above the 80% target). The LD CYP service performance against the 4-week target dropped in February 2025, due to fluctuations in demand and additional activity planned by the team for the half term period.
- Dementia diagnosis rates had deteriorated as a result of seasonal challenges, with decline in diagnosis rates coinciding with the start of the flu season. With lowest performance dropping to 64.8% in January, there has now been an increase with February reaching 65% of the estimated population with dementia receiving a formal diagnosis. Significant work is ongoing in the system, in particular review of the Memory Assessment Service to reducing waiting times for assessment.
- Access to perinatal mental health services continues to exceed targets, with a rolling 12-month access rate target of 672. Latest 12- month access is 835 across Gloucestershire. Performance against all timed assessment targets was met in February, with performance recovered from challenges due to illness and capacity in the team during December and January.
- Out of Area placement days remain lower than in previous years and Gloucestershire has been held up as the best performer across the South West in this area. There have been no patients remaining out of county at the end of the month as of March 2025.
- The Talking Therapies service continues to demonstrate strong reliable recovery rates, achieving 68.0% in February 2025 well above the target of 67%. The reliable recovery rate (for patients meeting caseness at the start of their therapy course – i.e. patients whose clinical anxiety or depression exceeds a defined threshold, as measured by talking therapy outcome measures specific to their symptoms) was 50%, meeting the target of 48%. 2025/26 ambitions are increasing the targets for these measures to 68% and 50% respectively, with the service in a strong position to deliver this based on current performance. The service has continued to reduce the “in-step” waiting time, i.e. the time between first and second appointment for treatment, in line with national ambitions from a high of over 50% in June 2024 to 31% in February 2025.
- Access rates for community mental health services remain stable, and there has been investment in strengthening the assertive outreach team to proactively engage and support patients who are not engaging with services by facilitating smaller caseloads and joining up services used by these patients. This is particularly important in ensuring longer term recovery for patients with schizophrenia.

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

Retention

- An analysis of feedback from the system-wide Legacy Mentor pilot which ran from July 2023 to December 2024 has been completed. This is being reviewed and will then be incorporated within a full evaluation of the pilot to be fed back to NHSE and partners who participated in the pilot.
- No further funding available from NHSE for Legacy Mentors. GHC and Primary Care not continuing the roles, GHFT have retained and funded their nursing, midwifery and dietetics Legacy Mentors into 2025/26 (with varying end dates from May 25).

Valuing and looking after our people

- The HWB review has been concluded. The review highlights the importance of HWB services in supporting staff and improving the quality of care provided to patients and service users. By addressing the identified gaps and exploring opportunities for collaboration, the ICS can enhance the effectiveness and efficiency of its HWB services

Education, Training and Development

- First cohort of the level 4 Associate Project Management apprenticeship has started with 28 apprentices from across the system, including Social Care, Primary Care, GCC and NHS Organisations. This is a closed cohort for Gloucestershire with Corndel training provider. Looking to run a second cohort in July 2025
- Developing career pathways with the ICB PMO team to support project management career development across the system. Currently exploring replicating this with the digital team for an AI training offer.
- Exploring a closed Gloucestershire cohort for L3 and L5 leadership and management apprenticeships to run in September 2025
- Healthcare Science and AHP careers event attended at Cleeve Secondary school in conjunction with the Medical Science and Engineering department at GHFT. Over 120 people attended with stands from multiple professional groups across the NHS, showcasing different professions and routes in.
- Continued career conversations with a range of individuals seeking support and guidance on application processes, personal statements, and career choices, Working with DWP, Young Gloucestershire and other external partners on a coordinated package of support
- Targeted workshop working with the Well Being Line, aimed at young people (under the age of 25) starting into employment for first time to overcome fears and anxieties, supporting them to transition into the workplace.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

Arts Health & Wellbeing Centre

Small Grants in Research, Evaluation and Innovation – Round 2

- Following a Dragons Den process, 9 out of the 14 shortlisted bids have been awarded small grants to take forward their proposals. Approved bids included :
  - Home blood pressure monitoring for expectant and post-natal mothers in collaboration with Health Innovation West of England
  - Reducing the impact of chronic pain through an innovative school-based biopsychosocial education package
  - A service evaluation of mouth care at Gloucestershire Hospitals Trust across two Care of the Elderly Wards. The first phase of a multi-stepped research project to prevent healthcare-associate pneumonia (HAP)
  - Assessing the Health and Wellbeing Risks faced by Young Carers Not in Formal Education in Gloucestershire
- A showcase event is also planned in the new Gloucester City Campus in November to share the insights from round 1 of the small grants, all of which will be complete in the autumn 2025.

Research & Evaluation Training for ICS staff

- During early May, 11 staff across the ICS commenced on the next fully funded research and evaluation module at the University of Gloucestershire, with a further cohort planned in the autumn.

Leadership and Culture

- *One Gloucestershire Leadership Conference -2nd July 2025 : Anti-racist Leadership Practice in Action*
  - This Leadership Conference is a response to requests from staff who wish to build the knowledge, capabilities, and habits to address racism, and support the growth of antiracist thinking and decision-making. The focus of the day will be to support participants to critically reflect on their experiences and leadership to date, to better align their leadership practice with antiracist intentions. The outcome is for leaders to have a better grasp of how to create lasting change, whilst supporting others to do the same.
  - Indicative content:
    - Surfacing ideas that have informed my practice
    - Understanding race, racism and racialisation.
    - Key mindset shifts that I need to make
    - Helpful tools for antiracist practice and progress
    - Ongoing learning

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

Digital, Data and Technology

Project 1: Digital Skills Project:

- Currently on hold as no resource available from ICB to support this project.

Project 2: Technology Enhanced Learning (TEL) Project – TEL is the application of technology to teaching and learning, examples include Virtual Reality (using headsets), Augmented Reality, 360º Video, simulation-based experiences

- Completed:
  - VR Work Package Brief submitted and approved by ICS Digital Workforce Programme Board.
  - TEL Project Closure Report and VR Work Package Brief submitted to ICB DT Governance Group for approval.
- Areas of Focus:
  - TEL Project Closure Report to be submitted to ICS Digital Workforce Programme Board for approval.
  - Explore options for resourcing VR Work Package at ICS Digital Workforce Programme Board.

Project 3: Learning Management System (LMS) Project – LMS are applications used to administer and manage the learning journey and host computer-based training packages. This Project was used to manage the Oliver McGowan training programme.

- Completed:
  - Feedback and usage numbers obtained for Primary Care, awaiting numbers for ICB. The key improvements highlighted were clearer registration instructions, making pre-course reading more visible, and smoother certificate access.
- Areas of Focus:
  - DPIA to be refreshed and approved for LMS system.

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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

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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

Maternity

- The Quality Improvement Group (QIG) chaired by the CNO continues following the CQC section 31 warning notice issued in May 2024. The service remains rated inadequate and on increased surveillance, under the National Quality Board guidance. The QIG has moved to monthly with progress being seen in the five areas of concern identified by CQC, scanning capacity and the closure of the antenatal screening SI.

- The service remains on the NHSE Maternity Safety Support Programme with Midwifery and Obstetric Improvement Advisors continuing to support the service. The Trust are currently in the improvement phase of the MSSP. It was agreed by all stakeholders at a meeting at the end of April 2025 that the Trust would remain in the improvement phase with a further review and reset meeting taking place in four months to review the progress and improvements and to be assured that the changes implemented are sustainable. The Trust also reports all progress monthly to the CQC. Although midwifery staffing has significantly improved with recruitment to establishment now in place concerns have been identified with Obstetrics staffing levels. This has been added to the risk register and Obstetric MIA is supporting with the review and development of additional Consultant roles. 3 new Consultant Obstetricians have been appointed which will support improved staffing levels. LMNS has refreshed priorities to focus on completing actions from the Maternity & Neonatal 3 Yr Delivery Plan 2023-26, the Equity & Equality Action Plan and undertaking a Needs Assessment of maternity services. A stillbirth review has been undertaken following an identified rise, learning and actions have been identified, and a perinatal action plan will monitor progress.

Maternity Interface with GPs

- The ICB/LMNS have been leading an MDT to improve communications and between GP's and maternity services and GP's. Quarterly touchpoint meetings between maternity and LMC continue, and a number of task & finish groups are in progress to address specific issues e.g. prescribing medication for pregnant women, flow of safeguarding information and communications via Badgernet.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The POD Q4 Quality Report has been received from the SW Collaborative Commissioning Hub (CCH). There were 2 General Pharmaceutical Council inspections for GICB in Q4 and 2 new community pharmacy safety incidents notified to the CCH. There were no new quality issues, risks or concerns for optometry and dentistry reported.
- 2 pharmacy, 7 dental and 0 optometry complaints were received in the quarter.

Community and Mental Health

- GHC have continued on focused work on the closure of open incidents on Datix. This month a reduction in open incident numbers has been seen (403) and this downwards progression is being monitored to ensure a continued trajectory.
- 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. An Enhanced Oversight Group, is in place to retain the system commitment to supporting Berkeley House, focus is currently on the discharges that is due in May and then work will commence on the application to remove the Section 31 notice.

Integrated Urgent Care Service (IUCS)

- The addition of the IUCS service to GHC has led an expected increase in overall complaint figures (with an additional 15-17k contacts a month) however the complaint figures coming through are comparatively low (less than 1 in 1000). Good data is now coming through allowing identification of key areas to work on such as increasing the rate of selection of the Top of the DOS and Pharmacy First.

Migrant Health

- Beachley Barracks has now closed.
- A new continency accommodation site has opened in Cheltenham. Current occupation is 95 service users (capacity 124). Numbers remain steady in our contingency accommodation in Gloucester.

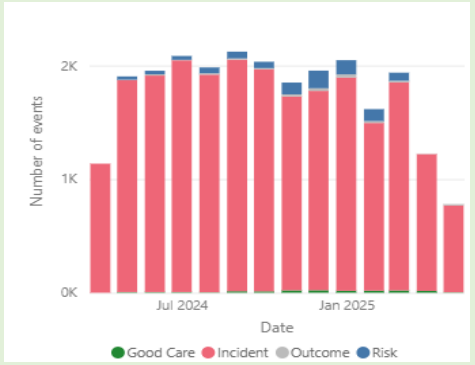
Please note: The Quality report is updated bimonthly.

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 March and April 2025 seven PSIIs have been opened; one for GHC and four for GHFT and two for SWAST These seven PSIIs will go forward for a full investigation with the respective Trusts' boards holding oversight, as is policy under PSIRF.



Quality Alert

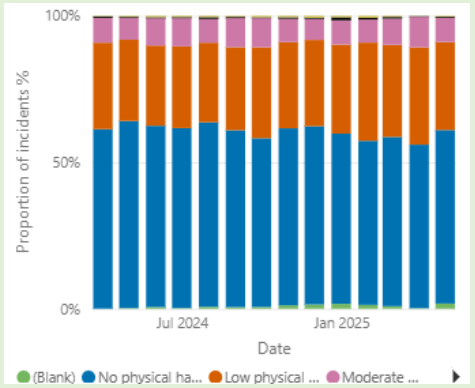
- We received seven Quality Alerts during March and four different practices. While the volume is too low to consider reports a trend, there appears to be an ongoing issues around communication.
- We have now improved processes to ensure all alerts and investigated with reports now going back to the reporter.

Primary Care Patient Safety Strategy

- NHS England recently launched the new Primary Care Patient Safety Strategy.
- We are continuing our work to understand how this can be effectively implemented in Primary Care.

Learn from Patient Safety Events (LFPSE)

- NHS England have updated the tool that will eventually enable ICBs to look at whole system LFPSE data. While it cannot yet be used for planning or official statistics (due to lack of data validation) it is starting to show what might be possible in the future.
- The first chart on the right shows the volumes of events being submitted to the LFPSE. The second chart shows the proportion of physical health events by harm type.
- LFPSE has now been included in the GP contract. General Practice must now register and maintain an LFSPE account, which will increase the data flows.
- We recently attended a PCN practice managers meeting to explain the system and the requirement. LFPSE takes over from the NRLS which has now closed.



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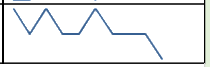
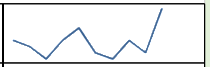
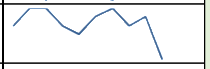
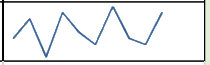
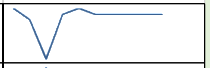
Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April – January 2025 (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%	92%	93%	93%	94%	94%			
	% Negative	4%	3%	4%	3%	3%	4%	3%	3%	3%	2%			
GHT A&E	% Positive	79%	78%	76%	79%	81%	77%	76%	79%	77%	84%			
	% Negative	14%	16%	16%	14%	13%	15%	16%	14%	15%	10%			
GHC Mental Health	% Positive	86%	80%	94%	81%	89%	86%	81%	90%	90%	82%			
	% Negative	6%	9%	3%	10%	7%	5%	11%	6%	5%	10%			
GHC Community	% Positive	95%	93%	86%	94%	95%	94%	94%	94%	94%	94%			
	% Negative	2%	3%	8%	2%	2%	3%	2%	3%	3%	2%			

< Best performance in 24/25 to date

The Friends and Family Test (FFT)

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

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Quality – Safety, Experience and Effectiveness

Effectiveness

Mortality Focus - Mortality data from NHS England runs six months behind and now covers the period up to November 2024.

There are three key metrics we pay close attention too:

- 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. Crude percentage mortality for elective admissions is currently at 0.6%, against the English average of 0.6%. For non-elective it is currently at 3.0%. This is below the English average of 3.4%.

- The **Summary Hospital-Level Mortality Indicator** (SHMI) on now back within control levels for the first time in a year. The latest official data shows that the Trust's SHMI has now dropped to 1.13 for the 12 months to November. Local monthly data (which extends into Jan 25) shows that it has now stabilised at just below 1.

- **In Hospitals deaths** are relatively low at 66% compared to the England rate of 69%. SHMI for **Out of Hospital deaths** following an admission to Cheltenham has been a cause for concern. Local monthly data now shows that the Trust has reduced the variation and Out of Hospital Deaths is now within monthly control levels.

Metric	Source	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Crude Mortality	NHSE	2.7%	2.7%	2.9%	2.9%	2.9%	2.9%	2.8%	2.8%	2.9%	2.8%	2.8%	2.80%	2.70%	2.70%		
Overall SHMI (12 month)	NHSE	1.124	1.135	1.144	1.149	1.137	1.158	1.15	1.156	1.175	1.173	1.168	1.164	1.147	1.137		
Monthly SHMI	Local Data	125.89	120.69	106.56	123.61	111.15	129.28	106.04	122.81	134.17	114.79	107.99	107.14	98.39	106.91	98.5	98.74

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 28th May 2025

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		20/5/25	GHC Quality Committee		06/05/25	
Executive Summary	Following the tragic multiple homicides in Nottingham 2023, CQC made several recommendations to improve services and safety across mental health teams and organisations. During 2024/25 ICBs and provider NHS Trusts were 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 worked together and completed a self-assessment using the ICB Maturity Index Self-Assessment Tool and the outcomes and system opportunities were shared with NHSE in September 24. Since this submission a multidisciplinary task and finish group has been working to develop a detailed action plan, built on clinical and operational service review and in line with CQC and NHSE principles, to ensure our local psychosis pathway meets the needs of this patient cohort and responds to the opportunities identified within current service provision. This paper provides further update to the opportunities and next steps outlined in the November 24 public board paper, in line with the NHSE Intensive & Assertive Community Mental Health review governance.						
Key Issues to note	Ensuring patient safety and assessment of risk are key considerations in completing the review. GHC have confirmed that DNAs (did not attend) are never exclusively used as a reason for discharge from care for this vulnerable patient group. As per national guidance the ICB and GHC NHS Trust has rapidly checked existing service polices and practice and have confirmed the above with NHSE regional mental health colleagues. The system has now produced a comprehensive action plan that addresses any areas identified as areas for improvement.						

<table>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">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 has identified actions and/or initiatives 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 Assertive Outreach Teams (AOT) and also exploring opportunities with VCSE partners. This is a significant risk, as service users move across services as clinical presentation changes and robust monitoring will require improvements recording and monitoring, which should be supported by the development of a patient cohort dashboard. 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. Since the previous update the group has explored how the current workforce and roles could be utilised differently and/or how training could support new ways of working. Additional funding for further clinical resource has been approved from the Mental Health Investment Standard and work is ongoing with clinical leadership to scope workforce training requirements. Residual Risk: 9

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 have utilised the Dartmouth Fidelity Scale tool and have completed the ICB Maturity Matrix. The Dartmouth Tool is specific to Assertive Outreach Team(s) (AOT), and not to other teams treating psychosis. Locally we developed a template that enables the tool to be utilised for a contemporary clinical review, removing ambiguity, whilst ensuring a comprehensive review against the core principles of the tool/protocols. The review across AO teams has been led by a dedicated clinical lead and coproduced with local workforce. Residual Risk: 9</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">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 rowspan="2">Resource Impact (X)</td><td>Financial</td><td>x</td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>x</td><td>Buildings</td><td></td></tr>
</table>

Financial Impact	The paper summarises the key improvements and next steps identified in the action plan. During the 24/25 NHSE submission the ICB and GHC prioritised mitigations, actions and assessed financial impact, considering the potential additional resource i.e., workforce and investment in training. No additional funding has been made available to the system for this work (as part of SDF of core allocation) and so investment has been identified as part of the system MHIS process to support additional clinical, medical and leadership roles.
Regulatory and Legal Issues (including NHS Constitution)	None identified. Review via ICB Maturity Matrix aligned to core values of NHS Constitution.
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 Transformation Team and will be prioritised as part of our local embedding of our neighbourhood teams. 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 therefore considers 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 draft action plan summary has been shared with the Adult Mental Health and Neurodiversity Clinical Programme Group and updates shared with our local Mental Health & Wellbeing Partnership Board. The Task & Finish Group have been working with AOT colleagues to identify people with lived experience of psychosis who may wish to engage with work programme and next steps have been agreed to work with the partner led mental health lived experience group, MHELO.		
Recommendation	The ICB Board is asked to: • Note the update of progress in developing the action plan since the previous board update in November 24.		
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)	**Marie Crofts**	**Role Title**	Chief Nursing Officer, , ICB

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

1.0 Background

NHSE required all ICB's and provider NHS Trusts to review their community services by Q2 2024/25 to ensure that they had 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 to 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 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. In Q4 2024/25 the system submitted an overview of the areas for improvement and a draft outline action plan and work has been ongoing to develop and implement these changes.

2.0 Key Themes from Task & Finish Review

To recap, the Intensive & Assertive Task and Finish Group completed the self-assessment over several workshops, 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. The table below provides a summary of findings:

Identified Strengths	Identified Opportunities
• Dedicated AOT in place across county	• Improving Interfaces across pathways and between services
• Assessment Risk Assessment & Care Planning Met Criteria	• Local Community Demographics
• Community Rehabilitation Offer	• Intervene more quickly and prevent relapse
• Improving Recruitment Picture	• Diversity Profile
• Relevant Criteria in Place in Policy & Pathways	• Discharge Processes
	• Embedding Lived Experience

In February 25, clinical leaders from the Task & Finish Group completed the Dartmouth Assertive Community Treatment Scale (DACTS) across each of our AO teams (North, South, West), which outlines fidelity to the National Service Framework view of Assertive Outreach. As noted in the risks, the model is 35 years old and so 100% compliance would be of concern given the progression in delivery of care, however our localised template mitigated some of this risk. Overall, there was little variation of scoring across the 3 teams and the overall fidelity score was 65%. Key opportunities noted were:

- Consideration of a more flexible approach to providing intensive and assertive approach i.e. number of contacts with patient driven by need not time, deployment of other team members dependent on the needs of the service, team flow to support caseload sizes.
- An aligned service with two functions: an intensive and a rehabilitative function. Opportunities to bring teams/functions together i.e. Specialist Rehabilitation, Assertive Outreach and our out of county placements team.
- Information sharing between teams – improving referrals and discharge interfaces.
- VCSE support offers and interface with GHC services – including vocational and accommodation.
- Proactive involvement of patient's families/carers in planning and delivery of care. Work with teams and people who use our services to develop Peer Support Worker roles across community mental health services. Invite carers and service users to be experts by experience.

- Require clear strategy on engagement: 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.
- A no wrong door approach – likely cohort will present outside of secondary care services. Rapid and direct access back into the Intensive and Assertive team for people previously on the caseload (or meeting the criteria for psychosis with engagement issues)
- Enhance robust risk assessment – staff are adequately supported through training to manage the often-high ongoing risks this client group present.
- Comprehensive training offer – training for support workers and role consistency across all teams to ensure we are using this resource effectively to improve health and care outcomes for people on the caseload, improving training in psychological interventions.
- The DACT tool does not distinguish the services offered to racialised people and those from ethnic minority backgrounds. Further work needs to be done on who is currently accessing services and identifying and engaging with population groups who are currently not receiving services.

2.1 Action Plan Priorities and NHSE I&A Principles

Following the system submission of review findings and noted areas of opportunity, the national team have developed a set of Intensive and Assertive Community Mental Health principles. The Task & Finish group have mapped the action plan against these mandated and/or suggested criteria. An overview of priorities is provided below:

ICBs & Trusts Must Ensure	Action Plan Summary
NHSE Principle: Everyone should have a coproduced and personalised care and treatment plan	
• Reviewed minimum every 6 months • Suitably trained key worker remains in contact with individual throughout period of non-engagement. • Use of depot is carefully considered and used as part of wider treatment plan (inc. access to psychological therapies, social intervention, and practical support) • Responsive to coexisting needs i.e. substance misuse and links with support services	ICB Maturity Matrix and DACT Reviews acknowledged that personalised care and treatment plans were a current strength across AO and Recovery Teams.
	Explore opportunities within current recommissioned Substance Misuse Services i.e. flexibility of offer with challenging to engage, access and equity.
	Amalgamate Assessment Care Management Policy include review of discharge protocol and development of Opt- in process for rapid and direct re-access to services.
	Undertake focused pathway review and consider interventions for drug induced psychosis, particularly where the pathway crosses organisations.
NHSE Principle: Engaging families, carers and support workers is essential	
• Establish formal process for engaging families at critical decision-making points – care planning, safety, and risk management. • Implement review and update confidentiality policies. • Implement feedback mechanisms to assess impact of family engagement efforts.	Formalise protocol in Standard Operating Procedure to ensure multi agency and lived experience representation (including carer/families) supported by a coproduction approach.

• Ensure all family engagement policies and processes align with PCREF	
NHSE Principle: Seamless care between community and inpatient settings is a core component of intensive and assertive community treatment.	
• Joint care planning meetings – inpatient and community teams • Key workers provide relevant clinical insights to inpatient teams – reducing need for repeated assessment. • Clinical Review Panel or Escalation Forum established. • Ensure views of all care givers are considered in long term care planning	Our aim is to provide a 'Flexible Assertive Community Treatment Team.' This will be an integration of existing teams (Assertive Outreach, Specialist Rehabilitation, Specialist Out of County) with the ability to 'in reach' to services such as Recovery and Forensic Teams when a person's health becomes a concern. (N.B. The operation and level of integration and is yet to be confirmed how that will be configured, and necessary service specifications be developed).
	Implementation of Flexible Assertive Community Team approach would include development of MDT review approach including stratification of patients.
	Review the positive aspects of the 'care co-ordination' role to define and develop assertive interventions to include structured case management.
NHSE Principle: Ensuring the right workforce with appropriate skills and competencies, is essential for delivering high quality care	
• Appropriate staff, necessary skills • Comprehensive training, regular supervision and support • Confidence in application of legal frameworks i.e. s117, MHA, CTOs. • Establish Peer Support Programme	Completion of workforce skills and training audit across community mental health teams in line with ongoing work led by GHC Clinical Forum.
	Develop training protocol re delivery clinical conversations – i.e. structured visits, goal-based discussions (DIALOG) and agree principles regarding team approaches to staff skill mix i.e. considered whenever there is a vacancy.
	Scope and implement Peer Support Worker role.
	Develop and embed arrangements for ongoing supervision i.e. community mental health team & AO such as motivational interviewing training, CBT programme, family work.
	Review s117 policy and consider practical application of discharge from s117.
NHSE Principle: Intensive and Assertive Community Mental Health treatments are embedded across community teams with robust governance.	
• Local expertise and data – improving risk identification. • Limited staff caseloads	Introduction of Engagement Score (ORES), continued care planning based on DIALOG and when indicated PANNS all recorded routinely and captured in EPR (RiO).

• Establish multiagency forums to review cases. • Ensure local serious incident policies comply PSIRF	Develop clinical criterion to ensure clear oversight of patient cohort profile. Implement I&A live dashboard based on clinical criterion (using elements above) that can alert team(s) to change in risk factors and every person who is discharged (that has met the criterion during their current clinical episode.)
	Take steps to ensure routine recording of service user, family/carer protected characteristics, focusing on ethnicity, to support development of robust patient cohort profile.
NHSE Principle: Effective information sharing and collaboration between system partners are essential to delivering coordinated care.	
• Inter-agency governance group to share information. • Multiagency case discussion is embedded in care planning and noted in EPR • Clear protocols for timely multiagency data sharing • Improve interoperability to ensure timely sharing of clinical and risk related information across care settings.	Development of I&A live dashboard (as noted above.)
	Implementation of Flexible Assertive Community Team – considering interface with multiagency partners.
	Develop opportunities to share data via JUYI and comms approach with partners.
	Link to development of CMH VCSE Forums across the county, led by Rethink.
NHSE Principle: Ensure patient safety and reduce risk of serious harm.	
• Coproduced, formulation-based risk assessment – personalised relapse signature and actions to support staying safe and well.	Consider options for out of hours assertive support – AOT does not currently have an OOH offer and improvements can be made to the interface with Crisis Resolution Home Treatment Team.
• Monitor early warning signs and implement appropriate interventions.	Implement a rapid re-access process directly to the Intensive and Assertive team that can be triggered by the service user, health professional or friends and family (noting the nature of the illness this may be without the service users consent.) Consider approach to consistently embed behavioural family interventions, as per ongoing focus on local psychological interventions offer (part of community mental health transformation programme.)

3.0 Next Steps

The ICB will submit a further update of the Intensive & Assertive Community Mental Health Action Plan to regional NHSE colleagues in Q1 25/26. The Task and Finish Group will continue to meet and oversee the delivery of the actions and implementation timeline, led by the appointed Clinical Lead.

Immediate prioritisation of actions has been completed and following completion of the DACT Review and team engagement, our immediate next steps will be the scoping and development of the I&A Live Dashboard. This will require some improvements and changes to clinical recording and reporting and further insights into our patient profile will develop over time, however an immediate digital resolution to ensure a real time, multiagency risk escalation and alert system is a priority.

Concurrently we will also continue to engage people with lived experience of psychosis (specifically those who services have found challenging to engage) and their families/carers to consider the interventions and improvements proposed in the action plan and provide opportunities to give regular insight and feedback into any service developments or proposals.

Whilst the review has indicated several areas of opportunity and development need, most improvements can be delivered within existing workforce and resource. However, the system has supported investment into additional medical resource within AOT and specialist rehab functions that will support the implementation of the FACT model, a more robust MDT approach and improved interfaces between teams.

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 28th May 2025

Report Title	**ICB Constitution and Scheme of Reservation and Delegation (SoR)**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	Discussion and advice from SW Governance Network; National Governance Network and submission of the constitution and change form to NHSE South West for advice and then approval.				
Executive Summary and Key Issues	The ICB Constitution has been updated to reflect current requirements and changes requested by NHS England including the removal of some paragraphs and the change of wording in others such as reference to the 'Deputy' Chair rather than Vice Chair and . These are minor changes and are tracked changed. There are two key changes that have been made to the constitution which are also tracked changed: Section 2.2.2 reference to the Interim Chief Delivery and Transformation Officer and the removal of the Director of Strategy and Transformation (this reflects the change in the postholder from Ellen Rule to Gemma Artz). The portfolio for the Chief Delivery and Transformation Officer is the same as for the Director of Strategy and Transformation. A further change has been made in relation to the appointment of the Deputy Chair as the Senior Independent Member, there are several references in the document commencing with section 2.2.3. Section 2.2.3 5 Non executive members(one of which, but not the Audit Committee Chair, will be appointed Deputy Chair, and one of which, who is the Deputy Chair will be appointed the Senior Non-executive Member). These changes are categorised by NHSE as Tier 2 level changes and SW NHSE will advise before the ICB Board meeting if the changes made can be approved. The Scheme of Reservation and Delegation has had two key changes to take account of delegated commissioning of Podiatry, Optometry and Dentistry and Specialised Commissioning. With regard to the changes the wording used has been recommended by NHS England, there is significant detail about the delegation of POD to be found in the PCDC Committee Terms of Reference appendices and in the Delegation				

	Agreement that was approved by the ICB Board, the Specialised Commissioning arrangements and Delegation Agreement was approved by the Board at its most recent meeting in March 2025. It is noted that further more detailed changes to the ICB Constitution and SoRD are expected to support the strategic direction of ICBs and pace of change required with the ICB reset and model ICB describing its functions.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The ICB is required to have a constitution / standing orders to govern the way the organisation operates and allows for decisions to be made lawfully by a statutory organisation. The Scheme of Reservation and Delegation provides a framework that allows for the delegation of functions and responsibilities to committees, executives, and via joint arrangements. Add a risk rating, even if low: (4x2) 8 (4x1) 1 (residual meaning accepted risk)
Management of Conflicts of Interest	There have been no conflicts of interests in updating these document as national and local guidance has been followed.
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	There is no financial impact.
Regulatory and Legal Issues (including NHS Constitution)	The changes to the ICB Constitution are in line with NHSE guidance and the legal framework provided by the Health and Care Act 2022/
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	N/A
Recommendation	The Board is requested to: • Agree the changes made to the updated Constitution noting NHSE SW will advise on the acceptability of the changes made and will approve the changes • Approve the updated Scheme of Reservation and Delegation.
Author	**Christina Gradowski** **Ryan Brunsdon**	**Role Title**	**Associate Director of Corporate Affairs and Board Secretary**
Sponsoring Director (if not author)	**Tracey Cox , Director of People Culture & Engagement**

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

NHS Gloucestershire Integrated Care Board

CONSTITUTION

Version	Date approved	Effective date
Final Version v1.0	N/A	July 1st 2022
Amended Version v2.0	TBC	28th May 2025

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1. Introduction

1.1 Background/Foreword

1.1.1 NHSE has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.1.2 Gloucestershire's Integrated care systems (ICSs) is a partnership of health and care organisations that have come together to plan and deliver joined up services and to improve the health of people who live and work in Gloucestershire.

1.1.3 We exist to achieve four key aims:

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

1.1.4 Gloucestershire Integrated Care Board and One Gloucestershire Integrated Care System have a shared vision to work together in an inclusive and collaborative way to transform and improve services: Our vision is:

"*To improve health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people"*

1.1.5 The Integrated Care Board (ICB) will work to deliver the strategy and our key strategic priorities set by One Gloucestershire Health and Wellbeing Partnership. In 2019 we set out our ambitions in our five year plan.

1.1.6 Functions of the ICB

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1.1.5i The functions of the ICB and purpose of One Gloucestershire ICS are defined in the ICS Design Framework as detailed in 1.1.5ii. In addition to the four key strategic aims, the 168 statutory functions, duties and powers of CCG's shall be conferred on ICBs as per the Health Act 2006 amended by the Health and Care Act 2022.

1.1.5ii The functions of the ICB are set out in the ICS Design Framework and have been adopted in full, and supplemented with locally agreed functions. They are:

1. Developing a plan to meet the health needs of the population;
2. Allocating resources to deliver the plan across the system;
3. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities;
4. Establishing governance arrangements to support collective accountability between partners;
5. Leading system wide arrangements through which the delivery of health services is ensured in line with allocated resources and conforming to national and Constitutional standards;
6. Leading system implementation of the People Plan;
7. Leading system wide action on digital and data;
8. Using joined up digital and data capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement;
9. Working alongside councils to invest in local voluntary sector and community organisations and infrastructure;
10. Driving joint working on estates, procurement, supply chain and commercial strategies;
11. Planning for, responding to and leading recovery from incidents (EPRR);
12. Functions NHS E/I will be delegating – e.g., commissioning of primary care and specialised services;
13. *Promotion of Health and Population Health Management;
14. *Engagement and participation of local people and communities (*locally agreed functions).

This Constitution establishes the principles, statutory duties and governance arrangements of the ICB

It also describes the governing principles, rules and procedures that the ICB will establish to ensure probity and accountability in the day to day running of the ICB, to ensure decisions are taken in an open, collaborative and transparent way and that the interests of patients and the public remain central to the values/aims of the ICB and One Gloucestershire ICS.

This Constitution applies to all ICB employees, individuals working on behalf of the ICB including anyone who is a member of the Board of the ICB, its sub-committees, joint committees and any other employee or other person working on behalf of the ICB.

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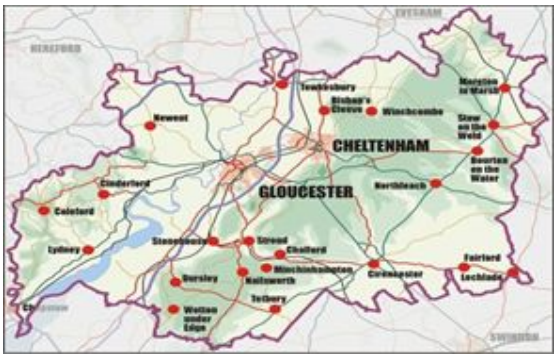
1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Gloucestershire Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB the Borough of Cheltenham, District of Cotswold, District of Forest of Dean, City of Gloucester, District of Stroud, Borough of Tewkesbury, comprising 271,207 hectares with a population of over **600,000**.



1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at https://nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/icb-constitution/

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1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) Adult safeguarding and carers (the Care Act 2014);
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000);
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing,

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or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).[1]

1.5 Status of this Constitution

1.5.1 The ICB was established on 1st July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

~~This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.~~

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution shall be as follows:

a) Upon a recommendation of the Audit Committee as part of the annual review of the Constitution (*see SoRD 1.5 (c) subsection (a));*
b) Upon a recommendation of the Chair and/or Chief Executive included on the agenda for the meeting;
c) Recommendations shall be considered by the board:
   - provided that the meeting is quorate, whereby 8 members of the board are present at the meeting including:
     - Three of the six non executive members (including Chair or Deputy ~~Vice~~ Chair);
     - Two of the six executive members (including Chief Executive or Deputy);
     - Either the Chief Nursing Officer or Chief Medical Officer;
     - Two of five of the partner members; (see SO 4.7.1); where the variation or amendment is being discussed

[1] To update with the Health and Care Act 2022 amendment of the 2006 Act to confer on ICBs the functions of primary care commissioning.

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and that at least half of the ICB members vote in favour of the amendment;

- provided that any variation or amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by NHS England;

d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing Orders –** which set out the arrangements and procedures to be used for meetings and the process to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published

a) **The Scheme of Reservation and Delegation (SoRD) –** sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map -** a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) – c);
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.

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- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- Role profiles for board members;
- Risk Management arrangements;
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2.

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it **–** including:
   - Standards of Business Conduct Policy which contains the Conflicts of Interest policy and procedures;
   - Counter Fraud Policy;
   - Health and Safety Policy.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 The ICB shall consist of members as set out in sections 2.1.3 – 2.2.3 covering mandated members (as per NHS England policy) and locally agreed ordinary members.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website https://nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles/ .

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as “the board” and members of the ICB are referred to as “board Members”) consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

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2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
   - Chief Financial Officer
   - Chief Medical Officer
   - Chief Nursing Officer

b) at least two Non-Executive Members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has five Partner Members.

a) A member nominated by NHS Foundation Trusts
b) A member nominated by NHS Foundation Trusts with knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism;
c) A member nominated by Primary Medical Services;
d) A member nominated by the Local Authority;
e) A member nominated by the Local Authority that brings the perspective of Population Health and Prevention.

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:

a) Five Non-executive members;
b) Two Executive Directors (Interim Chief Delivery and Transformation Officer ~~Director of Strategy and Transformation~~ and Director of

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People, Culture and Engagement).

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner member(s) NHS and Foundation Trusts
d) 1 Partner member(s) Primary Medical Services
e) 2 Partner member(s) Local Authorities
f) 5 Non executive members(one of which, but not the Audit Committee Chair, will be appointed Deputy Chair[18]; and one of which, who is the Deputy Chair will be appointed the Senior Non-executive Member)[18]
g) Chief Financial Officer
h) Chief Medical Officer
i) Chief Nursing Officer
j) 2 Executive Directors (Interim Chief Delivery and Transformation Officer ~~Director of Strategy and Transformation~~ and Director of People, Culture and Engagement)

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 At the discretion of the Chair, the board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

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2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

2.3.5 Participants will be invited to each meeting of the board and will include:

a) A participant from NHS Foundation Trusts;
b) A participant from NHS Foundation Trust – with the knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism;
c) A participant from Primary Medical Services;
d) A participant from the Local Authority;
e) The Chair of the Integrated Care Partnership, known as One Gloucestershire Health and Wellbeing Partnership.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be committed to upholding ~~willing to uphold~~ the Seven Principles of Public Life (known as the Nolan Principles);
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification;
d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in the role profiles (see Governance Handbook);
e) Comply with the requirements of the ICB Standards of Business Conduct policy that includes the Conflicts of Interests policy.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or

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b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A Health Care Professional meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or

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d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to—
a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under—
a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria
a) The Chair will be independent.
b) Fulfil the eligibility criteria set out in the role profile included in the Governance Handbook.

3.3.3 In addition to criteria specified in 3.2, individuals will not be eligible if:
a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

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3.3.4 The term of office for the Chair will be two years followed by a further three years, with the maximum of 2 terms of office.

3.4 **Deputy Chair and Senior Non-executive Member**

3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.4.1 **No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.**

3.4.2 **The Senior Non-Executive Member is to be appointed from amongst the non-executive members by the board and is the Deputy Chair subject to the approval of the Chair.**

~~1.1~~3.5 Chief Executive

~~1.1.1~~3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

~~1.1.2~~3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

~~1.1.3~~3.5.3 The Chief executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

~~1.1.4~~3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role;
c) If they fail to fulfil the eligibility criteria set out in the role profile contained in the Governance Handbook.

~~1.2~~3.6 Partner Members - NHS Trusts and Foundation Trusts

~~1.2.1~~3.6.1 These Partner Member are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition. Those trusts are:

a) Gloucestershire Hospitals NHS Foundation Trust;
b) Gloucestershire Health and Care NHS Foundation Trust;
c) South Western Ambulance Service NHS Foundation Trust.

~~1.2.2~~3.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

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a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area;
b) One shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism.

~~1.2.3~~3.6.3 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply;
b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.

~~1.2.4~~3.6.4 These member(s) will be appointed by the Appointments Panel subject to the approval of the Chair.

~~1.2.5~~3.6.5 The appointment process will be as follows:
a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make 1 nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment is subject to approval of the Chair under c)
- The full list of nominees will be considered and assessed by a panel convened by the Chief Executive or their nominated deputy.
- The panel will assess the suitability of the nominees against the requirements of the role (the Partner Role Profiles are contained in the Governance Handbook) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

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~~1.2.6~~3.6.6 The term of office for these Partner Member will be 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

~~1.3~~3.7 Partner Member - Providers of Primary Medical Services.

~~1.3.1~~3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility

~~1.3.2~~3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

~~1.3.3~~3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Specify any other criteria set out by NHS England's guidance;
b) Health professionals who provide primary medical services within the ICB area.

~~1.3.4~~3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;
b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.

~~1.3.5~~3.7.5 This member will be appointed by the Appointments Panel and subject to the approval of the Chair.

~~1.3.6~~3.7.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make up to 2 nominations to be sent to ICB Corporate Governance Team.
- The nomination of an individual must be seconded by **2** other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the

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nomination process will be re-run. until majority acceptance is reached on the nominations put forward

b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - The full list of nominees will be considered and assessed by a panel convened by the Chief Executive or their nominated deputy.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.1, 3.6.2 and 3.6.3.
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~1.3.7~~3.7.7 The term of office for this Partner Member will be 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

~~1.6.1~~3.8.1 This Partner Member is nominated from the local authority whose area coincide with, or include the whole or any part of, the ICB's area. The local authority is:

(i) Gloucestershire County Council.

~~1.6.2~~3.8.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or relevant Executive level role of one of the bodies listed at 3.7.1;
b) One partner member shall bring the perspective of population health and prevention;
c) Be from a local authority at 3.7.1 which has statutory social care responsibility;
d) Specify any other criteria set out by NHS England's guidance.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply;
b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
c) and any criteria set out in NHS E guidance.

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3.7.4 This member will be appointed by the Appointments Panel subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make 1 nomination.
- Eligible organisations may nominate individuals from their own organisation.
- The eligible organisations will be requested to confirm whether they agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run. until majority acceptance is reached on the nominations put forward

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered and assessed by a panel convened by the Chief Executive or their nominated deputy.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.1 and 3.7.2
- In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for these Partner Member will be 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

~~1.7~~3.9 Chief Medical Officer

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19~~8~~(4)(b) of Schedule 1B to the 2006 Act;

b) Be a registered Medical Practitioner;

c) Specify any other criteria set out by NHS England's guidance.

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3.8.2 Individuals will not be eligible if:

b) Any of the disqualification criteria set out in 3.2 apply;
c) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
d) and any criteria set out in NHS E guidance

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair

~~1.8~~3.10 Chief Nursing Officer

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19~~8~~(4)(b) of Schedule 1B to the 2006 Act;
b) Be a registered Nurse;
c) Specify any other criteria set out by NHS England's guidance.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Failure to comply with the eligibility criteria for board role profile described in the Governance Handbook;
c) and any criteria set out in NHS E guidance.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

~~1.9~~3.11 Chief Financial Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Shall be a qualified accountant;
c) and any criteria set out in NHS E guidance.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;
b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
c) and any criteria set out in NHS E guidance.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

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~~1.10~~3.12 Non-Executive Members

3.11.1 The ICB will appoint Five Non-Executive Members. One of these members shall be appointed by the Chair as the Deputy ~~Vice~~-Chair.

3.11.2 These members will be appointed by an ICB recruitment panel arranged by the Chief Executive and will be subject to the approval of the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be employee of the ICB or a person seconded to the ICB;
b) Not hold a role in another health and care organisation in the ICS area;
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the System Quality Committee;
f) Specify any other criteria set out by NHS England's guidance.

3.11.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.
d) and any criteria set out in NHS E guidance.

3.11.5 The term of office for a non-executive member will be 2 years followed by 3 years term of office. A further 1 year appointment is permitted in circumstances where continuity of serving members is required.

3.11.6 Initial appointments may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

Other Board Members

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3.12.1 The board shall comprise a further 2 Executive Directors:

a) Interim Chief Delivery and Transformation Officer~~Director of Strategy and Transformation~~;
b) Director of People, Culture and Engagement.

3.12.2 These members shall fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
b) Comply with the role profiles for Executive Director, Board Member as described in the Governance Handbook.

3.12.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply;
b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.

3.12.4 These members will be appointed by the Chief Executive subject to the approval of the Chair.

~~1.12~~3.13 Board Members: Removal from Office.

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
b) If they fail to attend three consecutive meetings unless agreed with the Chair in extenuating circumstances;
c) If they are deemed to not meet the expected standards of performance at their annual appraisal;
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to:
    i. failing to meet the ICB standards of business conduct;
    ii. misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position;
    iii. non declaration of a known conflict of interest;

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iv. seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise:
v. gross misconduct.
vi. are deemed to have failed to uphold the Nolan Principles of Public Life;
vii. are subject to disciplinary proceedings by a regulator or professional body.

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~1.13~~3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on https://nhsglos.nhs.uk/ and any guidance issued by NHS England or other relevant body.

3.14.2 Remuneration for the Chair will be set by NHS England.

3.14.3 Remuneration for Non-executive members will be set by the Remuneration Committee whose membership will have a balance of Non-executives and partner members to allow the committee to effectively discharge its duties, following regional and national guidance and pay frameworks.

3.14.4 Other terms of appointment will be determined by the Remuneration Committee.

3.14.5 Terms of appointment of the Chair will be determined by NHS England.

~~Specific arrangements for appointment of Ordinary Members made at establishment~~

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4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the

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functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full on the ICB website https://nhsglos.nhs.uk/

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published https://nhsglos.nhs.uk/

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS

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trust, NHS foundation trust, local authority, combined authority or any other prescribed body;

d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published on the ICB website https://nhsglos.nhs.uk/

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to have:

a) Terms of Reference that describe the membership of the committee and the sub-committees that report into that committee. The board of the ICB, shall approve committee terms of reference;
b) An annual review of their ToRs;
c) Amendments and changes to committee ToRs that shall be approved by the board of the ICB;
d) Minutes of board committees reported to the board of the ICB at each of its meetings;
e) The Chair of the committee of the board be a board member of the ICB;
f) The board committee and sub-committees comply with Internal Audit findings and committee effectiveness reviews.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

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4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) Audit Committee: This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit. The Audit Committee will be chaired by a Non-executive member (other than the Chair and Deputy Chair ~~of the ICB~~) who has the qualifications, expertise, or experience to enable them to express credible opinions on finance and audit matters.

b) Remuneration Committee: This committee is accountable to the board for matters relating to remuneration, fees, and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. The Remuneration Committee will be chaired by a Non-executive member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published on the ICB website https://nhsglos.nhs.uk/

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the governance handbook on ICB website https://nhsglos.nhs.uk/

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

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4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published on the ICB website https://nhsglos.nhs.uk/

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

a) conducting the business of the ICB;
b) the procedures to be followed during meetings; and
c) the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published on the ICB website https://nhsglos.nhs.uk/

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not,

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(and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest, which is contained in the ICB's Standards of Business Conduct policy. The policy forms part of the Governance Handbook and is published on the ICB website https://nhsglos.nhs.uk/

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB. The ICB will publish the registers of interests on its website https://nhsglos.nhs.uk/

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

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a) Conflicts of Interests shall be dealt within in accordance with the ICB's conflicts of interests policy (contained within the Standards of Business Conduct policy) and NHS England statutory guidance for managing conflicts of interests.
b) Recognising that the perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it. For a conflict of interest to exist, financial gain is not necessary.
c) Being proactive, not reactive – the ICB will seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity for instance by considering potential conflicts of interest when appointing individuals to join the board or other decision-making bodies, and by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest.
d) Being balanced, appropriate and proportionate to the circumstances and context – rules will be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making processes are transparent and fair whilst not being overly constraining, complex or cumbersome.
e) Being transparent – the ICB will document the approach and decisions taken at every stage in the decision-making process so that a clear audit trail is evident.
f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:
a) Members of the ICB Board
b) Members of the board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website https://nhsglos.nhs.uk/

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

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6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB Standards of Business Conduct policy (including Conflicts of Interests policy) to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Accountability

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement

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for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 We will act with honesty and integrity and solely in terms of patients and public interests.

7.2.2 We will make collective decisions in an open and transparent manner that best serve the interests of our local population in Gloucestershire.

7.2.3 We adhere to a collective model of accountability, where we hold each other mutually accountable for respective contributions to shared priorities and strategic objectives.

7.2.4 We will demonstrate this by:

a) holding meetings of the ICB board in public with exception to 7.3**;**
b) board meeting dates, times, venues, and papers will be published on the ICB's website, including notice of the AGM;
c) holding an Annual General Meeting (AGM) where the Annual Report will be adopted.

7.2.5 We will publish on the ICB website:

a) Constitution;
b) Governance Handbook including the SoRD;
c) Agreed System Plan;
d) Annual Report inclusive of the annual accounts;
e) Registers of interests;
f) Procurement decisions;
g) Notices of procurements, public consultations, and forthcoming meetings.

7.2.6 Key policies such as the Standards of Business Conduct (conflict of interests policy) and Complaints Policy, Patient and Public Engagement strategy and policy;

7.2.7 Freedom of Information Publication Scheme - the above documents and notices will also be available on request from the ICB.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

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7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and governance handbook will be published as well as other key documents including but not limited to:

a) Standards of Business Conduct Policy including the Conflicts of Interest policy and procedures;
b) Scheme of Reservation and Delegation;
c) Standing Financial Instructions;
d) Registers of interests;
e) Key policies.

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

sections 14Z34 to 14Z45 (general duties of integrated care boards);

set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25

set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

~~c)~~a)

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

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7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including complying with existing procurement rules until the provider selection regime comes into effect. This will also include:

a) evidencing that it has properly exercised the responsibilities conferred on it by the regime by:
   - publishing the intended selection approach in advance;
   - publishing the outcome of decisions made and the details of contracts awarded;

b) keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified;

c) recording how conflicts of interest were managed;

d) monitoring compliance with this regime via an annual internal audit processes the results of which will be published;

e) including in the annual report a summary of contracting activity as specified by the regime;

f) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

The ICB will comply with local authority Health Overview and Scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

~~a)~~b) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards);

~~b)~~c) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan);

~~c)~~d) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

~~d)~~e) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

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8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) Professional Human Resources advice and support;
b) Professional advice on remuneration frameworks;
c) Legal advice from the ICB's lawyers in relation to employment law.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook https://nhsglos.nhs.uk/

8.1.6 The duties of the Remuneration Committee include

a) Agreeing the ICB salaries policy and standard terms and conditions for employees;
b) Setting remuneration, allowances, terms and conditions for board members;
c) Setting any allowances for members of committees and sub-committees of the ICB who are not members of the board.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff in line with the ICB Secondment Policy.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z54(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

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a) the planning of the commissioning arrangements by the Integrated Care Board;
b) the development and consideration of proposals by the ICB;
c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made arrangements to consult its population on its system plan in line with its policy on Public Involvement.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
d) Build relationships with excluded groups – especially those affected by inequalities;
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
g) Use community development approaches that empower people and communities, making connections to social action;
h) Use co-production, insight and engagement to achieve accountable health and care services;
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities;
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 In addition the ICB has agreed the following arrangements, including:

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a) implementing a system-wide strategy for working with people and communities which will ensure adoption of the 10 principles throughout Gloucestershire;
b) working with partners across the ICS to develop arrangements for ensuring that the Integrated Care Partnership (ICP) and locality-based partnerships continuously engage with local people and in developing, reviewing and evaluations strategies and plans;
c) gathering intelligence about the experience and aspirations of people who use care and support and embedding clear approaches to using these insights to inform decision-making and system governance;
d) publish our Working with People and Communities Strategy on the ICB website [weblink] and confirm our commitment to adopting the ten national principles within the Governance Handbook.

9.1.6 The ICB will ensure that ICS partners adopt an integrated approach to communications, using established and innovative methodologies and infrastructure. This will:
a) ensure One Gloucestershire ICS applies best practice principles in developing its communication and engagement infrastructure and associated activity;
b) ensure the One Gloucestershire ICS strategic plans and programmes are supported by comprehensive communications and involvement activities tailored to the needs of each audience.

9.1.7 The ICB will establish and maintain a range of opportunities for the following groups (a-f) to inform the development and delivery of the system-wide strategy for working with people and communities:
a) Local residents, people who access care and support (and those who do not), unpaid carers and families;
b) Healthwatch;
c) VCSE partners;
d) Leaders in our system who will champion and embed this work;
e) Involvement, experience and communications practitioners employed by all system partners;
f) NHS non-executives, foundation trust members and governors, local government councillors.

9.1.8 The ICB strategy, plans and involvement activities will build on existing local good practice derived from the approaches of ICS partners, as well as seeking to drive innovation and new knowledge in public and community involvement.

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Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

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	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Chief Medical Officer	The lead executive medical officer within the ICB.
Chief Finance Officer	The executive director with responsibility for financial leadership within the ICB.
Chief Nursing Officer	The lead executive nurse within the ICB.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'
Eligible organisations	This refers to all partner members eligible to nomination for a given partner appointment. Eligible nominators are listed in sections 3.5.1 and 3.7.1
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
The ICB will add local definitions as required and always include any local terms that refer to legally prescribed roles or functions.	

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Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Gloucestershire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 01 July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per 1.6 of the Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from Associate Director of Corporate Affairs will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

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3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1. Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of the meeting to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.1.1 The Chair of the ICB shall preside over meetings of the board.

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4.1.5. [the Deputy Chair shall preside over meetings in the Chair's stead[18]~~add agreed local arrangement-there may be a deputy appointed or there may be provision for the assembled members to appoint a deputy~~].

4.1.2 If both the Chair and the Deputy ~~Vice~~-Chair are unable to participate in a meeting or part of a meeting the Chair shall be a Non-executive Director who does not have a conflict of interest. Should Non-executive Directors have a conflict of interest that preclude them from Chairing and or taking part in the meeting, a Partner member shall be nominated by the ICB Chair.

4.1.3 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting, in discussion with the Chief Executive.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at https://nhsglos.nhs.uk/

4.4 Petitions

4.4.1 The board shall receive questions from the public at least 3 calendar days before the board meeting. Questions will be submitted in line with the ICB's protocol for public questions, deputations and petitions which is available on the ICB's website. The Corporate Governance Department shall establish and maintain this protocol.

4.4.2 Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to

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attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf.

4.5.2 The substantive office holder shall confirm their nomination of a deputy in writing to the person presiding over the meeting in advance of the meeting.

4.5.3 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be 8 members, including:

a) Three of the six Non executive members (including Chair or Deputy ~~Vice~~ Chair);
b) Two of the six executive members (including Chief Executive or Deputy);
c) Either the Chief Nursing Officer or Chief Medical Officer;
d) Two of five of the partner members.

4.7.2 For the avoidance of doubt:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply: The quorum will be based on 6 members to include:

a) Either the Chief Executive or the Chair;
b) Either the Chief Medical Officer or the Chief Nursing Officer;

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c) At least one Non-Executive Director;
d) At least one Partner Member.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each. Where required the Chair shall have a casting vote.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraphs 2.3 of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 Disputes - Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

4.9.4 Urgent decisions - In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

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4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members, at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

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5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 2 other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1 The ICB shall have a seal for executing documents where necessary.

6.2 The following individuals or officers are authorised to authenticate its use by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Director of Finance:

a) Chief Executive;
b) the Chair of the Integrated Care Board;
c) the Deputy ~~Vice~~-Chair of the Integrated Care Board; and
d) the Chief Financial Officer.

6.3 The following individuals are authorised to execute a document on behalf of the ICB by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Chief Finance Officer:

a) Chief Executive;
b) the Chair of the Integrated Care Board;
c) the Deputy ~~Vice~~-Chair of the Integrated Care Board; and
d) the Chief Financial Officer.

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NHS Gloucestershire
Integrated Care Board

Scheme of Reservation and Delegation (SoRD)

v1.1
1st April 2025

1. Background

1.1. NHS England has set out the following as the four core purposes of Integrated Care Systems:

a) improve outcomes in population health and healthcare;
b) tackle inequalities in outcomes, experience and access;
c) enhance productivity and value for money;
d) help the NHS support broader social and economic development.

1.2. The Integrated Care Board will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.3. ICBs are statutory bodies and as such their powers, functions and duties are conferred, in the main, by legislation. Additional responsibilities for other functions may be conferred through delegation to the ICB from other bodies (such as NHS England).

1.4. ICBs are able to delegate to a committee or sub-committee of the board, or to an individual member of the board or an employee. The legislation gives the ICB board flexibility to appoint to ICB committees and sub-committees members who are neither ICB employees nor board members. In addition, ICBS' have the power to agree with specified other statutory organisations (NHS trusts/foundation trusts, local authorities) that they will exercise their functions on behalf of the ICB or jointly with the ICB.

1.5. This Scheme of Reservation and Delegation (SoRD) sets out those decisions that are reserved to the ICB Board and those decisions that have been delegated to ICB Committees, individuals, joint committees and other statutory organisations.

2. Background	Reference
The power to obtain information from the ICB and intervene where NHS England is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so.	S 14Z58 of NHS Act 2006 and s.14Z59).[1] Constitution 1.4.8
Approval of the ICB Constitution and any changes made to it; changes to the ICB constitution will not be implemented until, and are only effective from, the date of approval	Constitution 1.5.1 1.5.3
Variation of the ICB Constitution other than on application by the ICB;	para 15 Schedule 1B NHS Act 2006 Constitution 1.6.1b
Appointment of the ICB Chair, with approval of the Secretary of State	Constitution 3.3.1
Removal of the ICB Chair, subject to the approval of the Secretary of State	Constitution 3.13.4
Terminate the appointment of the Chief Executive and direct the Chair as to the appointment of a replacement where NHSE is satisfied that the ICB is failing or has failed to discharge any of its functions or there is a significant risk that the ICB will fail to do so	Constitution 3.13.6
Remuneration of ICB Chair	Constitution 3.14.1

[1] To update with the Health Bill amendment of the 2006 Act to confer on ICBs the functions of primary care commissioning.

3. Decisions and functions reserved to the ICB Board	Reference
Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's Constitution, including the Standing Orders	s14Z25 (5) and s1B NHS Act (2006) constitution 1.6.1a, 1.6.3
Make arrangements to publish the ICB Constitution	Constitution s1.4.4 s. 14Z29 NHS Act (2006).
Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	s14Z34 NHS Act (2006) Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Formal review of the ICB Constitution at the end of year three of the ICB's establishment.	Constitution 1.6.2
Approval of the Partner Role Profiles, Nominations & Appointment process	Constitution 3.5.4
Appointment of the Board of the ICB	Constitution s2.1.4 para 3 of Sch 1B 2006 Act
Appointment of the ICB Independent Non-Executive Members	Constitution 3.11.1
Comply with directions and guidance issued by Secretary of State for Health and Social Care, NHS England; and have regard to statutory guidance including that issued by NHS England;	Constitution 4.2.1 (a, b, c, d)
Respond to reports and recommendations made by local Healthwatch organisations within the ICB area	Constitution 4.2.1 (f)

3. Decisions and functions reserved to the ICB Board	Reference
Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB	Constitution 4.3.2
Under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority including the establishment of the ICB and local authority pooled fund	Constitution 4.3.2 s. 65Z5 Health Act (2006)
Accountable for exercising its statutory functions and may grant authority to act on its behalf to: • any of its members or employees • a committee or sub-committee of the ICB	Constitution 4.3.1
Approve the SoRD and any amendments to the SoRD, which sets out: • those functions that are reserved to the board; • those functions that have been delegated to an individual or to committees and sub committees; • those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act	Constitution 4.4.2 & 4.4.3 s. 65Z5 and 65Z6 of the 2006 Act.
Determines the overarching vision of the ICB, the principles for working collaboratively and the joint system plan	(*New section 14Z50 of the Act refers.)*
Approve Functions and Decisions Map	Constitution 4.5.1
Establish Terms of Reference and reporting arrangements for all Committees of the Board	Constitution 4.6.3
Approval of amendments and changes to committee ToRs	Constitution 4.6.3 (c)

3. Decisions and functions reserved to the ICB Board	Reference
Receive reports from committees of the ICB including those which the ICB is required by its Constitution, or by NHS England, or the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action	Constitution 4.6
Confirm the recommendations of committees where committees do not have executive powers	Constitution 4.6
Appoint and dismiss committees of the ICB that are directly responsible to the Board	Constitution 4.6.1
Enter into strategic or other transformation discussions with its partner organisations on an informal basis.	Constitution 4.7.5
Approve Standing Financial Instructions (SFIs)	SFIs 1.1.1 Constitution 5.2
Approve all disposals of property and/or land	SFIs 12
Approval of the arrangements for discharging the ICB's statutory financial duties.	constitution 5.2
Make arrangements for Registers of Interests to be maintained and published to: • Members of the ICB; • Members of the Board's committees and sub-committees; • Its employees.	s14Z30 NHS Act (2006) Constitution s6.3
Approve the Standards of Business Conduct Policy including the Conflicts of Interests Policy	Constitution 6.1.2
Comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment.	Constitution 6.1.3, 6.4.1
Approve the appointment of the Chair of the Audit Committee to be the Conflicts of Interests Guardian	Constitution 6.1.6

3. Decisions and functions reserved to the ICB Board	Reference
Approval of the annual NHS England performance assessment of the ICB	Constitution 1.4.6
Approval of the ICB Long Term Plan and annual operational plan, including financial plans	Constitution 7.3.8
Approval of the ICB's Annual Report and Accounts	Constitution 7.5
Approve any urgent decisions taken by the Chair of the ICB Board for ratification in public session	SO s4.9.4 – 4.9.7
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.	Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB.	Constitution 4.2.2
Approval of the ICB's corporate budgets that meet the ICB's financial duties	Constitution 4.2.2
The exercise of Delegated Functions to empower the ICB to commission a range of primary care services for the people of Gloucestershire as described in the Delegation Agreement and delegated by NHS England to the ICB	S65Z5 NHS Act 2006 Delegation Agreement (ref) Delegation Agreement (ref.)
Establish effective, safe, efficient, and economic arrangements for the discharge of Delegated Functions	S65Z5 NHS Act 2006 Delegation Agreement (ref)

3. Decisions and functions reserved to the ICB Board	Reference
Develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions (this may be included in this Scheme of Reservation and Delegation) and determining the arrangements for the exercise of the Delegation Functions	S65Z5 NHS Act 2006 Delegation Agreement (ref.)
Ensuring the ICB compliance with the NHS Provider Selection Regime including approval of the ICB's Procurement Policy	Constitution 7.4.3
The ICB will comply with local authority Health Overview and Scrutiny requirements	Constitution 7.4.4
Effective discharge of legal duties in respect of initiatives that promote equality and address health inequalities.	Constitution Equality Act (2021)
Approve arrangements for handling complaints and ensuring publication of the process	Constitution 7.3.4
Approve arrangements for handling Freedom of Information requests.	Constitution 7.3.5
Approve arrangements for contributing to and working with agencies responsible for safeguarding for children's, adults and carers.	Constitution 1.4.5 Children Acts 1989 and 2004, and the Children and Families Act (2014); Adult safeguarding and carers (the Care Act 2014);
Receipt and approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and receive updates on significant changes to the initial allocation and the uses of such funds.	SFIs 3.2.1

3. Decisions and functions reserved to the ICB Board	Reference
Receive and review the Annual safeguarding report of safeguarding and the annual children in care report	Constitution 1.4.5
Decision to join the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes.	SFIs 14.1.4
Approve plans for public consultation in relation to service changes and reconfiguration	Constitution 1.4.7 section 14Z44
Approve Strategy for Public Involvement and Engagement – called Working with People & Communities	Constitution 1.7.3
Approve the ICB's People and Organisational Development Strategy	People Committee ToR
Approve the ICB Health & Safety Policy	Committee ToR
Approve the arrangements for discharging the ICB's statutory duties as an employer, including Human Resource and employment policies	Constitution 8
Approve any urgent decision taken by the Chair / CEO or relevant lead director in the case of committees) for ratification in public session	Standing Orders 4.9.5
Make arrangements for Board meetings to be held in public are enacted	Standing Orders 7.3.1
The joint committee for the ICB's area called the Integrated Care Partnership shall be established by the ICB and GCC the responsible local authority whose area coincides with or falls wholly or partly within the ICB's area	Interim guidance on functions and governance of the ICB

3. Decisions and functions reserved to the ICB Board	Reference
Make arrangements for partners across the ICS to develop arrangements for ensuring that the Integrated Care Partnership (ICP) and locality-based partnerships have representation from local people and communities in priority-setting and decision-making forums.	Constitution 9.1.5
Make arrangements with Gloucestershire County Council (GCC) to develop Gloucestershire NHS Integrated Care Strategy for its whole population using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.	Interim guidance on functions and governance of the ICB
To have due regard to the ICP's - Gloucestershire NHS Integrated Care Strategy for its whole population	Interim guidance on functions and governance of the ICB

4. Decisions and functions reserved to the ICB Chair	Reference
Appointment of the Chief Executive	Constitution 3.4
Assessment, selection, and appointment of partner members is subject to the approval of the Chair	Constitution 3.5 - 3.7 inclusive
Appointment of the ICB Vice-Chair from one of the five independent Non-Executive Members	Constitution 3.11.1
Approval of appointment of the Independent Non-Executive Members	Constitution 3.11.2
Subject to satisfactory appraisal the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role	Constitution 3.11.7
Approval of appointment of the Chief Medical Officer	Constitution 3.8

4. Decisions and functions reserved to the ICB Chair	Reference
Approval of appointment of the Chief Nursing Officer	Constitution 3.9
Approval of appointment of the Chief Finance Officer	Constitution 3.10
Approval of appointment of the Director of People, Culture and Engagement	Constitution 3.12.4
Approval of the appointment of the Director of Strategy and Transformation	Constitution 3.12.4
Approve the membership of commissioning boards, committees etc	Constitution 4.6.6
Authority to suspend Standing Orders with agreement of two other board members	Standing Orders 5.1
Authority to veto membership of commissioning boards / committees where the independence of the NHS is compromised.	Constitution 4.6.6

5. Decisions and functions delegated by the Board to the ICB Committees

5.1. Decisions and functions delegated by the Board to the ICB Audit Committee	Reference
To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board	Committee Terms of Reference 7
To agree the risk management framework, policies and procedures ensuring that the risk management structure and processes within the ICB are robust and effective	SFIs 2.3 Committee Terms of Reference 7
Review the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.	Committee Terms of Reference 7 SFIs 2.3
Establish an auditor panel as a sub group to ensure the contract arrangements, including the procurement and selection, with the External Auditors is appropriate	Committee Terms of Reference SFIs
Internal audit services provided under arrangements proposed by the chief financial officer are approved by the Audit and Risk Assurance Committee, on behalf of the ICB board	SFIs 10.1.2
Endorse and recommend the ICB internal audit charter and annual audit plan, to the ICB board	SFIs 10.1.4

5.1. Decisions and functions delegated by the Board to the ICB Audit Committee	Reference
Ensure there is an effective internal audit function including; costs of audit services, performance of service, review and approval of the annual internal audit plan, the findings of audit work including the Head of Internal Audit Opinion and management responses to these, adequate resourcing of the function.	SFIs 10.1
Review the work and findings of the External Auditor and management responses	SFIs 10.2
Review schedules of losses and compensations and make recommendations to the Board	SFIs 11.1.5
Review the annual report and financial statements prior to submission to the Board	SFIs 2.3
To be assured that the ICB has adequate arrangements in place for the counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.	Committee Terms of Reference 7
To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters.	Committee Terms of Reference 7
To provide assurance to the Board that there is an effective framework in place for the management of Information Governance within the ICB including risks associated with information governance	Committee Terms of Reference 7
To monitor the integrity of financial statements of the ICB and any formal announcements relating to its financial performance, ensure systems for financial reporting to the Board are subject to review	Committee Terms of Reference 7
To be assured that the ICB has adequate arrangements for the management of declared interests and conflicts of interest, including gifts and hospitality	Committee Terms of Reference 7

5.2. Decisions and functions delegated by the Board to the ICB Remuneration Committee	Reference
Determine all aspects of remuneration for the Chief Executive, Directors and other Very Senior Managers including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine arrangements for termination of employment and other contractual terms and non-contractual terms for the Chief Executive, Directors and other Very Senior Managers	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine all aspects of remuneration for the Independent Non-Executive members of the ICB Board	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference 7
Determine the ICB pay policy for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7
Setting any allowances for members of committees and sub-committees of the ICB who are not members of the Board	Committee Terms of Reference 7
Oversee contractual arrangements for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7
Determine arrangements for termination payments and any special payments for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference 7

5.3. Decisions and functions delegated by the Board to the ICB System Resources Committee	Reference
Committee will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board for matters relating to system resources allocation, performance against strategic plans and strategic financial performance: • Efficiency, outcomes and value for money in the use of resources across the ICB footprint • Financial performance of the ICB • Financial performance of NHS organisations within the ICB footprint	Committee Terms of Reference 2
To agree key outcomes of the ICB financial strategy	Committee Terms of Reference 7
To agree the strategic financial framework of the ICB and monitor performance against it.	Committee Terms of Reference 7
Oversee the development of an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood	Committee Terms of Reference 7

5.4. Decisions and functions delegated by the Board to the ICB Quality Committee	Reference
Develop and recommend to the ICB Board the key outcomes, quality and performance priorities to be included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Committee terms of reference 7
Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee	Committee terms of reference 7

5.4. Decisions and functions delegated by the Board to the ICB Quality Committee	Reference
Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern;	Committee terms of reference 7
Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained	Committee terms of reference 7
Make arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	Committee terms of reference 7
Cooperate with the Health Service Safety Investigations Body (HSSIB) when carrying out an investigation into the same or related incident, must cooperate with each other regarding practical arrangements for coordinating those investigations	Committee terms of reference 7
Make arrangements for Business Continuity & Emergency Planning	Committee terms of reference 7
Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities: • Infection control; • Medicines optimisation and safety; • Equality and diversity as it applies to people drawing on services.	Committee terms of reference 7
Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children	Committee terms of reference 7
Make arrangements for the handling of complaints	Committee terms of reference 7

5.5. Decisions and functions delegated by the Board to the ICB People Committee	Reference
Oversee the development of the people strategy, ensuring it remains current and relevant to the people drivers and requirements of the One Gloucestershire Integrated Care System	Committee terms of reference 7
Hold the People Board to account for delivering the People Strategy and its impact in the One Gloucestershire Integrated Care System, including the external reporting requirements contained within the System Oversight Framework	Committee terms of reference 7
Ensure that the ICB has well defined system EDI objectives, underpinned by strategic plans, measures and reporting arrangements that strengthen accountability and progress	Committee terms of reference 7
Oversee the strategic approach to developing system leaders, shaping culture, and facilitating behaviour change within the system, creating an environment for success	Committee terms of reference 7
Make arrangements for discharging the ICB's statutory duties as an employer, including Human Resources policies	Committee terms of reference 7

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Decisions in relation to the commissioning, management, planning (including carrying out needs assessments), and undertaking reviews, of Primary Medical Services and other ancillary activities that are necessary to exercise the delegated functions	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
The management of Delegated Funds in relation to Primary Medical Services	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Ensure action is taken related to issuing breach/remedial notices and removing a contract where there breaches occur.	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Design and commission Enhanced Services, including re-commissioning of services (in line with the ICB SFIs (put in reference)	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Design and offer Local Incentive Schemes for Primary Medical Services providers (in line with the ICB SFIs (put in reference)	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference
Make decisions on discretionary payments or support	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Plan and manage Primary Care Networks	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Approve Primary Medical Services provider mergers and closures	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9
Make decisions in relation to the Premises Costs Directions Function	Delegation Agreement 2015 (2A inclusive) Committee Terms of Reference 9 SFIs
Make procurement decisions relevant to the exercise of the Delegated Functions in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issues and updated by NHS England and in line with ICB SFIs	Delegation Agreement 2015 (2A inclusive) Terms of Reference 9
Agreeing arrangements for the delivery of Essential Services, Advance Services, and Enhanced Services across the ICB footprint	Delegati Committee Terms of Reference 9on Agreement 2015 (2A inclusive)

5.6. Decisions and functions delegated by the Board to the ICB Primary Care & Direct Commissioning Committee	Reference
Duty to consult with Local Medical Committees and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;	Delegation Agreement Schedule (2A inclusive) Committee Terms of Reference 1.3
Approving consultations with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z2of the NHS Act 2006	Delegation Agreement Schedule (2A inclusive) Committee Terms of Reference 1.3
Committee shall report on and make recommendations to the ICB on the following: • Primary medical care strategy for Gloucestershire; • Planning primary medical care services in Gloucestershire (including needs assessment).	Committee Terms of Reference 9
Decisions in relation to the commissioning, management, planning (including carrying out needs assessments), and undertaking reviews, of Schedule 2B: Primary dental services and prescribed dental services; Schedule 2C: Primary ophthalmic services; Schedule 2D: Pharmaceutical services and local pharmaceutical services. and other ancillary activities that are necessary to exercise the delegated functions	Delegation Agreement between NHSE and GICB Committee Terms of Reference 9.4 • Appendix B – Schedule 1 2B – list of delegated functions for Primary Dental Services • Appendix C – Schedule 1 2C – list of delegated functions for Primary Ophthalmic Services • Appendix D – Schedule 1 2D – list of delegated functions for Primary Pharmaceutical Services
To publish information about such matters as may be prescribed in relation to primary medical services (including primary dental services, primary pharmacy and ophthalmic services)	Delegation Agreement Schedule (2A inclusive)

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Executive Officer	Convening a panel to advise on the appointment of ICB Board partner members	Constitution 3.5 - 3.7 inc
Chief Executive Officer	Appoint the Chief Medical Officer	Constitution 3.8.3
Chief Executive Officer	Appoint the Chief Nursing Officer	Constitution 3.9.3
Chief Executive Officer	Appoint the Chief Finance Officer	Constitution 3.10.3
Chief Executive Officer	Appoint the Director of People, Culture and Engagement	Constitution 3.12.1
Chief Executive Officer	Appoint the Director of Strategy and Transformation	Constitution 3.12.1
Chief Executive Officer	Ensure that lists of all contractors, for which the ICB is responsible, are maintained in an up to date condition; ensure that systems are in place to deal with applications, resignations, inspection of premises, etc., within the appropriate contractor's terms and conditions of service	SFIs 16.1.2
Director of People, Culture & Engagement	Ensures the ICB complies with Health and Safety laws and regulations.	Health & Safety at Work Act (1974); (2004)

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Nursing Officer	The CNO is designated the Accountable Emergency Officer	Quality Committee ToR
Chief Executive Officer	CEO is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.	SFIs 2.2.1
Chief Executive Officer	Sets out the procedures on the seeking of professional advice regarding the supply of goods and services	SFIs 8.1.2
Chief Executive Officer	Endorses the ICB internal audit charter and annual audit plan	SFIs 10.1.4
Chief Executive Officer	To monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.	SFIs 10.3.1
Chief Financial Officer	Preparation and audit of annual accounts.	SFI 2.2.4
Chief Financial Officer	Ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners.	SFIs 2.2.4
Chief Financial Officer	Ensure that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss.	SFIs 2.2.4
Chief Financial Officer	Meeting statutory requirements relating to taxation.	SFIs 2.2.4
Chief Financial Officer	Ensuring that there are suitable financial systems in place	SFIs 2.2.4
Chief Financial Officer	Meets the financial targets set for it by NHS England	SFIs 2.2.4

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Use of incidental powers such as management of ICB assets, entering commercial agreements	SFIs 2.2.4
Chief Financial Officer	Planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets	SFIs 2.2.4
Chief Financial Officer	Adherence to the directions from NHS England in relation to accounts preparation;	SFI 2.2.4
Chief Financial Officer	Ensure the Governance statement and Annual Accounts & Reports are signed	SFI 2.2.4
Chief Financial Officer	Ensure that planned budgets are approved by the Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets	SFI 2.2.4
Chief Financial Officer	Making use of benchmarking to make sure that funds are deployed as effectively as possible	SFI 2.2.4
Chief Financial Officer	Executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs	SFI 2.2.4
Chief Financial Officer	Specific responsibilities and delegation of authority to specific job titles are confirmed;	SFIs 2.2.4
Chief Financial Officer	Provide financial leadership and ensuring financial performance of the ICB including advice to the Board of the ICB;	SFIs 2.2.4
Chief Financial Officer	Identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions;	SFIs 2.2.4
Chief Financial Officer	Responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB	SFIs 3.1.1

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	To delegate the budgetary control responsibilities to budget holders through a formal documented process	SFIs 3.1.2
Chief Financial Officer	Financial leadership responsibility for the following statutory duties: • the duty of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year; • local capital resource use does not exceed the limit specified in a direction by NHS England; • local revenue resource use does not exceed the limit specified in a direction by NHS England	SFIs 3.1.4
Chief Financial Officer	Prepare and submit budgets for approval by the Board of the ICB. Such budgets will: • be in accordance with the aims and objectives set out in the plan; • accord with workload and staffing plans; • be produced following discussion with appropriate system partners and budget holders; • be prepared within the limits of available funds (resource limits); • identify potential risks.	SFIs 3.3.2
Chief Financial Officer	Devise and maintain systems of budgetary control.	SFIs 3.6.1
Chief Financial Officer	Responsible for establishing effective systems and processes, including robust internal control mechanisms to discharge the ICB's statutory duties related to Income, banking arrangements and debt recovery in accordance with legal and regulatory requirements	SFIs 4 (inclusive)
Chief Financial Officer	Responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB	SFIs 5

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting including procurement, monitoring and performance arrangements in place to ensure the delivery of effective health services	SFIs 6 Public Contracts Regulations 2015 (PCR)
Chief Financial Officer	Oversee and contract for NHS Security Management Services	SFIs 10.3.3
Chief Financial Officer	Responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision. This includes reporting requirements to the Board and Audit Committee, and defining roles and accountabilities for those involved as part of the process of providing assurance to the Board	SFIs 10.4
All Executive Directors	Responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Operating Plan and a balanced budget	SFIs 3.7.2
Chief Financial Officer	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data	SFIs 17 Health Records Act (2001) Records Management Code of Practice for Health and Social care 2016
Chief Financial Officer	Ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments	SFIs 7.1

6. Decisions and functions delegated to individual board members and employees		
Individual	**Decisions and functions delegated to the individual**	**Reference**
Chief Financial Officer	Ensure that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use	SFIs 13
Chief Financial Officer	Responsible for providing robust management of grants, including the governance of grants and assurance to the ICB	SFIs 13.2
Chief Financial Officer	Ensure that contractors who are included on ICB's approved lists receive payments and that there is no evidence of inequality in payment value or method	SFIs 16.1.3
Chief Financial Officer	Responsible for the accuracy and security of the computerised financial data of the ICB whether this is 'in house' or hosted in an outsourced arrangement	SFIs 5.1
Director of People, Culture & Engagement	Operationally responsible for; • defining and delivering the organisation's overall human resources strategy and objectives; and • overseeing delivery of human resource services to ICB employees. • management and governance frameworks that support the ICB employees' life cycle	SFIs 7.2
Director of People, Culture & Engagement	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.	Committee Terms of Reference 7

7. Decisions and functions delegated by the Board to be exercised jointly		
Joint committee	**Decisions and functions delegated to the joint committee**	**Reference**

8. Decisions and functions delegated by the Board to other statutory bodies		
Statutory body	**Decisions and functions delegated to the statutory body**	**Reference**
NHS Somerset ICB	The service areas in scope are: 1. the delegated specialised services delegated directly to the ICB by NHS England under the March 2025 Delegation Agreement between the same; In relation to the service areas in scope, the following functions are delegated to NHS Somerset ICB: A. All commissioning responsibilities, powers, and financial allocations, subject to these being exercised in accordance with the March 2025 ICB Collaboration Agreement, including the conditions set out in that Agreement requiring NHS Somerset ICB to jointly exercise aspects of those functions through a Joint Committee of the South West ICBs	March 2025 Delegation Agreement signed between the ICB and NHS England South West. March 2025 ICB Collaboration Agreement signed between: • NHS Cornwall and Isles of Scilly ICB • NHS Devon ICB; NHS Somerset ICB • NHS Bristol, North Somerset and South Gloucestershire ICB • NHS Gloucestershire ICB • NHS Bath, Swindon and Wiltshire ICB • NHS Dorset ICB AND • NHS England South West

9. Decisions and functions delegated to the board by other organisations		
Delegating body NHSE	**Decisions and functions delegated by the delegating body**	**Reference**
Gloucestershire ICB	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for the people of the Area, as described in Delegation Agreement between NHSE and Gloucestershire ICB The Delegated Functions are the functions described as being delegated to the ICB in such of the following Schedules as have been marked as included within this Agreement: Schedule 2A: Primary medical services; Schedule 2B: Primary dental services and prescribed dental services; Schedule 2C: Primary ophthalmic services; Schedule 2D: Pharmaceutical services and local pharmaceutical services.	section 65Z5 of the NHS Act (2006) ToR s. 9.4 Appendices 2-4

Agenda Item 13

NHS Gloucestershire ICB Public Board meeting

Wednesday 28th May 2025

Report Title	**Infrastructure Strategy 2024/2034: Public Summary Version**						
Purpose	**For Information**		**For Discussion**		**For Decision**		
					X		
	The purpose of this report is to provide members with a public summary version of the ten year ICS Infrastructure Strategy to be published on the ICB website by the end of May 2025.						
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
	n/a		n/a				
Executive Summary	**<u>Background & context</u>** The detailed ten year ICS Infrastructure Strategy was approved by the ICB Board at the July 2024 meeting and submitted to NHSE for their review. NHSE feedback was delayed and provided mid -December 2024. There were some questions and clarification matters, which were dealt with in early 2025. Members were keen to have a high level public summary version that succinctly sets out the key elements. The public summary version is attached at appendix 1 and key points are as follows. Sitting above individual organisational plans, the vision is for '*sustainable infrastructure that supports our journey towards net zero carbon and enables the delivery of our Joint Forward Plan and Joint Health and Wellbeing Strategy.'* Our strategy is focussed on what we need to achieve to enable our infrastructure to support the transformation of our services and what we need to do together at the ICS level. Our partners have their own infrastructure or estate strategies and strategic asset management plans. This strategy is intended to provide a framework to support ICS partners to prioritise and focus dis/investment as they implement and develop their own strategies. The infrastructure strategy needs to be affordable and demonstrate value for money. It needs to support the delivery of our focus on early prevention and the wider impacts on health. It needs to promote access. It needs to facilitate joined up and integrated care in our communities and support specialised services in Cheltenham and Gloucester. It needs to make sure buildings are well used, maintained and provide a great environment for the people of Gloucestershire, including our workforce and patients. Finally, wherever, possible, it needs to be developed in collaboration with each other. The public version is focussed on the eight core principles around which work will be organised and these are set out below: - • **Quality** - high quality, flexible infrastructure that is safe, compliant and well maintained. • **Usership**- Infrastructure that is highly utilised and that ICS partners can easily share with standard processes. • **Green** - Greener infrastructure that supports our move to the net zero carbon.						

<table>
<tr><td></td><td>

Cost effective – cost efficient estate infrastructure where we constantly seek to drive down running costs, use spare public sector capacity and dispose of infrastructure that we do not need.
New infrastructure- new infrastructure that will support the delivery of key clinical and service strategies, provides necessary capacity for population growth or replacement of buildings that are no longer fit for purpose.
Governance – planning and delivering together by collectively understanding our challenges, needs and risks collectively and prioritising, working on shared solutions and being clear about each organisation’s responsibility for delivery.
Wider value- Delivering wider economic and social value by maximising the impact of our infrastructure in our neighbourhoods, including how it is designed, commissioned, used and disposed.
Workforce- our infrastructure supports our People Strategy, and we always think about our people when we consider our dis/investment options.

As well as providing an overview of the scope of the strategy, the clinical model, population/ demography, estate figures and key risks, the public summary is then focussed on each principle explaining why it is important; what we have done; what we are proposing to do; key measures and for some elements, case study examples.
</td></tr>
<tr><td>Key Issues to note.</td><td>We know that we face significant resource challenges in addressing our backlog maintenance and compliance requirements across our existing infrastructure. We will need to continue to focus future investment in these areas.</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk(CxL)</td><td>Key risks and mitigations relating to the Infrastructure strategy are set out in the summary document. From an overarching perspective, the key risk is as follows: -
<table>
<tr><td>Risk</td><td>Original risk Score</td><td>Controls & mitigation</td><td>Revised score</td></tr>
<tr><td>Insufficient funding to undertake critical backlog maintenance/ compliance which leads to some estate not being able to be used with major service disruption experienced</td><td>4x4=16</td><td>Risk profiling of estate and prioritising funding on key identified areas of the core estate</td><td>4x3=12</td></tr>
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<tr><td>Management of Conflicts of Interest</td><td>No conflicts of interest have been identified in the production of this work.</td></tr>
<tr><td>Resource Impact (X)</td><td>
<table>
<tr><td>Financial</td><td>X</td><td>Information Management & Technology</td><td>X</td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Financial Impact</td><td>Whilst the Infrastructure Strategy sets out developing aspirational capital plans and includes investment requirements contained in some supporting plans, and financial investment will be subject to individual Business Cases.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td>In terms of the NHS Constitution the author considers ‘You have the right to be cared for in a clean, safe, secure and suitable environment’ as the most pertinent NHS Constitution rights applicable to the strategy.</td></tr>
</table>

Impact on Health Inequalities	No specific impact assessment has been carried out. However, the Infrastructure Strategy will support the delivery of key policies in this area of work particularly in respect of access to services and improving the experience of using ICS facilities. One of the key principles is to deliver wider economic and social value by maximising the impact of our infrastructure in our neighbourhoods, including by how it is designed, commissioned, used and disposed.		
Impact on Equality and Diversity	An equality and diversity impact assessment has not been carried out in the production of this strategy. Where applicable, these will be undertaken for specific projects and/ or proposals.		
Impact on Sustainable Development	A main part of the vision is to have a sustainable infrastructure that supports our journey towards net zero carbon. The document sets out plans for how it will support the NHS Estates input into the Net Zero Carbon Delivery Plan.		
Patient and Public Involvement	The Infrastructure strategy had been previously discussed at the Countywide Practice Patient Participation Network.		
Recommendation	The Board is requested to agree the ICS Infrastructure Strategy public summary for publishing the public website.		
Author	**Andrew Hughes**	**Role Title**	**Associate Director of major projects**
Sponsoring Director(s)	**Kevin McNamara, ICS Executive Sponsor for the ICS Strategic Estates workstream** **Cath Leech, Chief Financial Officer and Lead ICB Director for strategic estates.**		

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
NHSPS	NHS Property Services

One Gloucestershire
Transforming Care, Transforming Communities

May 2025

Gloucestershire Infrastructure Strategy Summary

2024-2034

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- Our Population……p7
- Our Current Estate – Overview……p8
- Our Vision and Principles……p9
- Our Principles – Detail……p10
- Our Key Risks and Mitigations……p18

One Gloucestershire
Transforming Care, Transforming Communities

Foreword

Gloucestershire has a diverse, growing and ageing population. Our Integrated Care System (ICS) partners are working together to continue to make Gloucestershire a better place for the future, transform what we do and improve health and care services.

We have achieved significant improvements in our infrastructure over the last 5 years, including investment through our Fit for the Future Programme, Working as One, Joining Up Your Information (JUYI) and new primary care premises. But there is still much more to do to enable excellent patient care.

Looking forward, we know that working within our current financial parameters will continue to be challenging as we continue to deliver more services whilst also focusing on prevention.

We have made a collective commitment and agreed a detailed Strategy to work towards our Vision and Principles for a sustainable infrastructure that supports our journey towards net zero carbon and enables the delivery of our Joint Forward Plan and Joint Health and Wellbeing Strategy. This is a summary public version.

We have developed eight Principles to support our vision and know that we need to continue to focus on integration and collaboration to provide high quality, compliant, flexible infrastructure that is sustainable, accessible and well used.

Our Strategy has been developed taking account of our other One Gloucestershire Strategies (including Digital, Workforce and our Green Plan), other Strategies that have been adopted by our partners and engagement through interviews and workshops.

In producing the Strategy, we recognise that our ageing and growing population across our localities will impact service demand and delivery. We will continue to work collaboratively to understand and mitigate the impact of demographic change, including by sharing and making best use of our existing infrastructure.

We know that we face significant resource challenges in addressing our backlog maintenance and compliance requirements across our existing infrastructure. We will need to continue to focus future investment in these areas.

We also know that we will need to replace some of our infrastructure that is no longer fit for purpose and need to work together to prioritise disinvestment, as well as investment.

Resources will be required to meet our Net Zero Carbon commitment, including to insulate buildings and decarbonise heating systems across our estate, and we will take forward these requirements through this Strategy and our Green Plans.

We need to do more work to ensure that we provide wider economic and social value from our estate, ensure flexibility in its use and optimise the use of digital technology.

This Infrastructure Strategy sets out a clear Vision and our Priorities. We will need to continue to enhance collaborative working to maintain existing and develop new infrastructure to support growth and our evolving clinical needs over future years.

Kevin Macnamara

Lead ICS Executive Sponsor for Strategic Estates Planning

One Gloucestershire
Transforming Care, Transforming Communities

Introduction

Strategic Objective 9 in our **Joint Forward Plan** recognises that we need to create the conditions for change and that we need to transform care through technology and the effective use of our estate (our infrastructure).

Infrastructure in our ICS is owned and managed by our ICS partners who provide health and social care. However, a shared and common understanding of our infrastructure is vital to us realising our ambition to:

- make Gloucestershire a better place for the future;
- transform what we do; and
- improve health and care services today.

We need to understand the infrastructure that we have today and the infrastructure that we will need in the future to enable the delivery of our health and social care services.

Our partners have their own Strategies and Plans for managing their infrastructure. This Strategy therefore seeks to focus on our areas of shared and common interest that will help us to realise our ambition, including how we will need to work together to:

- address the challenges with outdated infrastructure;
- make the best use of our infrastructure;
- adapt our infrastructure to support our service transformation;
- understand our need for investment and how we will prioritise the use of our limited capital;
- focus on opportunities for running cost savings, including disinvestment;
- meet our Net Zero Carbon objectives for our infrastructure;
- benefit from digital and technology solutions;
- get, grow and keep our infrastructure workforce.

This Strategy sets out our Priorities to address our challenges and deliver our ambition.

The collaboration and engagement involved in producing this document has to date been effective and productive – this will continue as we implement this Strategy.

ICS Strategy

Ambitions:

1. Prioritise prevention
2. Improve integrated working and collaboration of the workforce
3. Reduce inequalities
4. Improve quality and outcomes

Joint Forward Plan:

Our Pillars

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

One Gloucestershire
Transforming Care, Transforming Communities

Scope of Our Infrastructure Strategy

The focus of this Strategy is the NHS estate and other NHS infrastructure, including major equipment and our digital infrastructure. However, our Strategy also acknowledges our dependency on infrastructure owned and managed by others, including that of our local authority and One Public Estate (OPE) partners, and the voluntary, community and social enterprise (VCSE) sector.

This strategy focuses on what we need to achieve to enable our infrastructure to support the transformation of our services and what we need to do together at ICS level. Our partners have their own infrastructure or estate strategies and strategic asset management plans. This Strategy is intended to provide a framework to support ICS partners to prioritise and focus dis/investment as they implement and develop their own strategies.

Our Model of Care

Our Joint Forward Plan seeks to move more care from hospitals to communities, make better use of technology in health and care and focus on preventing sickness, not just treating it.

We know that when people have health needs, they want accessible and timely diagnosis as well as support. We believe that maintaining independence and health is best achieved when care and support is delivered closer to home. We are committed to delivering services that are as close to where people live as possible, including services that provide early and accurate diagnosis and support people with health needs or complex long-term conditions.

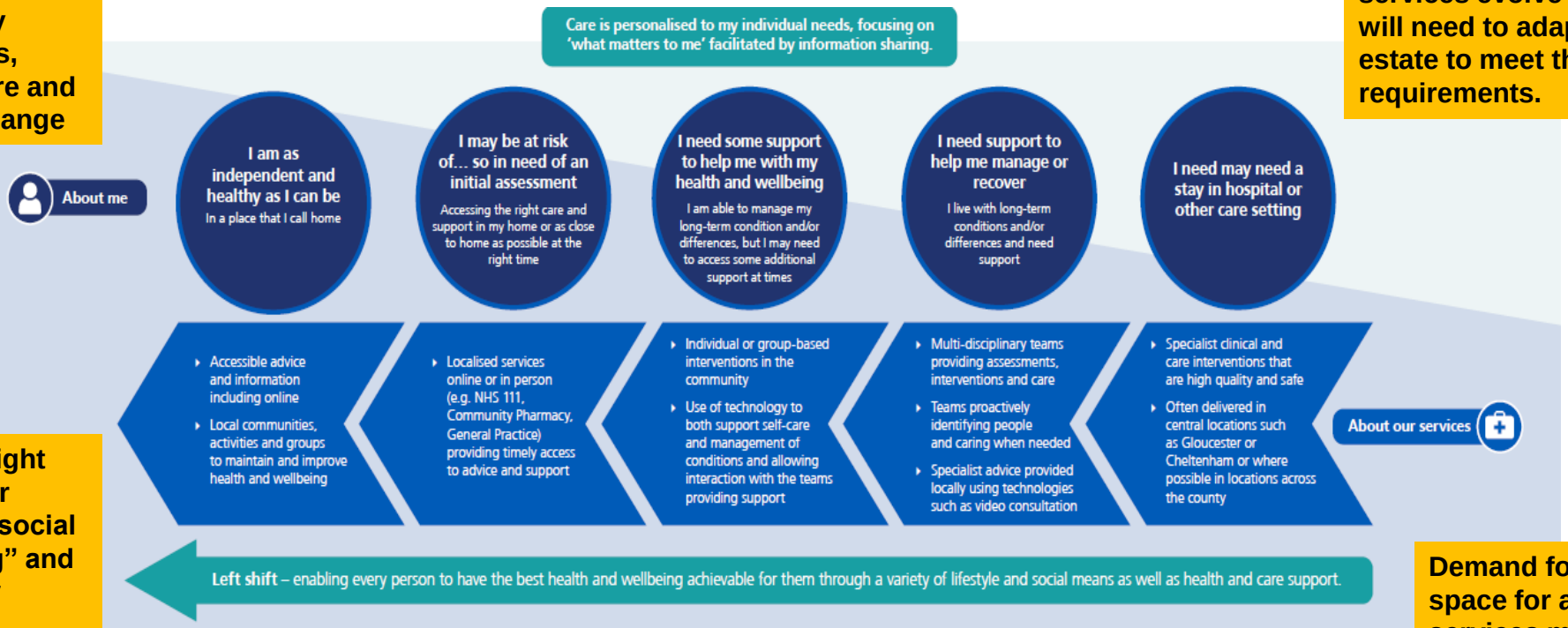
We are committed to Neighbourhood Health and Care Services that are already bringing multi-disciplinary teams together to proactively identify and support people with complex care needs in the community. Our new care approach (starting with a focus on people living with frailty) will be underpinned by better use of digital technologies and data sharing to provide more seamless care around what matters to people.

We also know that there are reasons why we may need to provide some health and care services centrally – in locations such as Gloucester or Cheltenham. The development of specialist services at Cheltenham General Hospital and Gloucester Royal Hospital into ‘Centres of Excellence’ is a good example of where this has been happening.

Our Model of Care

Demand for space for Community Diagnostics, primary care and INT may change

We will need to understand the future demand for space in our estate as our services evolve and will need to adapt our estate to meet their requirements.



Demand might increase for space for "social prescribing" and community activities

Demand for space for acute services may change

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Our Population

The data below is for Gloucestershire. However, it's important to note that some of our providers deliver services beyond Gloucestershire, including GHFT who provide cancer services for Herefordshire and parts of Worcestershire.

For Gloucestershire, ONS projections indicate that our population will increase by **c. 42k** to **c. 707k** to 2034/5. The highest growth is expected in our Tewkesbury and Cotswolds Localities. Our population will continue to age and this will impact the care we provide and our workforce.

Population

	2011	2021	2032
ONS Population Change	598,289	646,485	700,069
Population growth since 2011		48,196	101,780

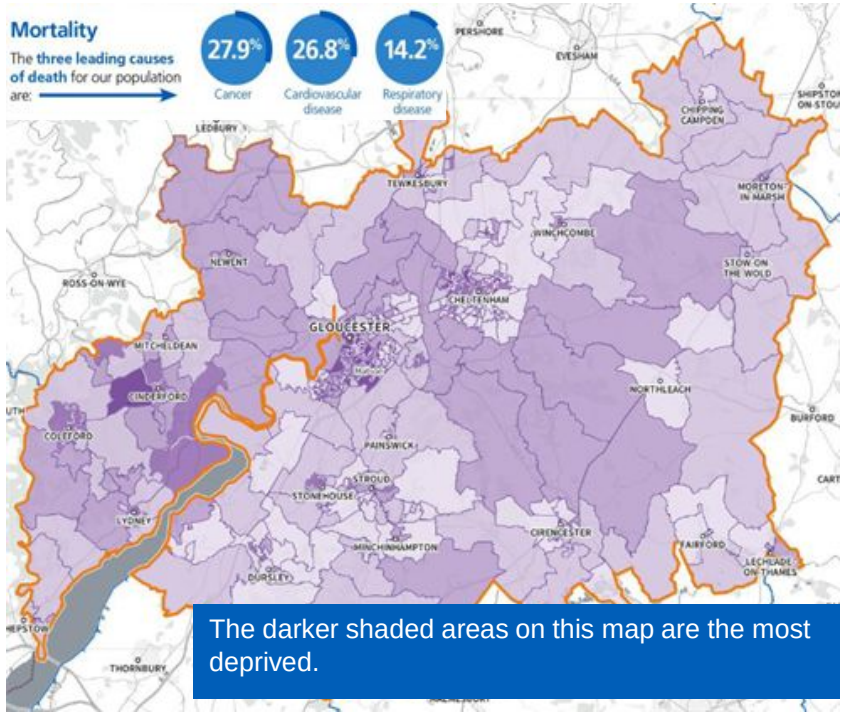
Age Demographics (ONS 2021)

	2021	2032	2042
Children and young adolescents (0-15)	16.3%	15.4%	15.4%
Working age population (15-64)	61.9%	58.5%	56.7%
Elderly population (65 years and older)	21.8%	26.1%	27.9%

Index of Multiple Deprivation

National Average	**21.67**
Gloucestershire	14.93

Gloucestershire is relatively healthy and affluent. Life expectancy at birth is above the national average. However there are 12 LSOA within the 10% most deprived nationally and 31 LSOA (c. 8.2% of our population) are amongst the most deprived 20% in England (**Core 20+5**). People are likely to live 11 years longer in good health in the least deprived area of Gloucestershire compared to the most deprived area.



The darker shaded areas on this map are the most deprived.

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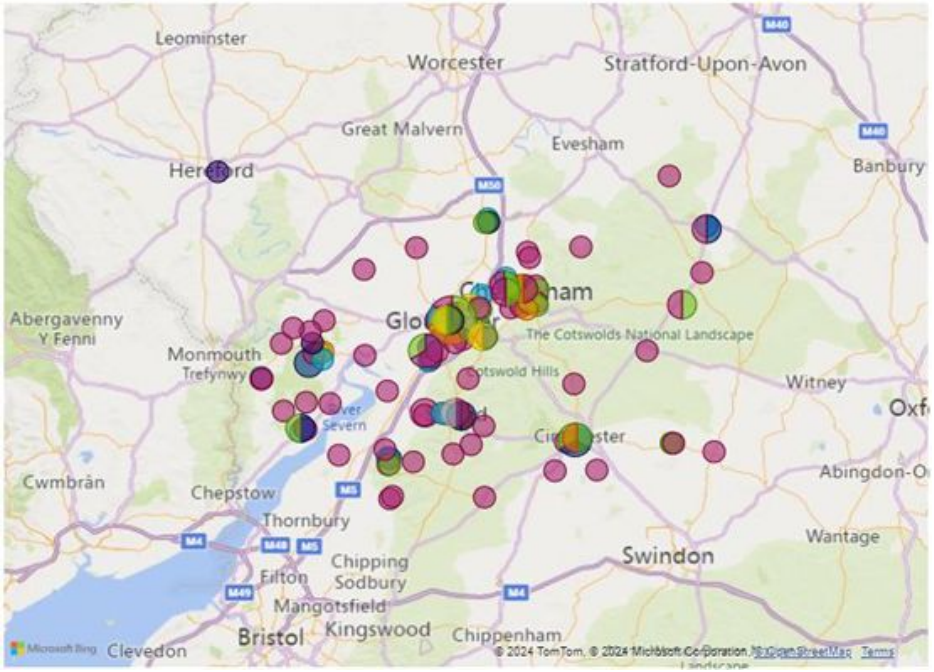
* Population data varies between sources.

7

Our Current Estate - Overview



Key

Acute Ambulance Community Hospital Community Services
GP Mental Health Office Residential Vacant

Service Type	Number of Sites	Floor Area (sqm)	Running Costs (£m pa)	BLM* (£m)
GP owned/leased	84	49.3k	£10.7m	N/A**
GHFT – acute	7	181.7k	£76.7m	£80.5m***
GHC - Community Services	31	11.1k	£3.1m	£0.6m
GHC - Mental Health	15	23.8k	£6.8m	£4.9m
GHC – Community Hospitals	8	34.8k	£9.7m	£8.1m
Offices	9	15.1k	£3.3m	£3.9m
Ambulance Trust	14	TBC	TBC	TBC
Other	4	2.1k	£0.5m	£0.7
Totals (rounded)	**164**	**318k**	**£110.9m**	**£98.7m**

Tenure	Properties	Percentage
Freehold	97	58%
Leasehold	54	32%
PFI	1	1%
Unknown	15	9%

*Backlog Maintenance (BLM) is as per the data reported via NHS England's Estates Returns Information Collection (ERIC)
**Backlog maintenance liabilities for primary care providers is not reported through ERIC
***Backlog maintenance data for GHFT is based on surveys undertaken c. 5 years ago. New surveys are being commissioned to inform the current position

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Our Vision and Principles

Our Vision

Our Vision is for sustainable infrastructure that supports our journey towards net zero carbon and enables the delivery of our Joint Forward Plan and Joint Health and Wellbeing Strategy.

Our infrastructure must:

- be affordable and demonstrate value for money;
- support the delivery of:
  - our focus on early prevention and the wider impacts on health
  - accessible, joined up and integrated care in our communities, including the home; and
  - specialised services in Cheltenham and Gloucester;
- be well used, maintained and developed by our partners on a collaborative basis; and
- provide a great environment for the people of Gloucestershire, including our workforce and patients.

Our Principles

Principle	
QUALITY	High quality, flexible infrastructure that is safe, compliant and well maintained
USERSHIP	Infrastructure that is highly utilised and that ICS partners can easily share with standard processes
GREENER	Greener infrastructure that supports our move to net zero carbon
COST EFFICIENT	Cost efficient infrastructure where we constantly seek to drive down running costs and dispose of infrastructure that we don't need
NEW INFRASTRUCTURE	New infrastructure that will support the: • delivery of key clinical and service strategies; • necessary capacity for population growth; • replacement of buildings that are no longer fit for purpose.
GOVERNANCE	Planning and delivering together by collectively understanding our challenges, needs and risks collectively, prioritising and working on shared solutions, and being clear about each organisation's responsibility for delivery
WIDER VALUE	Delivering wider economic and social value by maximising the impact of our infrastructure in our neighbourhoods, including by how it is designed, commissioned, used and disposed
WORKFORCE	Our infrastructure supports our People Strategy and we always think about our people when we consider dis/investment options

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Principle 1: QUALITY

Why is this important?

We need to deliver our services from the best possible estate. However, across Gloucestershire, our reported backlog maintenance liability is in the region of £100m, with the majority of that liability falling within our major hospitals in Cheltenham and Gloucester. Our backlog maintenance liability is not static and it's vital that we address it (particularly the "high risk" in our "core" estate) to maintain patient safety; provide high quality care; provide a quality environment in which our colleagues work; ensure cost and operational efficiencies; and ensure the sustainability of our estate.

What have we done?

Significant capital has been invested in new facilities over the last 5 years, including new primary care facilities, a new Forest of Dean Community Hospital and the development of new and refurbished buildings at our Cheltenham and Gloucester hospitals (where we have invested c. £45m in our Fit for the Future Programme that includes a new surgical unit, a reconfigured and extended acute medical unit at CGH and a reconfigured and extended emergency unit at GRH).

What are we doing next?

We will focus the majority of our capital investment over the next 5 years to address our backlog maintenance liabilities across our "core" estate. Wherever possible, we will seek to pursue alternative solutions for our "tail" estate, including opportunities to dispose of properties that no longer meet the requirements of modern healthcare.

Forest of Dean Community Hospital

Completed in 2024, the c. £25m, 24-bed community hospital with outpatient facilities replaces the outdated community hospitals in Cinderford and Lydney.

The benefits include reduced backlog maintenance liabilities and a new energy efficient building that meets modern healthcare requirements.

Measure	Where are we?	Where do we want to be?
Backlog maintenance across our estate	Current backlog maintenance estimate is reported as c. £100m (NHS England ERIC data)	Eliminate "high risk" backlog maintenance in our "core" estate by 2030
Proportion of our estate that is categorised as "tail"	16% of the buildings (c. 6% of the floor area) that we have categorised are "tail"	No more than 10% of our buildings are "tail" by 2030

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Principle 2: USERSHIP

Why is this important?

The nature and delivery of healthcare is changing and impacts our need for space. On average, it costs about £350 per square metre of floor area to run our estate and we therefore need to ensure that we make the best use of it. However, there are opportunities to increase the use of some of our estate and to dispose of under used estate that we no longer need. We need to gather evidence about the use of our estate to inform our decision making.

What have we done?

We have worked to release estate that we no longer need. For example, in 2023, NHS Gloucestershire ICB relocated its under used offices from third party leasehold premises into a much smaller footprint within Gloucestershire County Council's offices to realise a saving of c. £0.5m pa. We have also sold surplus properties that we no longer need. The sale of surplus property has generated funds to invest in modern fit for purpose buildings, including the new Forest of Dean Hospital.

What are we doing next?

We will undertake utilisation surveys across a selection of our estate in FY 25/26. This evidence will enable us to make informed decisions about the potential to deliver integrated care and out of hospital services across Gloucestershire, and to identify opportunities to rationalise our estate (particularly our offices).

We're also working to develop proposals that will enable ICS partners to more readily share each others' estate. This will help support more flexible ways of working and will also help us make the best use of our estate.

ICB Office Relocation

The end of a lease and under utilisation of the ICB offices provided an opportunity to implement a One Public Estate option to co-locate in the County Council's Shire Hall offices in Gloucester.

The relocation was completed in 2023 and resulted in a right sized office in a central, accessible location with a significant reduction in running costs and a lower carbon footprint.

Measure	Where are we?	Where do we want to be?
Utilisation of our estate is well understood and optimised	We don't currently have a comprehensive understanding of the utilisation of our estate	We will undertake 3 no. pilot utilisation surveys across our estate by the end of March 2026.
Sharing of our estate by ICS partners	Sharing of estate between our ICS partners is currently limited	Our ICS partners can, where appropriate, freely work within each other's buildings

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Principle 3: GREENER

Why is this important?

The NHS' vision is to "*deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.*" Energy emissions from our buildings and other infrastructure form a large share of core NHS emissions: our building energy use comprises c. 10% of our overall emissions; water and waste comprise a further c. 5%; and "business" travel and fleet vehicles comprises a further c. 4%. It's vital that we work to reduce our emissions from our infrastructure to work towards our commitment to net zero core emissions by 2040, with an 80% reduction by 2032.

What have we done?

Our ICS Green Plan 2022-25 and our partners' Green Plans set out our plans to support our transition to net zero and we are in the process of renewing these.

We have successfully secured funding from the Public Sector Decarbonisation Fund to improve the energy performance of our estate, including c. £10m of investment at Gloucester Hospital and we have developed new infrastructure that is BREEAM Excellent to replace outdated estate.

What are we doing next?

We are refreshing our Green Plan to take account of our progress over the last 3 years and to prioritise our activity over the next 5 years, including progressing the electrification of our transport fleet.

We will prioritise investment in improving our existing infrastructure. Where we need new infrastructure, we will ensure that it meets NHS Net Zero standards.

Gloucester Hospital

The 1970s 10-story Tower Block provides inpatient accommodation. GHFT secured £10 million from the Public Sector Decarbonisation Scheme to upgrade the external fabric, including replacement double glazed windows and an insulated powder-coated aluminium panel rainscreen with completion expected in 2025.

Measure	Where are we?	Where do we want to be?
Implementation of our Green Plans	We have an ICS Green Plan and our partners have their own Green Plans. New Green Plans will be published in 2025.	Our ICS Green Plan and our partners' Green Plans are updated for the period to 2030 and we implement the measures in them.
New developments achieve BREEAM Excellent and meet the NHS Net Zero Building Standard	We have delivered a number of schemes that meet BREEAM requirements.	All new developments meet the Net Zero Building Standard.

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Principle 4: COST EFFICIENT

Why is this important?

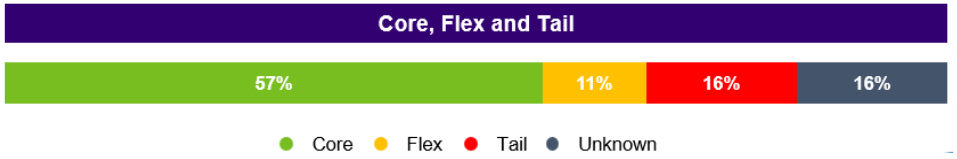
We have limited resources available to continue to maintain our existing estate and to develop new infrastructure. However, we have more than 300,000 square metres of building footprint that we maintain at a cost of more than £100m each year. It's vital that we use our resources to ensure that our estate provides cost effective space to deliver health services for the people of Gloucestershire.

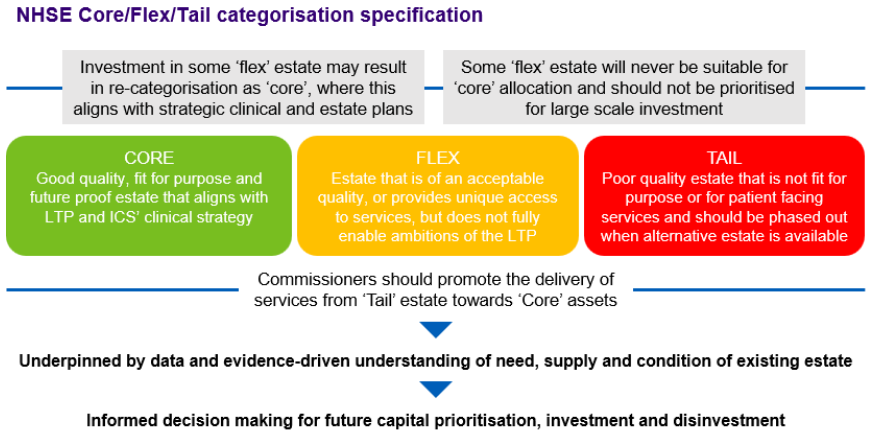
What have we done?

Over the last 5 years, we have made our estate more efficient by releasing buildings that are no longer suitable for the delivery of modern healthcare, including both freehold and leasehold properties. We are working to identify all of our "tail" estate and to develop a pipeline of opportunities that will provide alternative solutions and to vacate that estate at the earliest opportunity, as funding becomes available.

What are we doing next?

We will complete the Core, Flex, Tail classification of all of our estate and will focus on opportunities to vacate our "tail" estate to reduce our running costs, mitigate the cost of backlog maintenance and release capital for reinvestment in our "core" estate.





Measure	Where are we?	Where do we want to be?
Disposal of our "tail" estate	We have identified our "tail" estate and are developing a pipeline of work to release the estate that is no longer suitable for the delivery of healthcare.	By the end of March 2026, we will categorise all of our estate. By 2030, we will have identified all "tail" estate that we are intending to release.
The running costs of our estate (on a £/sqm basis)	We have undertaken benchmarking data analysis and identified estate where the running cost is a significant outlier.	By 2030, the running costs for each of our buildings benchmarks well in Gloucestershire and against national metrics (including Model Hospital).

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Principle 5: NEW INFRASTRUCTURE

Why is this important?

The need for space to deliver healthcare services is changing as a result of factors including demographics (our population is growing and ageing), technology (including remote monitoring, work from different locations and shared patient records) and our model of care (including the development of our Integrated Neighbourhood Teams and moving activity “out of hospital” into community settings including the home). We will need new infrastructure to meet the changing requirements for healthcare, including new and refurbished space in existing and new locations.

What have we done?

We have secured funding to develop new infrastructure for primary care (including a new £5+m surgery at Minchinhampton), our community estate (including a new £25+m Forest of Dean Community Hospital and a new £25+m hub incorporating GP and community diagnostic services at Quayside House in Gloucester) and our acute Hospitals in Cheltenham and Gloucester (with investment of more than £100m including new theatres and laboratories over the last 5 years).

What are we doing next?

Our focus over next 5 years will be on securing further investment in primary care to implement our Primary Care Strategy (including new GP surgeries incorporating community services) and focusing on reducing backlog maintenance at both Cheltenham and Gloucester Hospitals.

We will also develop a Strategic Outline Case that will set out the current challenges of running services from our two acute hospital sites that incorporate both modern and outdated estate, and how we could best integrate other health and social care services at those sites. In parallel, we will develop a business case to explore the future options for our inpatient mental health services in Cheltenham and Gloucester.

Measure	Where are we?	Where do we want to be?
Implementation of our Primary Care Premises Development plans. Strategy	We currently have five approved GP premises proposals, prioritised a number of new priorities and progressing Dental Access Centre and Centre of Dental Excellence proposals	Delivery of 5 new approved surgery approvals. Dental facilities completed and open, and new Business case approved for implementation,
Development of a Strategic Outline Case for the development of our two acute hospitals	We are starting work to identify the challenges of delivering services from our two acute hospital sites	By the end of 2030, we will have developed a Strategic Outline Case for the future direction of our acute hospital services.
Development of a Business Case for the delivery of mental health services at Wotton Lawn, Gloucester and Charlton Lane, Cheltenham	Our existing estate for the delivery of inpatient mental health services at these sites is becoming outdated and we need to consider options to improve it	By the end of 2030, we will have completed a Strategic Outline Case with Outline and Full Business Cases being subject to the availability of capital.
Secure s106 and CIL funding to invest in healthcare	We are engaging with our Council partners to raise awareness of the investment that’s needed in our estate to support Gloucestershire’s growing population.	By 2030, we have supportive Local Plan policies and have secured financial contributions, land and infrastructure to enable new healthcare estate.

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Principle 6: GOVERNANCE

Why is this important?

Health and social care services for the people of Gloucestershire are delivered by a wide range of partners including our NHS Trusts, primary care partners and their networks, local authorities, the voluntary sector and other third parties. Whilst each organisation is responsibility for their own estate and infrastructure, it's vital that we work together as an ICS to share and understand our individual requirements and consider opportunities for shared working, investment and disinvestment.

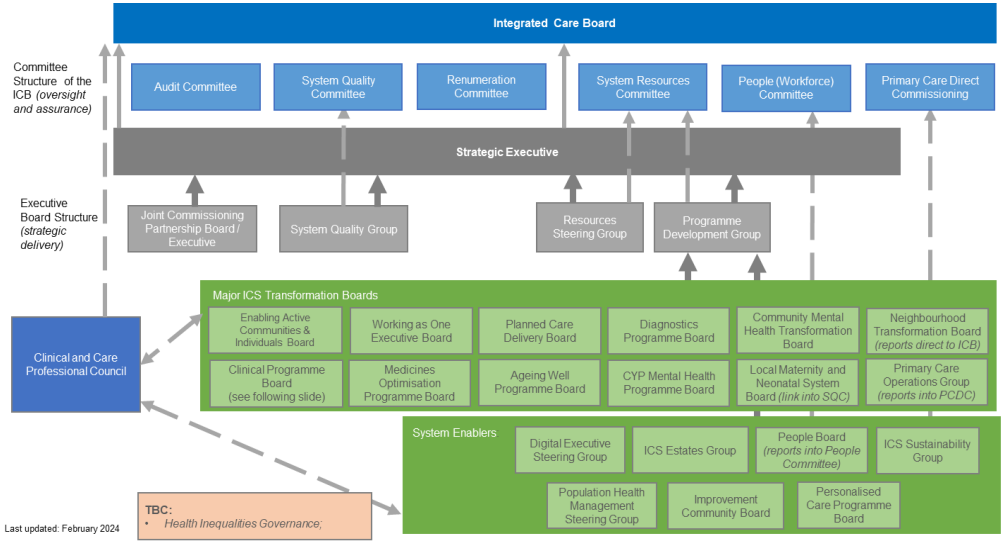
What have we done?

We have an established ICS Estates Group that is an enabler to support our Major ICS Transformation Boards. It sits alongside other infrastructure groups (Digital, People and Sustainability) and reports to the Programme Development Group and Strategic Executive. It is the ICS Estates Group's responsibility to oversee and deliver this Strategy and to ensure that we pursue our Objectives in accordance with our Vision and Principles. Through these routes, our ICS partner organisations hold each other to account for the elements of this strategy for which they are responsible.

What are we doing next?

Our ICS Estates Group provides the strategic leadership, oversight and governance to support and ensure the implementation of this Strategy. We will continue to work together to deliver this Strategy and implement our Delivery Plan, including reviewing and managing utilisations, potential disposals and acquisitions, investments, lease events and infrastructure risks across ICS partners.

NHS Gloucestershire **Integrated Care Board** – Transformation Programme Structure



Measure	Where are we?	Where do we want to be?
Implementation of our Strategy and Delivery Plan	This document sets out our Strategy, including our Vision and Principles. We have also developed a Delivery Plan that we are working towards	Our Strategy is implemented through our Delivery Plan and we have realised the benefits that we have identified through this Strategy

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Principle 7: WIDER VALUE

Why is this important?

We recognise that our ICS partners are anchor organisations in Gloucestershire, with Gloucestershire Hospitals NHS FT being the largest employer in the area. Our NHS institutions make a significant contribution to the local economy and Gloucestershire's Economic Strategy will support people's health and wellbeing. The NHS forms a critical part of Gloucestershire's community. There is increasing evidence that NHS organisations, as anchor institutions, can make a meaningful impact on the long-term health of their communities. The NHS acts as an anchor in the number of jobs it creates and in its support for the health and wellbeing of its staff.

What have we done?

We have been working to together to support the development of Gloucestershire Council's Economic Strategy and to explore opportunities for the sharing of space and other initiatives through the One Public Estate forum. We are also working with our local planning authority partners to develop a shared understanding of the planned growth across Gloucestershire and the infrastructure requirements to support that growth.

What are we doing next?

We will support the Council's Economic Strategy by establishing a new business group focused specifically on the Health and Social Care sector. This will help us to develop the role of our ICS partners as anchor institutions in Gloucestershire and to realise the wider value that the NHS contributes to Gloucestershire.

3. THE FUTURE VOICE OF BUSINESS		
REF	STRATEGIC ACTIONS	EXPLANATION
BIS – 3.4	Establish a Health and Social Care business sector group.	To establish a new Health and Social Care group to address some of the current challenges the sector is experiencing with an ever-increasing ageing population.

Measure	Where are we?	Where do we want to be?
We have established a new business group focused specifically on the Health and Social Care sector to support GCC's Economic Strategy	Our ICS partners have been working with local authority partners through the One Public Estate initiative	Our ICS partners participate in a new business group that is focused on Health and Social Care
Local authority Development Plans incorporate policies to facilitate the development of healthcare infrastructure and services to facilitate growth	We are working with our local authority partners as they development their Development Plans for Gloucestershire	Our local authority partners' Development plans incorporate policies to facilitate the development of healthcare infrastructure and services and the disposal of surplus estate

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Principle 8: WORKFORCE

Why is this important?

Our estates and facilities management (E&FM) workforce across Gloucestershire exceeds 1,200 people. A skilled and confident workforce is vital to enabling us to maintain and develop our estate and transforming what we do. It's vital that we retain our existing workforce and attract the best talent to join us. We think that by working together across our ICS, our partners we will better be able to retain and recruit our E&FM workforce.

What have we done?

Our People Strategy provides the opportunity to build on our established joint working and to set the roadmap and actions to support the retention and recruitment of a skilled and sustainable E&FM workforce. Our Integrated Care Strategy highlights that our workforce is key to transforming what we do and sets out our ambition to create One Workforce for Gloucestershire.

What are we doing next?

We will bring forward specific proposals for our E&FM workforce as part of our work to develop One Workforce for Gloucestershire to ensure that we have a skilled and confident workforce.

There are **c. 18,000** people working in the NHS in Gloucestershire (**over 50,000** when we include the people who work in social care, voluntary, community and social enterprise organisations).

Measure	Where are we?	Where do we want to be?
We have specific proposals for our E&FM workforce as part of our One Workforce for Gloucestershire.	We have developed our People Strategy and set out our ambition for One Workforce for Gloucestershire in our Integrated Care Strategy.	By the end of 2030, our strategy for the E&FM workforce will be established as part of our People Strategy and our move to One Workforce for Gloucestershire

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Key Risks and Mitigations

Principle	Risk	Mitigation
Quality	• we do not have sufficient capital to address backlog maintenance and compliance within our estate that results in service disruption and a poor quality environment	• we prioritise capital expenditure in our existing core estate
Usership	• we waste resources by not making the best use of our estate and the wider public estate	• we need to better understand the use of our estate, have a greater awareness of the wider public estate and develop solutions to enable us to share our estate
Greener	• we do not have sufficient capital and other resources to meet our Net Zero Carbon obligations • electricity supply capacity is inadequate	• we ensure that we identify all opportunities to secure external funding • we work with electricity suppliers to communicate our requirements
Cost Efficient	• we fail to review and benchmark our infrastructure running costs • we do not use our infrastructure efficiently and effectively • we retain infrastructure that we no longer need	• regular review of infrastructure running costs within and beyond the ICS via Model Hospital etc • we better understand the utilisation of our estate and enable the sharing of our estate • we focus on opportunities to dispose of our “tail” estate
New Infrastructure	• we are unable to afford investment to refurbish our existing estate and develop new infrastructure to enable us to transform our services	• we ensure that we are making the most of our existing estate • we seek external sources of funding, including s106 and CIL • we vacate (and sell freehold) estate that we no longer need
Governance	• we fail to work collectively as an ICS	• we refresh our Strategic Estates Group and associated governance
Wider value	• we fail to recognise the scale and impact of our infrastructure and its economic and social value	• ICS partners and other stakeholders work to ensure that our infrastructure supports our wider social and economic goals
Workforce	• our People Strategy does not focus on our E&FM workforce	• we develop an E&FM workforce strategy for One Gloucestershire

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Agenda Item 14

NHS Gloucestershire ICB Public Board Meeting

Wednesday 28th May 2025

Report Title	**System Resource Committee – updated Terms of Reference**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
					X	
Route to this meeting	System Resources Committee – 2nd May 2024					
Executive Summary and Key Issues	System Resource Committee TOR have been very slightly updated as per a review from the Committee. There have been two additions found in page 7 which reference specialised commissioning and health inequalities.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Without ToR ICB Board sub-committees would be unclear under what terms the committee operates, its jurisdiction and powers would not be defined and could lead to committees assuming powers they do not have and making inappropriate decisions. Add a risk rating, even if low: (4x1) 4 (4x1) 4 (residual meaning accepted risk)					
Management of Conflicts of Interest	The changes have been considered by members of the committee and supported. It is the Board's decision whether to approve the changes to the ToR. No conflicts of interests have been declared or identified.					
Resource Impact (X)	**Financial**		**Information Management & Technology**			
	Human Resource		**Buildings**			
Financial Impact	The Committee will provide oversight and assurance to the Board in relation to efficiency, outcomes and value for money in the use of resources and oversee and recommend proposals to allocate resources where appropriate across ICS partners to address finance and performance related issues that may arise					
Regulatory and Legal Issues (including NHS Constitution)	The System Resource Committee will obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice as authorised by the ICB Board.					
Impact on Health Inequalities	As detailed in the ToR					
Impact on Equality and Diversity	Not referenced in the ToR					

Impact on Sustainable Development	Not referenced in the ToR		
Patient and Public Involvement	N/A		
Recommendation	The Board is requested to: • Approve the updated System Resource TOR		
Author	**Ryan Brunsdon**	**Role Title**	**Governance Manager**
Sponsoring Director (if not author)	**Tracey Cox , Director of People Culture & Engagement**		

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

NHS GLOUCESTERSHIRE
INTEGRATED CARE BOARD

SYSTEM RESOURCES COMMITTEE

Version	Author	Approved by	Review	Type of changes
V1.0		Integrated Care Board	Annually	Approved Terms of Reference
V1.1	Ryan Brunsdon / Mark Golledge		Reviewed by System Resources Committee on 07.3.2024	Clarified the aims of the System Resources Committee Clarified the role of the Committee regarding the NHS Oversight Framework Highlighted that the Committee business would take place in two parts to make effective use of time of partners Clarified definitions including definition of value-based decision making Ensured that digital is within the remit of this Committee
V2.0	System Resources Committee	Integrated Care Board – 29/05/2024	Final Terms of Reference reviewed by System Resources Committee on 02.5.2024	

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1. Introduction

1.1. The System Resource Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution. These Terms of Reference (ToR), set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2. The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

2.1. NHS England outlined the role of the ICS in the delivery of integrated care in the paper 'Integrating care: Next steps to building strong and effective integrated care systems across England'. The ICS's role is to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money;
- helping the NHS to support broader social and economic development.

2.2. Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility.

- Each Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions.
- Each Committee will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members.

2.3. The overall purpose of System Resources Committee is to support the ICB to ensure that the system delivers value in health and care. This means '*achieving our priority outcomes through the most effective use of the resources available to us'*.

2.4. Achieving our priority outcomes means:

- Achieving health and wellbeing outcomes for our population
- Achieving outcomes for people that use our services, and
- Ensuring we improve health equity across specific population groups (in service access and experience as well as health and wellbeing outcomes).

2.5. In order to fulfil this function, the Committee will provide oversight and assurance for matters relating to system resources allocation, performance against strategic plans and financial performance including:

- Delivery of population health and wellbeing outcomes and service performance
- Impact of outcomes and performance on specific groups of the population.
- Efficiency, productivity and value for money in how the outcomes and performance are being delivered across the system.
- Financial performance both of the ICB and of NHS organisations within the ICB footprint including understanding how and where we spend our money.

2.6. Specific areas the Committee may consider that enable delivery of these objectives includes:

2.6.1. Improving population health and healthcare: by ensuring that resources are prioritised to support:

- improvement in health outcomes;
- increased efficiency and value for money of the delivery of healthcare across the ICS.

2.6.2. Tackling unequal outcomes and access: by ensuring that resources are prioritised to support:

- reducing health inequalities;
- increasing social justice and health equity.

2.6.3. Enhancing productivity and value for money: by ensuring that resources are prioritised to support:

- the system to take an approach that assesses value in decision making across organisations and programmes of care;
- delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches.

2.6.4. Helping the NHS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership.

2.7. In support of these functions, the specific areas for the Committee to consider are outlined within the Appendix to these Terms of Reference.

2.8. The Committee will have for oversight for Gloucestershire's performance within the NHS System Oversight Framework which is the NHS England framework for oversight of Integrated Care Boards and Partner Trusts.

2.9. The current Oversight Framework places ICBs and Partner Trusts into one of four segments based on overall performance. The Committee will pay particular attention to performance within the oversight themes relating to performance/outcomes and finance and use of resources.

2.10. Should NHS Gloucestershire ICB be placed into "Segment 1" (highest performing) or "Segment 4" (Recovery Support Programme) the Committee will be responsible for overseeing the response. For Segment 1 this will include identifying exploring opportunities from 'earned autonomy'. For Segment 4 this will include oversight of contributory work within the NHS England Recovery Support Programme.

2.11. The Committee will approve policies and standard operating procedures (SOPs) as relevant to the committee's business.

3. Delegated Authority

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

3.2. The System Resource Committee is authorised by the Board to:

3.2.1. Investigate any activity within its terms of reference;

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

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

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

3.2.5. Establish mechanisms to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the

membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3.2.6. Ensure NHSE requirements regarding Specialised Commissioning are followed and continue with Board's support of the delegation of Specialised Commissioning under the Principal Commissioner operating model

3.2.7. Seek regular updates and assurance with regards to Health Inequalities and population management to allow for challenge and direct specific work where required.

3.3. For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

4. Membership

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

4.2. The Committee will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

4.3. The Board will appoint no fewer than five members of the Committee including:

- Independent Non-Executive Director of the ICB who leads on Resources (Chair);
- A Non-Executive Director who ideally holds a finance qualification – this could be a co-opted member from one of the ICS Partner Boards (Vice Chair);
- Chief Executive Officer of the ICB;
- Chief Financial Officer of the ICB;
- Director of Strategy and Transformation of the ICB;
- Director of Operational Planning and Performance of the ICB.
- A Non-Executive Director, who ideally holds a finance qualification, in an ex-officio role to provide a finance input.

4.4. Members will possess between them knowledge, skills and experience in accounting; risk management; strategic and financial planning; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.5. Chair and vice chair

4.5.1. In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Director of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.5.2. The Chair of the Committee shall be independent and therefore may not chair any other committees.

4.5.3. Committee members may appoint a Vice Chair who will be a Non-Executive Director who ideally would hold a finance qualification – this could be a committee member co-opted from one of the ICS Partner Boards.

4.5.4. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.6. Attendees and other Participants

4.6.1. Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by other invited and appropriately nominated individuals who are not members of the Committee.

4.6.2. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the health and wellbeing board(s), secondary, mental health and community providers, notably:

- Directors of Finance of each main health system Provider partner (Community & Mental Health; Acute);
- Directors of Strategy of each main health system Provider partner (Community & Mental Health; Acute);
- Director of Finance and Director of Strategy of the Local Authority; notably as required for specific agenda items.
- One Independent Non-Executive Director of each main system partner (Community & Mental Health; Acute; Local Authority), who chairs their equivalent committee responsible for the allocation and utilisation of financial and other material resources.
- Primary Care

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

4.6.4. The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

4.7. Attendance

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

4.8. Structure

4.8.1. The business of the Committee shall consist of two sections:

Partnership Section – this will focus on areas of shared interest across system partners including matters relating to resource allocation (including financial – revenue and capital) and performance.

ICB Section – this will focus on areas of relevance for the ICB and will also include standing performance and financial updates.

4.8.2. This approach will also ensure that meetings are designed to make optimal use of partner time. Where possible, partners will be notified in advance of agenda items that would benefit from their involvement and engagement.

5. Quoracy

5.1. Quoracy is defined as a minimum of 50% of the Committee's core membership which must include the Chair or Vice-Chair or their nominated deputy.

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

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

6. Voting and decision-making

6.1. Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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

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

communication. Where any such action has been taken between meetings, then these will be reported to the next meeting. For the avoidance of doubt, this provision applies to and facilitates the Committee's decision making by email, should this be required to expedite an urgent decision.

7. Frequency and notice of meetings

7.1. The System Resource Committee will meet at least 6 times a year. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2. The Board, Chair or Chief Executive may ask the System Resource Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

8. Committee secretariat

8.1. The Committee shall be supported with a secretariat function which will include ensuring that:

8.1.1. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

8.1.2. Attendance of those invited to each meeting is monitored and those that do not meet the minimum attendance requirements are highlighting to the Chair.

8.1.3. Except in the event of urgent meetings, meetings (including date and time) will be scheduled a year in advance. Meetings will usually be held as a hybrid meeting (both virtual and in-person).

8.1.4. The agenda and supporting papers will be issued 5 working days before the meeting. There may be occasions where there is a need for papers to be issued later (e.g. during operational planning) but this will be the exception rather than the norm.

8.1.5. All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. This will be in addition to the formal declaration of interest log.

8.1.6. Good quality minutes are taken in accordance with the standing orders and agreed with the chair so that a record is kept of matters arising, action points and issues carried forward;

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

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

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

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

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

9.2. The Committee will have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the System Resources Committee.

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

9.4. The Committee will work closely with the other committees in the ICB where appropriate and relevant e.g. implementation of the Internal Audit recommendations and receive assurances to the Audit Committee.

9.5. The Committee will work closely with the other finance/resource committees in the ICS where appropriate and relevant to ensure consistency in best practice and appropriate transparency in the oversight, monitoring and probity of the use of public resources.

9.6. The Committee will investigate identified areas of concern with regard to the ICB's internal controls referred by another committee or the Board of the ICB.

10. Policy and best practice

10.1. When considering matters, the Committee should take into account the following points:

10.1.1. All statutory requirements applicable to ICBs (including Accounting, Health and Safety, Information Security, etc.);

10.1.2. NHS England requirements and standards;

10.1.3. Best professional practice and standards;

10.1.4. NHS Best practice and guidance;

10.1.5. Emerging risks and issues.

10.2. The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its terms of reference and within a limit determined by the Chief Finance Officer.

11. Monitoring and Reporting

11.1. When considering matters, the Committee should take into account the following points:

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

11.1.2. The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders;

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

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

12. Conduct of the Committee

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

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

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

12.2.2. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

12.3. Equality and diversity

12.3.1. Members must demonstrably consider the equality and diversity implications of decisions they make.

13. Review of ToR

13.1. The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

13.2. The System Resource Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

APPENDIX: Detailed remit and responsibilities of the Committee

1.1. The Committee will provide oversight and assurance to the Board in relation to:

Efficiency, Outcomes and Value for Money in the use of resources:

1.2. System Resources Allocation:

- Improve population health and healthcare delivery by ensuring that resources are prioritised to support improvement in health outcomes and increased efficiency and value for money of the delivery of healthcare across the ICS;
- Assure the approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICB strategy;
- Support the ICS objective of tackling unequal outcomes and access by ensuring that resources are prioritised to support programmes that reduce health inequalities and / or increase social justice and health equity;
- Support the ICS to support broader social and economic development, by ensuring that resources are allocated to support the strategic objectives as set out through the integrated care partnership;

1.3. Enhance Productivity and Value for Money:

- Provide leadership across the system to adopt a values-based decision making approach across organisations and programmes of care;
- Assure the delivery of enhanced efficiency, productivity and value for money through the application of rigorous management of resources, prioritisation and benefits realisation approaches to ensure financial resources are used in an efficient way to deliver the objectives of the ICB;
- to monitor the identification and delivery of system efficiencies across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged;
- to receive exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

1.4. System financial management framework

- to agree the strategic financial framework of the ICB;
- to have oversight of the ICB financial information systems and processes to be used for financial planning in line with the strategy and national guidance;

- to oversee and recommend proposals to allocate resources where appropriate across ICS partners to address finance and performance related issues that may arise;
- to consider all major and material investment/disinvestment service changes or efficiency schemes prior to submission to the Board for approval where appropriate.

1.5. Financial monitoring information

- to receive assurance on the effective monitoring of the ICB in-year financial performance against plan, with consideration of underlying activity and relevant performance data as appropriate, identifying key issues and risks requiring discussion or decision by the Board;
- to oversee and challenge the financial position and financial impacts (both short and long-term) to support decision-making;
- to be assured that all plans and reports are supported by robust activity and financial information;
- to be assured that there is robust financial and activity modelling to support the ICB priority areas;
- Provide oversight of the Financial Strategy including the medium-term financial plan (MTFP)
- to be assured there is a robust understanding of where costs sit across the system, the drivers of system cost, and the impacts of service change on costs;
- to oversee the development of an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood;
- to be assured that appropriate information is reported to manage financial issues, risks and opportunities across the ICB;
- to consider and comment on strategic risks on the corporate risk register.
- to have oversight of the financial position of ICS partners, and how this relates to the system control total to ensure that we achieve the best financial outcome for the system;
- to receive in year financial performance reports from ICS partners which are based on common approaches, estimates and judgements.

1.6. Performance

- Assure the ICB's performance against the Constitution and other Local Performance Measures.
- Assure that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

1.7. Capital

- Have oversight of the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers;
- Receive assurance that the estates plan is built into system financial plans;
- Have oversight of the digital strategy and plans that are delivered across the system;
- Assure the System capital programme and annual capital budgets against the capital envelope and consider actions that need to be taken to ensure that it is appropriately and completely used and recommend to the ICB;
- Consider proposals for investment in line with an agreed prioritisation process for the ICB and NHS partner organisations;
- Review recommendations from the capital prioritisation process and assure recommendation to the Board for approval.

NHS Gloucestershire Primary Care & Direct Commissioning Committee Meeting

Thursday 6th February 2025 - 14.00-17.00pm
Via MS Teams and Boardroom, Shire Hall

Members Present:		
Ayesha Janjua (Chair)	AJ	Non-Executive Director, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Jane Cummings	JCu	Non-Executive Director, NHS Gloucestershire ICB
Shofiqur Rahman *(deputising for Cath Leech)*	SR	Deputy Chief Finance Officer, NHS Gloucestershire ICB
Tracey Cox *(deputising for Mary Hutton)*	TC	Director People, Culture & Engagement, NHS Gloucestershire ICB
Participants Present:		
Becky Parish	BP	Associate Director Engagement and Experience, NHS Gloucestershire ICB
Carole Alloway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning, GCC
Dr Emma Crutchlow	EC	GP and Clinical Director of Inner City Gloucester PCN
Helen Edwards	HE	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Jo White	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
Dr Laura Halden	LH	GP and Clinical Chair of Gloucestershire Primary Care Training Hub
Lucy White	LW	Healthwatch Gloucestershire
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Kirsty Young	KY	Primary Care Senior Programme Manager, NHS Gloucestershire ICB
Jeanette Giles	JG	Head of Primary Care Contracting, NHS Gloucestershire ICB
Charlotte Griffiths	CG	PCN Service Development Manager, NHS Gloucestershire ICB
Andrew Hughes	AH	Associate Director of Major Projects, NHS Gloucestershire ICB
Meryl Foster	MF	Senior Programme Manager, NHS Gloucestershire ICB
Ryan Brunsdon	RB	ICB Board Secretary, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Dr Hein Le Roux *(Item 12)*	HLR	GP, Churchdown Surgery, Glos and Deputy Medical Director, NHS Gloucestershire ICB
Sharon Drewett *(Item 12)*	SD	GP, Churchdown Surgery, Glos
Rachel Merritt *(Item 12)*	RM	Strategic Business Manager, Churchdown Surgery, Glos
Clare Dilks *(Item 12)*	CD	Care Co-ordinator, Churchdown Surgery, Glos

1.	**Introduction & Welcome**	
1.1	The Chair welcomed members to the Primary Care & Direct Commissioning (PC&DC) Committee. The meeting was declared to be quorate.	
2.	**Apologies for Absence**	
2.1	Apologies were received from Mary Hutton, Marie Crofts, Cath Leech and Declan McLaughlin.	

2.2	The meeting was declared to still be quorate.	
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) Laura Halden declared an interest in being a Medical Lead for Community Hospitals and Urgent Care in Gloucestershire Health and Care NHS Foundation Trust (GHC).	
4.	**Minutes of the Previous Meeting held 5th December 2024**	
4.1	The minutes of the meeting held on 5th December 2024 were approved as an accurate record. There was an apology from Jane Cummings not having been noted, but this had now been added to the minutes by DC.	
5.	**Action Log and Matters Arising**	
5.1	**Action 36 – Digital Training for PPGs. February Update:** The December meeting of the PPG Network (13.12.24) included a focus on Digital Transformation with presentations from Peter Wathen and Kevin Gannaway-Pitts. PPGs were very keen to promote both digital and analogue choice. **Action Closed.**	
5.2	**Action 37 – Healthwatch Information. February 2025:** Information on Accessing Services Healthwatch Gloucestershire, the ICB and the LMC have come together to develop an information resource for local people to help them make the most of their GP practice. The resource is currently being shared with PPG representatives and the Healthwatch Readers Panel for testing and proofing. **Action to be Closed with further information on resource when available.**	
5.3	**Action 40 – Primary Care Issues Log. February 2025:** BP regularly attends PCOG meetings and has an opportunity to review the Issues Log and Risk Register. **Action Closed.**	
5.4	**Action 41 – Primary Care Quality metrics. February 2025:** Update at April meeting. **Action to remain Open.**	
5.5	**Action 45 – GP Premises Development. February Update:** Gap in income and needs to be decided by CEOs and CFOs. Committee wants to escalate as a future requirement which would likely be a future risk. There was no training or Integrated Neighbourhood Teams (INT) capacity. CGi said there was an Agenda Setting Meeting which could examine where this would sit. Action: CGi to take forward to Mary Hutton to discuss with Chief Execs. **Action to remain Open.**	
5.6	**Action 46 – Risk Scores on CRR for Primary Care. February 2025:** Register and scores had been re-examined and this is done regularly. **Action Closed.**	
5.7	**Action 47- Citizens Panel Feedback. February 2025:** Survey Report link shared from People's Panel with focus on Digital and Information Sharing, Virtual Wards and NHS. **Action Closed.**	
6.	**Community Pharmacy – Clinical Waste Collection Continuity Proposal**	

6.1	The proposal for consideration and recommendation for approval is, to transfer the existing provision for Clinical Waste Services for Gloucestershire's Community Pharmacy Providers, from the current contract managed by SW Collaborative Commissioning Hub (CCH) with Tradebe UK, to the ICB's similar existing contract for GP Contractors, also with Tradebe UK, with effect from 1st April 2025.	
6.2	No further information on a service provider was available around the recycling of inhalers yet. DM to look into this further. CAM raised carbon footprint and social value. CAM wanted to know where the waste was conveyed to and how it was disposed. **Action: Further information on conveyancing, disposal and recycling of waste to be reported back at the April Committee meeting.**	**DM/JW**
6.3	AR had been part of initial meetings, around the system applying for a National Institute for Health and Care Research (NIHR) grant to decarbonise the healthcare of Gloucestershire. **Action: AR to report back on decarbonisation at a future Committee meeting.**	**AR**
	Resolution*: The Committee members endorsed the decision of the Primary Care Operational Group (PCOG) to:** ***Approve Clinical Waste Re-Procurement Option 3 - to transfer the existing provision for Gloucestershire's Community Pharmacy providers from the current contract, managed by CCH with Tradebe UK, to the ICB's similar existing contract for GP contractors, also with Tradebe UK, with effect from 1st April 2025.	
7.	**Dental Items**	
7.1	***Dental - Urgent Care Proposal***	
7.1.1	HE explained that the papers 7.1 and 7.2 were directly related. The first one was seeking approval from the Committee for Gloucestershire to participate in a review of how urgent dental care and primary care was provided in the county. The proposal had come from the NHSE SW and the CCH with the recommendation was that whilst work had been done locally around the urgent care strategy through the ICB's own commissioning plan, it was felt useful to participate in the review to see if there was any learning that would be of benefit.	
7.1.2	The Chair mentioned capacity and resilience of call-handling and HE said that this had been invested in during the last financial year in terms of the provision of extra dental nurses to answer incoming calls. The Government would like to see urgent appointments increased nationally by 700k and information and more detail was awaited.	
7.1.3	BP informed that fewer complaints had been received lately and wanted to note the excellent working relationship between the Patient Advice & Liaison Service (PALS) team and the primary care Pharmacy, Optometry and Dentistry (POD) team which had demonstrated successes over the last few months. It was expected that the Health Overview and Scrutiny Committee (HOSC) would be reviewing dental appointments for young people in the near future and so it was advised to have a paper ready on that topic.	

7.1.4	The Chair asked whether the review of the helpline would have an impact on GHC. HE said this was why outcomes of the reviews had been requested before making any firm decisions. The Chair asked about a dental lead, and HE said that there would be resource available across the whole of the South West region and a Clinical Lead employed for two days a week for the ICB.	
	Resolution*: The Committee members:** ***i. Supported the funding of Clinical Capacity across the South West and agreed to dedicate to review clinical pathways for both UDC and Helplines; ***ii. Supported the review and committed to considering the outputs of the review work with regards to the commissioning of both services;*** ***iii. Committed to implementing suggested improvements for the benefit of patients;*** ***iv. Committed to the ambition of having a South West approach on both UDC and potentially Helpline provision.***	
7.2	***Dental - Review of South-West Dental Helplines (by ICB)***	
7.2.1	Committee members had read the paper circulated prior to the meeting held. The proposed review of the Dental Helplines would run simultaneously with the Urgent Dental Care Review (Item 7.1) and Future Plan provision. It was recommended that the ICB took part in this review. PCOG noted that the Valued Added Tax (VAT) implications were not fully understood and there would be an outcome of the review. There was an extensive conversation around patient consultation/discussion, and it was agreed that further details regarding the helpline and the overall review would be shared.	
	Resolution*: The Committee agreed and understood the following:** **i.** ***To review provision with ICB engagement and agreed a plan for immediate and long term that was consistent with PSR rules. ***ii. This work should run simultaneously with Urgent Care Review and Future Plan provision.*** ***iii. Understood VAT implications across services.*** ***iv. Agreed to develop a Task and Finish Group with dedicated clinical input into the review to identify gaps and any required pathway improvements, recognising local needs which may require a nuanced approach.*** ***v. That there was an ambition to achieve standardised processes across the SW Region but recognising local needs may require a nuanced approach.*** ***vi. That the ICB strengthen data and contract monitoring.*** ***vii. That the ICB promote greater collaboration between patients, Helpline Service providers and Dental Service providers.***	
7.3	***Contracting and Funding Methodology for Urgent Dental Care Services***	

7.3.1	The paper explained that Dental Urgent Care Services Contracts were limited from Gloucestershire Providers. Provider Selection Regime (PSR) procurement regulations could restrict the extent of an existing NHS contractor, increasing their current contract value or activity.	
	Resolution: The Committee members approved the recommendation of PCOG for the implementation of the Contracting and Funding Methodology for Urgent Dental Care Services.	
8.	**Primary Care Assurance Framework Process – 2024/2025 Internal Audit Approach Proposal**	
8.1	The purpose of the paper was to set out the SW CCH proposal for a collaborative approach to POD Internal Audit Work across the seven South West ICBs in 2024/25. The proposal was based on the approach taken by NHS Bristol, North Somerset and South Gloucestershire (BNSSG) ICB. CCH believed this proposal would maximise ICB and CCH Team learning and capacity.	
8.2	CCH had put forward three options for internal audit work for SW ICBs to consider for the remainder of 2024/2025 and a collaborative process for future years. The key principles of an audit approach had been discussed and agreed at the CCH Customer Management Board.	
8.3	It was noted that this paper only related to audit processes for POD services, not Primary Medical Care. PCOG also recommended that this paper was referred to the ICB's Audit Committee and the author of the paper had duly sent this.	
	Resolution: The Committee members: ***1. Approved Option 3 (as detailed in Part 4 of the paper).*** ***2. Approved of the Intelligent Automation process for future years (as detailed in Part 5 of the paper).***	
9.	**Board Assurance Framework (BAF) and Corporate Risk Register**	
9.1	The overarching trajectory for BAF 6 was reducing, with many aspects being more nationally driven. Struggling practices continued to be a huge concern but this list had reduced further, and final contract negotiations for collective action were still awaited. The Committee members felt that this risk should be reduced the Chair agreed, saying that this would reflect the mitigated actions. There was recognition that Collective Action might affect this score in the near future.	
9.2	LH agreed that the risk of struggling practices had reduced but some practices were struggling to replace Additional Roles Reimbursement Scheme (ARRS) staff. This could impact access, continuity and affect patient safety, as well as potentially leading to problems around resilience and burn out. JW updated on other risks that had been progressing well with anything else of note to be picked up by the Chair with CGi following the meeting.	
	Resolution: The Committee members noted the updates on the BAF and Corporate Risk Register.	
10.	**General Practice Collective Action**	

10.1	Compared to many other parts of the country, the impact had not been as profound, due to the ICBs good investment and level of commitment in general practice.	
10.2	A national meeting was expected to be held and if negotiations were not accepted by GPs, further Collective Action in the future would be anticipated.	
10.3	BP asked if specific practices would be offering services around ring pessaries to individuals who were registered with them. HG said it would be up to individual practices as to whether they signed up to the primary care offer in readiness for 1st April 2025. If there was a practice that did not, then it would be up to the ICB to provide the services in a different way for that population. Patients would receive the care, but this might come from another provider.	
	***Resolution:* The Committee members noted the verbal update on General Practice Collective Action.**	
11.	**National General Practice Pilot Update**	
11.1	It was noted that this pilot would be running for two years. JW explained some of the projects which are being worked up for implementation. **Action: HG to bring a presentation on the National GP Pilot to the next Committee meeting.**	**HG**
11.2	HG noted that some PCNs were already out of space to host staff and this would become an issue. Estates had not been cited as a clear workstream.	
11.3	JCu said it had been noted that the quota of GPs was good for Gloucestershire, and she asked whether there was a way of being able to demonstrate the impact of having care-coordination that was GP led, to potentially reduce numbers of people sent to hospital and thus deliver better outcomes.	
11.4	LH informed that a recent White Paper had addressed the ARRS roles and the impact that they had had on the nursing workforce within General Practice along with concerns over productivity and efficiency around multiple appointments. See Cogora White Paper 2025 summary of key points: https://cogoramedia.com/pdf/2025/cogora-general-practice-workforce-white-paper-2025-v1.pdf	
11.5	LH said members of the Workforce Team, HG and TC would be meeting with NHSE colleagues in early March to examine the workforce and training needs, thinking about different ways of working, considering INTs, digital enablers, and Voluntary, Community and Social Enterprise (VCSE) organisations. Other system partners would be included to ensure that there was a systemwide approach. The Chair said any updates as work progressed would be welcomed by the Committee.	
11.6	HG spoke about virtual wards in the community which had been successful during Covid and if frail and elderly patients could be identified, it was thought this approach could be adopted with this cohort of patients.	
11.7	AR acknowledged the high level of risk held by General Practice and that General Practice was being asked to do more. There needed to be a dynamic assessment of where risk was held in the system as it was felt this was disproportionate in certain places and it should be shared, understood, and tackled differently. The Interface work would certainly help with this debate.	

	***Resolution*: The Committee members noted the update on the National General Practice Pilot.**	
12.	**North and South Gloucester Primary Care Network (NSG PCN) Quality Improvement (QI) Project**	
12.1	The Chair welcomed colleagues from Churchdown Surgery (North & South Gloucester PCN) who introduced themselves and presented on some of the work they had done recently on what mattered to people, specifically around Frailty and Falls Prevention, Neighbourhood Health, and Population Health Management. The team were also taking part in the NHS South West's artificial intelligence app (Brave AI), designed to predict a patient's risk of emergency admission to hospital.	
	Post meeting note – the PowerPoint slides were shared post the meeting for members of the Committee.	
12.2	The presentation demonstrated that identifying patients in the local population meant that the Practice could take a more proactive and preventative health approach, to enable people to live well for longer in their homes with many personalised and co-ordinated aspects of care and projects centred around their individual needs, using Quality Improvement (QI) monies to build on the programme of falls prevention.	
12.3	***Discussion and Information*** HG said NSG PCN had been asked to come along because the Committee wanted to see the work that the QI funding had been doing as it was clear that the QI money would only be recurrent if it was focussing on severe and moderate conditions and on inequalities. This fits well with the national direction including the national GP pilot and national interest in our local whiteboard development.	
12.4	Another key element is the work that JCu and Graham Russell are leading on, which is Integrated Neighbourhood teams (INTs) and the next phase to ensure that the multi-disciplinary teams (MDTs) and the INTs were consistent. There were variations across the County but 15 PCNs had signed up to the whiteboard approach and there was a meeting to ensure that this progressed with a consistent model. This approach would be much more proactive and would make a difference to patients in the county. Gloucestershire's locally developed Whiteboard means we are much further ahead than other areas.	
12.5	BP said she would be sending the presentation as an example of good practice locally as part of the Gloucestershire feedback to the 10 Year Plan for Health Engagement, being run by NHSE for the Government.	
12.6	The Chair thanked NSG PCN for their dedicated and inspiring work which they had demonstrated to the Committee today.	
	***Resolution*: The Committee members noted the presentation from NSG PCN.**	
13.	**Update on Integrated Neighbourhood Teams (INT) Development**	
13.1	HG advised an update had been taken to the Board in December with an ask for a consistent roll out focussing on population cohorts. A new governance structure had been approved through Board with oversight from a senior executive group and an Integrated Delivery Group. A number of themes would be discussed with	

	more to present to the Committee once the first meeting had been held which would give structure to the consistent delivery programme.	
13.2	JCu said planning guidance had given clarity around this and the next phase was keenly anticipated. LH said that PCNs had not been mentioned in the guidance, which seemed an odd omission when PCNs were the only organisations currently contracted to deliver on INTs.	
13.3	HG said INTs had to make sense to all organisations. INT working would have to be at a level where provider organisations could respond. JCu said she would examine this further and said it would be important to do what worked well for the population of Gloucestershire, despite having been given frameworks and guidance.	
	Resolution: The Committee members noted the INT Development update.	
14.	**Primary Care and Quality Highlight Report**	
14.1	• JW said that procurement was being undertaken around the Special Allocation Scheme (SAS). • Finance training was coming to an end which had been well received. An evaluation was under way which would be shared. • Negotiations continued around local contracts.	
14.2	JCu pointed out that on Page 60 (Issue Log) was not dated and some of the actions had occurred some time ago and it would have been useful to have had a timeline to make this easier. Page 73 (PCN levels) did not give details about variation across Gloucestershire averages and whether there might be particular practices who were not giving such good experiences or delivering as well as others.	
14.3	JW said the Issues Log would be updated and would also be dated. Regarding variances in practices, HG said HLR and AR were very experienced in visiting practices and having clinical conversations with them, resulting in them having made huge improvements when they had often been unaware that they had been outliers. JW said phone calls to practices were made on a regular basis to see how things were going and often a drop in service was due to staff sickness or recruitment issues.	
14.4	After discussion, it was decided that this information could go to PCOG and a summary could be brought to the Committee around progress, impact, learning and improving, but this would need to be anonymised.	
14.5	The Chair queried the recent boundary review, which would first go to PCOG with the recommendation coming to the Committee. HG had been encouraged around the number of practices that wanted to expand in the county.	
	Resolution: The Committee members noted the information on the Primary Care Highlight Report.	
15.	**Primary Care and Quality Performance Report**	
15.1	HE updated on Dental Units of Oral Activity. This was listed as 42% in October 2024 for Gloucestershire. There had been an issue with the system and the actual figure was December 2024 had been 81%.	

15.2	There was a conversation about blood pressure figures being low, but it was thought that this was due to community pharmacies not having the uptake of people visiting them to have their blood pressures taken. HG would follow this up.	
	***Resolution*: The Committee members noted the information on the Primary Care and Quality Performance Report.**	
16.	**Finance Report – Month 8 for 2024/2025**	
16.1	• At the end of the November 2024 the ICB's Delegated Primary Medical Care co-commissioning budgets were showing a £0.066m underspend position on £88.341m year to date budget. • The Month 8 forecast position was breakeven on a total budget of £131.489m. • The Month 8 POD position was £0.655m underspent on a £36.617m£0.5 year to date budget, and a year-end £0.503m underspent position on a £54.609m total budget.	
16.2	LH raised Service Development Funding (SDF) and said that ringfencing had been lost a year ago for SDF for primary care. The new planning guidance said that the ringfencing for SDF as a whole would now be lost within the system and LH wanted to flag this as a potential risk for primary care investment.	
16.3	SR said there would be specific elements that would be ringfenced which would be part of the baseline and there were other elements yet to be determined. Once clear guidance had been received, SH would summarise that and share with the Committee. **Action: SR to bring back a summary on SDF and the implications of the planning guidance on POD to a future meeting.**	**SR**
	***Resolution*: The Committee members noted the update on the Finance Report.**	
17.	**PCOG Minutes from 14th January 2024**	
17.1	Minutes had been received on the day of the Committee. JW reported that there had been a very full agenda which had been handled extremely well and had contributed to the interesting meeting. There was nothing extra to note from the meeting.	
	***Resolution*: The Committee members noted the update on the PCOG minutes from 14th January 2025.**	
18.	**Any Other Business or Items of Escalation**	
18.1	The Terms of Reference were approved by the ICB Board in May 2024. Therefore, these would be coming to the Committee in April 2025 for the yearly review, and if any changes were needed, they would go to Board for approval in May 2025.	
18.2	CAM gave her apologies for the next PCDC meeting in April 2025 due to other commitments.	
18.3	EC said that there was no Community Diabetes Consultant at the moment and asked how she should raise this. **Action: AR to follow up recruitment of Community Diabetes Consultant and update a future Committee meeting. Date to be confirmed.**	**AR**

18.4	AH informed that the new Minchinhampton Surgery would be opening for patients and there would be a formal opening on 3rd March 2025. MH would be representing the ICB.	
	The meeting formally closed at 16.55 hrs.	
	Date and Time of next meeting: Thursday 3rd April 2025, 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)

NHS Gloucestershire System Quality Committee Meeting

Wednesday 5th February 2025, 2.00–4.30pm
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
Emily White	EW	Director, Quality Performance and Strategy, GCC
Hannah Williams	HW	Deputy Director of Nursing, Therapy and Quality, GHC
Jan Marriott	JM	Non-Executive Director, GHC
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marie Crofts	MC	Executive Nurse & Director for Quality, GICB
Matt Holdaway	MHo	Director of Quality and Chief Nurse, GHFT
Nicola Hazle	NH	Director of Nursing, Therapies and Quality, GHC
Suzie Cro	SC	Deputy Director of Quality Programme, Director Nursing and Midwifery Excellence, GHFT
Participants Present:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Katie Hopgood	KH	Consultant in Public Health, GCC
Mel Munday	MM	Associate Director Integrated Safeguarding, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Sarah Morton	SM	Chief Allied Health Professional, GICB
Christina Gradowski	CGi	Associate Director of Corporate Affairs, GICB
In Attendance:		
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Kerry Rogers	KR	Director of Integrated Governance, GHNHSFT
Ryan Brunsdon	RB	Governance Manager & Board Secretary, GICB
Simon Burchfield *(Item 8)*	SB	Divisional Director of Operations – Surgery, GHNHSFT
Andrew Bruce *(Item 9)*	AB	Head of EPRR, NHS Gloucestershire GICB
Christian Hamilton *(Item 12)*	CH	Associate Director of Elective Care, GICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the meeting. The meeting was confirmed to be quorate.

2. Apologies for Absence

2.1 Apologies were received from Sarah Scott (SS), Siobhan Farmer (SF), Trudi Pigott (TP), Julie Symonds (JS) and Becky Parish (BP).

3. Declarations of Interest

3.1 The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk).

There were no new Declarations of Interest to note for this meeting.

4. Minutes of the last meeting held Wednesday 4th December 2024

4.1 The minutes from the last meeting held on 4th December 2024 were approved as an accurate record with the exception of the job title of Sarah Morton being incorrect and which was corrected in those minutes following the meeting.

5. Matters Arising & Action Log

5.1.1 **Action 56 - Health Inequalities. February Update:** The Health Inequalities framework had been approved by the Board last week. Health Inequalities would be managed in future by the System Resources Committee. It was felt that it would be good for this to be dealt with by System Resources, with clinical involvement, which would need to be requested, due to clinical risk and safety issues around performance data and management. **Action to be Closed.**

5.1.2 **Action 78 – Care Home Data. February Update:** JSo would like to better understand the processes and controls around the care market. Collation of information will better inform the risks on the Risk Register. JSo would also like to discuss this at the March Audit Committee. **Action: EW to speak to BL and SS around presenting on Care Homes: Data, Risk, Quality of Care Priorities and Assurances at the April meeting.**

5.1.3 **Action 83 – Pharmacy Manufacturing Unit. February Update:** Latest inspection of pharmacy manufacturing took place on 15 January and the report is due in 6-8 weeks after this. An update will be included in the assurance report for February with the report being shared for the April meeting. **Action to remain Open.**

5.1.4 **Action 88 - Out of County Children's placements. February Update: This** matter is unresolved. Responses awaited from Jill Crook, Ann James and Mark Cooke. **Action to remain Open.**

5.1.5 **Action 89 - Special Allocations Service (SAS) February Update:** GHC will continue to provide the service. Concerns regarding flow of patients through the service remain and further information is included in the primary care report. **Action to be Closed.**

5.1.6 **Action 92 - ADHD and Autism Risk. February Update:** This will be planned for the April meeting. **Action to remain Open.**

5.1.7 **Action 93 – ICB Collaborative Falls Training. February Update:** Jane Haros is to co-ordinate this. Any further work and updates could be brought back if required but, in the meantime, it was agreed to close the action. **Action to be Closed.**

5.1.8 **Action 94 – PCREF Progress. February Update:** This has now evolved into a steering group structure with comprehensive input from NH. **Action to be Closed.**

5.1.9 **Action 95 – Migrant Health. February Update**: Update to be provided in April 2025. **Action to remain Open.**

5.1.10 **Action 96 – Quality Assurance Framework (QAF) for Older People's Services. February Update:** This has been forward planned for the April Committee. **Action to remain Open.**

5.1.11 **Action 97 - CQC Adult Social Care Inspection. February Update:** Verbal update given in February meeting and Report shared. **Action to be Closed.**

5.1.12 **Action 98 – Breast Screening Services. February Update:** On agenda for today. **Action to be Closed.**

5.1.13 **Action 99 - Section 140 Policy. February Update:** KG had spoken to Sarah Branton. Further discussions are to take place with GHC, and a decision will be made at Executive level around sign off. An update will come to the June meeting. **Action to remain Open.**

5.1.14 **Action 100 – Risk Score for Purchase of Equipment. February Update:** This is being followed up with an update coming to the next meeting. **Action to remain Open.**

5.1.15 **Action 101 - Delay Related Harm Report. February Update:** Due to data being refreshed, this will be provided at the April meeting. **Action to remain Open.**

5.1.16 **Action 102 - Pressure Ulcers. February Update:** This update is to be provided in April. **Action to remain Open.**

5.1.17 **Action 103 – Pressure Ulcers – Representation at IPC meetings. February Update:** Brenda Yearwood is on the invite list for attendance for the IPC Management Group. **Action to be Closed.**

5.1.18 **Action 104 – Circulation of BDO Audit Report. February Update:** Action completed. **Action to be Closed.**

6. Corporate Risk Register (CRR) and Board Assurance Framework (BAF) Updates

6.1 CGi stated that the annual assurance process would now reflect a more positive rating following the work undertaken on Emergency Preparedness, Resilience and Response (EPRR) by Andy Bruce, which was currently still at a score of at 12 as the BAF had been updated prior to Andy's work.

6.2 The Committee had a total of 23 assigned corporate risks with a score of 12+. This was an increase of 1 since the previous report. Changes to the BAF had been made in red and a refresh would be made before going to the Board.

6.3 JCu was unaware around any named support from GHFT on the Integrated Neighbourhood Transformation group. Kevin McNamara (KM) had expressed GHFT to be included along with Gloucestershire County Council (GCC) to ensure full integration. MHo offered to liaise with JCu over this.

6.4 JSo stated there had been feedback from various meetings about the risk mitigations having little or no effect on reducing the risk scores, especially around some of the higher rated or older risks. This would be examined by the Audit Committee again in March from an overall perspective to address the "so what" question through the reporting in order to give that assurance to the Board. There was a conversation about the circulation sequencing of the BAF and the narrative around the risks and assurance which would warrant further debate at the next Audit Committee.

6.5 RB reported that a timeline report was run which would go to the Audit Committee which contained all the risks dating back from 2019. This would enable an in depth examination and it could be that the Audit Committee might wish to review specific risks which fed into this Committee. MCr stated that the monthly internal Quality and Clinical Governance meeting examined those risks that were aligned to this Committee to which JSo's input was welcome.

Resolution: The Committee noted the content of the Risk Report and BAF update.

7. System Partner Highlight Assurance Reports

7.1 *GHFT Exception Reporting including Maternity*

7.1.1 MHo updated the Committee:

- Gloucestershire's Admiral Nurse, Asma Pandor, had been awarded the British Empire Medal for having demonstrated significant efforts for patients and families living with dementia. The Chair requested that formal congratulations and thanks be conveyed on behalf of the Committee to Asma for this extremely well deserved achievement.
- The overall Trust rating from the Care Quality Commission (CQC) remained as 'Requires Improvement,' along with Cheltenham General Hospital (CGH) and the Stroud site. Gloucestershire Royal Hospital (GRH) remained as 'Good.' Two previous CQC Service Inspection reports would be reported through to the Committee in due course.
- The overall Friends and Family Test (FFT) score had decreased from 92.8% in November to 92.2% in December, due to a decrease in scores for three care types; Outpatient, Maternity and ED for which monitoring would continue.
- The PALS team had improved this month's position with a 5% increase to 75% for numbers of concerns closed within five working days, which was on target and had been down to staff shortages and sickness.
- A Quality Improvement (QI) project was underway to embed a new Complaints Standard Operating Procedure (SOP) within the Trust to clear the large backlog in some areas.

7.1.2 MCr highlighted that there could be potential missed opportunities for early resolution to some of the complaints due to these being backlogged and thought there may be some value in liaising with Gloucester Health & Care NHS Foundation Trust (GHC) colleagues. SC explained that the two acute teams worked closely together, with anything resolvable being transferred from the Complaints to the PALS team.

7.1.3 MHo stated that divisions and clinicians needed to own relevant complaints. This would be the first step of changes on how quality of governance occurred within the acute trust. **Action: MHo would update a future Committee meeting, of the trust's new quality governance transformation work which would enable complaints to be dealt with in divisions and by clinicians, with appropriate Corporate support. Date to be confirmed.** **MHo**

7.1.4 HW informed that GHC had been in the same position as that of GHFT, with her organisation having completed a successful cultural and process change piece of work on complaints. GHFT was now following this process, with HW indicating willingness to liaise with GHFT colleagues. MCr was pleased to note that this work was being done and was keen to know what the projected timelines would be.

7.1.5 MCr was concerned that hospital cancellations had been flagged in December and asked whether this might be incorporated into a dashboard arrangement, similar to that of some of the other specialties. MCr also asked that Craig Bradley be thanked for the impressive work that he had undertaken on agency staff, which had been much appreciated.

7.1.6 AH had noted the number of pending histology reports and queried the current position. SC informed that this had involved dermatology, with medicine having reported it on their Key Issues and Assurance Report (KIAR). This had now been placed on the Risk Register and reported to the trust's Safety Panel, who would be arranging a Quality Summit to examine next steps. Further information would follow at the April Committee.
Action: SC/MHo to update the April Committee on the histology backlog. **MHo/SC**

7.1.7 AR drew the Committee's attention to a recent issue regarding raised diabetic haemoglobin A1C (HbA1c) test results. AR said he would like to see a brief summary of what had happened, what the position was and how this had impacted patient care, for a future meeting. MHo said he could look at this and report back. **Action: MHo to bring a report on recent diabetic HbA1c testing issues for the next Committee meeting.** **MHo**

7.2 *GHC Exception Reporting*

7.2.1 NH updated:

- Work was ongoing at GHC around integrated performance reporting, which would lead to improved reporting over time.
- Safeguarding Performance – training, supervision and the development of guidance and shared learning had been taking shape.
- There had been no new patient safety incidents in December but three After Action reviews had been completed.
- Reporting around the Integrated Urgent Care (IUC) service had started, and it was positive to see data coming through.
- Incidents had been reported from Minor Injury and Illness Units (MIIUs) in relation to the pathway from the IUC and the wider service. All incidents where harm was unknown and suspected would go through and end to end pathway review with input from clinical leads in the service.
- Rapid Tranquilisation December numbers for patients at Wotton Lawn, would be reviewed and the GHC's Quality Committee had made a request for a further briefing on this, which would be coming to their March meeting.
- There was a continuing focus on Open and Outstanding Incident data, working with operational colleagues around good governance.
- 33 formal complaints had been received in December, of which 19 related to the new IUC service. GHC was confident that this reflected the mobilisation period with additional support having been placed around the building of reporting lines.
- The Learning from Deaths report had indicated that none of the patient deaths reviewed during Quarter 2 in 2024-2025, had been judged more likely than *not* to have been due to problems in the care provided to the patient.

7.2.2 The Chair asked for a review of the new IUC service with a systemwide impact assessment relating to changes that had been implemented. HW confirmed that Eve Olivant was currently leading on this work with a focus on outcomes for patients and improved response times. AR suggested the IUC service be picked up at the Urgent and Emergency Care (UEC) Board with the quality element coming to this Committee. AR wished to place on record the phenomenal amount of work undertaken by colleagues during a difficult start. NH stated she would take this back to the team who would certainly appreciate that acknowledgement.

7.2.3 MCr recognised that Open Incidents where differing levels of harm were presented, could often be difficult to judge and manage. MCr had also noted that supervision and appraisal rates had been low. NH gave assurance that there was an active piece of work incorporating clarity and recognising the importance of management supervision already underway, with the trust's policy also under review.

7.2.4 MCr alerted NH and MHo that nationally and regionally, there appeared to be a renewed focus on the Developing Workforce Safeguards document, which would involve reporting safe staffing to the Board. MCr thought it was likely that GHC, GHFT and the wider system would be asked to sign off Equality Impact Assessments (EqIAs) around changes. This would also be discussed at the People Committee. NH responded, saying Safe Staffing work in GHC had been ongoing for around 18 months, offering to up-date MCr further should this be required.

7.2.5 SM had noticed that Page 145 of the report, referring to the Therapies Vacancy dashboard, had stated that there was a 100% vacancy rate for Occupational Therapy on Greyfriars Ward and this had been the case for over a year. Other vacancy lines had shown that recruitment had been taking place. HW said that there was a vacancy, but Exercise and Activity Practitioners had been used, and this issue was being examined as part of a wider overall review of Wotton Lawn.

7.3 *ICB Quality Reporting (Primary Care)*

7.3.1 MCr, NH and continued to discuss the flow through the Special Allocation Service (SAS). Currently there were four patients waiting for the service and the risk was currently being managed with further Review Panels planned throughout the next couple of months.

7.3.2 AH revealed that remuneration was being sought and discussed by the Finance Team and the Clinical Lead at Beachley Barracks, for staff involved, particularly for the Health Visiting team, in looking after the health of Entitled Persons (EPs).

7.3.3 NH recalled that Julie Symonds (JS) was going to work around migrant health and wondered if it would be feasible for that work to include an understanding of staff experience of working in these facilities during that time period. MCr noted the work was going to be more about intended changes occurring at Beachley. The Chair did, however, think that a future piece of work could be produced, if possible, on staff experiences to reflect the impacts on EPs and staff.

7.4 *Adult Social Care Exception Reporting*

7.4.1 The Chair referenced the timeframe for the Quality Assurance Framework for Older People, saying that it would be good at some point to understand what this looked like. EW said she would feed this into Action 96. The Chair had been pleased to see the dashboard despite data still being summarised. The ability to see across the system where pressures were, had been a useful perspective.

7.4.2 EW told the Committee that the Report for Adult Social Care had been published on Friday 31st January 2025 and as expected, it had been rated as 'Requires Improvement' which had reflected the GCC's self-assessment published last July. The transformation and leadership journey had been acknowledged over the last three years,

7.4.3 There was a long list of areas of improvements and EW acknowledged that it had been clear that the CQC needed Adult Social Care to accelerate the pace on what had already been started. Some of the changes desired in the improvement plan should be framed in the context of the wider system, so the shift to community and prevention, was the space in which Adult Social Care was best at and should excel in, and the proposed improvements would ultimately benefit the wider system as a whole. Preparation had involved a great deal of work and had drawn on resources from other areas, but there was now a framework in place to help the process in two years' time to be far less labour intensive.

7.5 *Verbal Report from System Quality Group and draft October Minutes*

7.5.1 MCr reminded members that escalations went to the SW Regional System Quality Group. There were no further queries or questions from Committee members on the minutes from the meeting held on 17th December 2024.

Resolution: The Committee noted the content of the System Partner Highlight Assurance Reports.

8. GHFT 2WW Breast Service Update

8.1 The Chair was pleased to inform that there had been great improvements in the Breast Screening service and introduced Simon Burchfield from GHFT who delivered a high level overview and update on the service.

8.2
- In September 2024, the Breast service line presented on its performance against the 93% national target 2 week wait target, which it had not been achieving since August 2023. This had been off the back of consistent achievement nearly every month prior to that.
- Despite the non-achievement of the 2 week wait target, the specialty did maintain the 62 day performance over that period due to the flexibility of the team to ensure the right patients were prioritised.
- From December 2024, performance went up to 87.6% against the 93% target and the forecast was an achievement of 86.5% in January (unvalidated position).
- Patients were being booked at Day 8 and that had been maintained. The update today was that bookings were being made at Day 7.
- The recovery, although improved, was still fragile and was currently based on locum cover of the breast radiology service which would not be sustainable until substantive posts were established. Saturday clinics would be implemented until a reduction in the backlogs had been demonstrated.

8.3 The main barriers to the service achieving the 2 week wait target, were demonstrated on slide 4 of the presentation, which had included equipment failures. Mitigations deployed explained how these had helped to deliver the required service improvements.

8.4 MCr raised the number of breaches, which SB explained were at 94 in January 2025. The reason was that a residue of breaches had been left in, which had been due to the uncertainty around the Picture Archiving and Communication System (PACS) and there was also an element of patient choice. From February forwards, this was still the trajectory based on current trends.

8.5 JSo wanted to find out more around the recruitment to the substantive posts, saying that if the adverts were expected to go out in the next month, it would probably mean that recruitment would not be complete until September/October. SB explained that there was a possibility that the locums might apply for the substantive posts, but this would have to follow due recruitment processes and procedures.

8.6 NH was interested to hear about the Saturday clinics being part of the recovery plan, querying whether this was purely part of the recovery approach or whether this was being seen as a sustainable offer in terms of access going forward. SB explained that this was currently not part of anyone's substantive job plan, and these clinics were being funded via the Cancer Alliance.

8.7 SB was clear that whilst this presentation had been around the two week wait service, the breast screening service was equally as important, being under a huge amount of pressure with the same group of staff delivering that service, which meant that not all Key Performance Indicators (KPIs) had been delivered. It was definitely a fine balance between both parts of the service in order to deliver the care to Gloucestershire residents, which was important to note.

8.8 NH queried whether screening activity had been sustained whilst achieving these improvements. SB explained that due to balancing the services, two week waits would be prioritised on the day. The service was under a QI Improvement Programme for the Breast Screening Service with an action plan in place to deliver an improved capacity to meet demand. The Committee recognised the input and commitment from the team and

thanked SB and colleagues for their efforts in the huge improvements having been made to the service.

Resolution: The Committee noted the update on the GHFT Two Week Wait Breast Service.

9. Emergency Preparedness, Resilience and Response (EPRR) Quarterly Update including EPRR Policy and Business Continuity Policy

9.1 The ICB's EPRR Policy and Business Continuity Policy had been updated as part of their annual review. The ICB was found to be non-compliant by NHS England (NHSE) in Business Continuity (BC) monitoring, evaluation and testing and therefore a great deal of work had been undertaken since that review and was reflected in the BC policy. The EPRR Manager had consulted with the Procurement Manager and Contracts Manager for the ICB in the development of the policy, and the appropriate arrangements featured within the policy.

9.2 AB informed the Committee that the policy documents had been shortened and simplified with the inclusion of flow charts and diagrams. The updated EPRR Policy included a mission statement on EPRR for the organisation and enhanced with clearer roles and responsibilities. The updated policies would improve the core standards assurance rating in 2025, moving the ICB from 'non-compliant' to 'fully compliant' against those standards.

9.3 The Chair commended on the policies saying that they had been clear and easy to read. The flow charts had also been appreciated, demonstrating alignment with providers. JSo stated that the Audit Committee would be seeking to move the current assessment for the ICB to a the more desirable 'fully compliant' position.

Resolution: The Committee approved the EPRR Policy and the Business Continuity Policy.

10. Gloucestershire Safeguarding - Quarterly Highlight Report

10.1 MM explained that quarterly reports were sent to the NHSE Regional SW England Safeguarding Team where key achievements, key challenges and priorities were requested.

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10.2
- The designated nurse for safeguarding adults had moved forward on Allegations Management work and was involved in the People in Positions of Trust Framework.
- The ICB Project Management Office (PMO) was now supporting to review the Multi-Agency Risk Assessment Conference (MARAC) information sharing process across the health system; this work would be ongoing for some months.
- The Safeguarding Team had been working with CGi on Sexual Safety Misconduct and mandatory Electronic Staff Record (ESR) training had now gone live for ICB staff.
- Katy McIntosh Named GP, retired in December, but a new named GP had been recruited and would be starting the role on 3rd March.
- The Designated Nurse for Children in Care (CiC) was retiring at the end of quarter 1 so recruitment would need to be progressed.
- The GP Primary Care Safeguarding Self-Assessment audit had been carried out with 48 returns by the deadline. The Primary Care team had been following up the remaining practices. The Safeguarding team would visit those practices that required support.
- Child Protection Medical Assessments continued to be a challenge in the safeguarding system. MCr told members that an independent paediatrician had been conducting a report with the final version now available. An implementation plan would be drawn up on how recommendations would be taken forward and embedded. Timelines and governance oversight would be worked out in due course.
- The CiC team work was ongoing with nothing further to report.

10.3 MCr requested that on sending the quarterly report to Ryan, that there should be no embedded documents contained within it.

Resolution: The Committee noted the quarterly update on Gloucestershire Safeguarding.

11. Quality Governance

11.1 *Quality Improvement Group (QIG) Updates*

11.1.1 *Summary Hospital-level Mortality Indicator (SHMI)*

AR gave an update on this topic, saying that whilst the SHMI data remained outside control levels and the impact on the 12 month rolling data was small, the monthly data revealed that in August and September 2024, the SHMI was 1.07. This much lower SHMI would pull through to the official data over the next 12 months. In-hospital deaths were relatively low at 66% compared to the England rate of 69%.

11.1.2 The main concern was around patients who died within 30 days of discharge, The aim was to try to get to the root cause. The change in the demographics within Cheltenham meant that most of the patients who were admitted to hospital were either oncology, stroke and/or a small amount of urology patients. Anyone else would go to the Gloucestershire site. Significant amounts of coding undertaken in Gloucester had significantly improved the Charlson score around co-morbidities.

11.1.3 There was a piece of work to be progressed around coding and AR offered assurance to the Committee that the Trust had conducted an internal review of deaths and so far, had not found any concerns regarding the quality of care delivered but further clarity of evidence was awaited. Region would be conducting a Mortality Insight visit in May.

11.2 *Maternity*

MCr updated by saying that two workstreams had been stepped down at the QIG to Business as Usual and it was likely that these would be followed by two more. The fortnightly meetings continued with enhanced surveillance which could be reviewed. A new Midwifery Officer had started in October/November and her views along with those of Ted Adams would be sought. MCr had spoken to KM independently and also to MHo and Mark Pietroni around the Section 31 notice. Regular senior leadership meetings around maternity matters were being set up.

11.2.1 Significant progress had been seen in all areas with detailed scrutiny and questions asked. Although screening and scanning had not initially been part of the Section 31 notice, there had been an outstanding Serious Incident (SI) from two years ago where all actions had not been completed. The senior lead for screening and scanning felt it was important to bring that to the QIG and had resulted in virtually all the actions having been closed down with good progress made on a few remaining actions.

11.2.2 There had been an increase in stillbirths and those cases were being carefully and fully examined by Amanda Pearson and other senior midwifery colleagues. Reviews would go through the governance processes. Support was also being offered to colleagues at the Maternity Service at GRH.

Resolution: The Committee noted the updates on Quality Governance.

12. Proposed Changes to ICB Commissioning Policy Review Process

12.1 CH joined the meeting to present this item, explaining the benefits of the simplified process:

- It would streamline the sign-off process for minor changes allowing simple policy changes to be implemented more quickly.
- It would avoid the need to bring minor changes to criteria to SQC, reducing the number of items of the SQC agenda allowing the committee to allocate more time to more significant issues.
- It would remove a step from the process reducing workload for policy leads.

In order to allow SQC to retain an overview of minor policy changes a section could be added to the Individual Funding Requests (IFR) annual report to update the committee on minor policy changes that had been agreed by CPRG over the past 12 months.

Resolution: The Committee:

- ***Approved the proposal to alter the commissioning policy review process so that minor policy changes could be approved by the Commissioning Policy Review Group (CPRG), whilst major changes would continue to require System Quality Committee (SQC) sign-off.***
- ***Approved the proposal to include a summary of minor changes agreed by the CPRG in the IFR annual report to ensure the SQC retained an overview of policy changes.***

13. Meeting Review, Items for Escalation to the Risk Register and Any Other Business

13.1 AR reported that there had been an incident with some diabetic needles, and it was not known at this point in time if this related to just a small batch or if there was a wider concern. HW explained that GHC's Patient Safety team had been liaising with the ICB Meds Optimisation Team as the diabetic specialist nurses had experienced some issues and the matter would be fully investigated and reported back.

Action: AR to report back to the Committee with more information on diabetic insulin needles at the next Committee meeting in April. **AR**

13.2 The Chair extended special thanks to Jan Marriott as it was her last Committee meeting. The Chair commended Jan for her support for service users, families and for those most vulnerable in the local community. Jan had offered good challenge and support during the meetings and was thanked for her contribution by the members of the Committee.

The meeting concluded at 16.30hrs.

Time and date of the next meeting:

Wednesday 23rd April 2025 – 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)

APPROVED

NHS Gloucestershire ICB System Resources Committee

Meeting Held at 2:00pm on Thursday 6th March 2025 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 Commissioning, 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
Sandra Betney	SB	Deputy Chief Executive Officer & Director of Finance, GHC
Karen Johnson	KJ	Director of Finance, GHFT
Jason Makepeace	JMa	Non-Executive Director, GHC
Rosanna James	RJ	Director of Improvement and Partnerships, GHC
Mark Golledge	MG	Programme Director- PMO & ICS Development, ICB
William Cleary-Gray	WCG	Director of Improvement and Delivery, GHFT
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon	RB	Board Secretary, ICB
Kat Doherty	KD	Senior Performance Management Lead, ICB
Tom Hewish (*Agenda Item 6*)	TH	System Operational Planning Lead, ICB
Dan Corfield (*Agenda Item 6*)	DC	Associate Director - ICS Development, ICB
Chris Buttery (*Agenda Item 11*)	CB	Finance Programme Manager, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members and others present.

2. Apologies for Absence

2.1 There were no apologies received.

2.2 The Chair confirmed that the System Resources Committee meeting was quorate.

3. Declarations of Interest

3.1 There were no declared interests received other than those presented by way of the Register.

4. Minutes of the System Resources Committee Meeting Held on 9th January 2025

4.1 Minutes of the meeting held on 9th January 2025 were approved as an accurate record of the proceedings subject to the following amendments:

1. The presence of Julie Soutter at the meeting held on 9th January 2025 should be included in the minutes.
2. The contributions made by Jaki Meekings-Davis (JMD) and Jason Makepeace (JMa) should be made clear in the minutes.

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 prioritised. Work in progress and members continue to monitor the impact of schemes. Further update required. **Item remains open.**

5.1.2 **05/09/2024, Action 41**. ICS Finance Report inc. Savings Plan System Financial Risk Share. CL stated that performance relating to the Financial Risk Share would inform monthly reports which are submitted to members for assurance. JC raised a concern that whilst the reports would be prepared on monthly basis, members are charged with providing oversight and assurance convene bi-monthly. The Finance team was addressing the process problem. **Item closed.**

5.1.3 **07/11/2024, Action 43.** System Resource Committee Workshop: Feedback and Next Steps. CL expressed a need for caution regarding the reality of resource limit impacting recommendations made in the workshop, but she explained that being creative with the resources already available would mitigate threats to programmes addressing inequality. MG stated that the issues raised in the workshop were receiving necessary attention and action. **Item remains open.**

5.1.4 **09/01/2025, Action 44.** Members recommended that the BAF 5 score be reviewed with a view to better reflect the increased risk due to failure of the mitigating actions to deliver the required impact on slippage. Actions to mitigate risk more effectively were however progressing well. **Item closed.**

5.1.5 **09/01/2025, Action 45.** ICS Data Strategy. HJ and DO were requested to take the ICS Data Strategy to the Finance and Resources Committee at GHFT. This was actioned. **Item closed.**

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5.1.6 **09/01/2025, Action 46.** Performance Report. Members requested a deep dive on RTT waiting lists. Performance team was working on this, and the outcome would be brought before members. **Item remains open.**

5.1.7 **09/01/2025, Action 47.** Performance Report. Members asked KD to liaise with Primary Care and provide greater insight on local appointment activity. KD is engaging Primary Care teams. **Item remains open.**

5.1.8 **09/01/2025, Action 48.** Financial Reconciliation/Planning. Members requested more information on financial planning. An update was brought before the Committee. **Item closed.**

6. Planning

6.1 Joint Forward Planning (JFP)

6.1.1 MG presented a draft and highlighted that the plan is refreshed/updated every year as a statutory requirement. MG outlined 10 strategic objectives in the plan as follows:

1. Strengthening prevention schemes and building resilient communities.
2. Promoting an approach centred on local health needs.
3. Providing the right care in the right place efficiently.
4. Creating a health model which addresses a person's needs during every stage of their life cycle.
5. Improving access to Health Care.
6. Creating an integrated workforce within the system for the benefit of the local community.
7. Delivering safe and sustainable health service.
8. Improving the timeliness of care and treatment.
9. Transforming care through technology and effective use of estate.
10. Creating a financially sustainable health and care system.

6.1.2 MG stated that the pressures posing a challenge to the plan largely emanated from the following:

- increase in aging population requiring more investment in long term health needs;
- lack of enough workforce equipped to tackle required health needs;
- financial resource constraints.

6.1.3 MG emphasised that the refreshed plan was a collective local partnership effort and clarified that the refreshed draft plan would go before the partners' Boards and the Health & Wellbeing Board. WCG confirmed that Gloucestershire Hospitals NHS Foundation Trust (GHFT) had received the draft and added its views. WCG commended the partnership's reflection on plans particularly the provision of re-alignment of operational plans with long term plans and optimal utilisation of resources. WCG highlighted that the above-

mentioned strategic objectives were delivered through a set of portfolios designed to minimise duplication of workstreams.

6.2 Operational Planning – Headline Submission Overview

6.2.1 TH delivered the report and stated that this was a two-part submission and Board Assurance was sought from the partnership Boards. TH explained that the first part was submitted on 27th February 2025 and feedback on the submission had been received, and the second submission was scheduled for 27th March 2025. TH stated that maintaining an equilibrium between financial discipline and quality delivery of service was becoming increasingly challenging.

6.2.2 TH outlined the metrics employed in the Headline Submission and highlighted areas of slippage. TH presented a heatmap showing an overview report from the region and stated that feedback ahead of the 27thMarch submission was comparatively favourable.

6.2.3 TH stated that the key strategic issues to work through, among other things, included realising:

- a balanced System financial plan;
- completion of prioritisation process;
- providing details of productivity and savings programmes.

TH emphasised that the ICB and its partners continued to identify savings and productivity opportunities to support a balanced financial plan. A workforce plan would also be finalised prior to submission.

6.3 2025-26 Planning Guidance

6.3.1 CL presented the financial aspect of the plan and stated that the ICB and its partners are required to achieve a local Integrated Care System (thereafter “System”) financial balance and to comply with System resource use limits set by NHS England. CL added that this could be achieved by:

- reducing waste;
- increasing productivity (without compromising on quality and safety);
- removing duplication;
- taking a forensic look at workforce;
- stopping lower value activity.

CL emphasised that operational plans must be in sync and aligned with available resources.

6.3.2 CL explained that Elective Recovery Funding (ERF) had increased from the previous £14.5 million to £17.25 million. CL stated that 2024-25 plan initially showed a recurrent deficit of £75 million but this position deteriorated through the year to £132.5 million due to various pressures. CL reassured that 2025-26 Savings plans were being progressed to reverse the deficit, and the 27thFebruary 2025 submissions to NHSE reflected a deficit of £36 million.

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6.3.3 CL described the tools and transformation portfolios which were enabling to the getting of the best outcomes at less cost at System level as well as within individual organisations. CL stated that informed transformation delivered value to maximise patient outcomes. CL added that existing investments should be included in the testing of Value for Money (VFM). CL presented the 2025-26 capital plan and explained that breaking even could result in a capital bonus. CL emphasised that the ICB and its partners should endeavour to breakeven as this would help the System retain its autonomy on health delivery.

RESOLUTION: The System Resources Committee noted the:

1. **Joint Forward Planning (JFP).**
2. **Operational Planning – Headline Submission Overview report**
3. **2025-26 Planning Guidance.**

7. Risk Management Report

7.1 MG presented the risks held in the Board Assurance Framework (BAF) and stated that the risks were within the remit of the System Resources Committee. MG explained that the System Resource Committee provided assurance over significant risks falling under its remit. In outlining the risk process, MG stated that the Governance team worked with Risk Owners and Risk Leads in reviewing existing risks, and also in scanning for emerging risks.

7.2 Members reviewed the risks. ER described the update on BAF5 which referred to the risk that the ICB could fail to deliver and/or sustain performance and improvement in Urgent and Emergency Care. ER cited significant pressures on operational capacity resulting from winter pressures. ER reassured that the approach to mitigation of system risk portfolio was being further strengthened. WCG suggested that BAF5 should extend its scope to cover Integrated Urgent Care (IUC). ER concurred and added that it is important to ensure that there is strong co-ordination and synchronisation of system-wide risks.

7.3 MG presented the risks in the Corporate Risk Register (CCR) as follows:

1. Risk U&EC6: Risk of failure to meet UEC performance metrics.
2. Risk Dig1: Risk to the delivery of the ICS Digital Strategy.
3. Risk S&T2: Risk that System partners cannot support or drive transformation programmes and projects due to operational and workforce pressures and insufficient ICB programme resources to facilitate change.
4. Risk S&T3: Risk to project delivery and that the realisation of benefits across the System may not be met.

Members discussed the risks and noted that Dig1did not have a recent update. MG reassured that he would follow-up on this matter.

Action: Update to be provided to the Digital Risk ahead of the next Committee.

8. Health Inequalities

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8.1 KD presented and reiterated that assurance of Health Inequality at ICB and at System level fell under the ambit of System Resources Committee. KD highlighted that a recent audit of the ICB's approach to Health Inequality and population management work recommended stronger oversight and reporting arrangements. KD cited the ICB Audit Committee's emphasis on the importance of reviewing data at a locality level, in addition to cross boundary scanning and utilisation of comparative data. KD cited a trust in London which developed a health inequalities index that reveal areas of health inequalities requiring redress.

8.2 KD reassured members that the local System was committed to aligning its health and inequality programmes with NHSE guidance. KD stated that the Planning team was focused on creating a reporting environment and tools supporting the enablement of health transformation. KD added that an update on progress would be brought before the Committee on 3rd July 2025. **Action: KD to bring an update before members on 3rd July 2025.** KD stated that the Planning team's focus was not limited to health inequalities and health policies only; it extended to a wider spectrum of health economy. **KD**

RESOLUTION: The System Resource Committee noted the Health Inequalities report.

9. Specialised Commissioning

9.1 MW and DC presented the report and MW described Specialised Commissioning as being in its early stages of life cycle which required sound planning and contracting competencies. MW reiterated that the setting up of Specialised Commissioning required Board assurance. Preparations were in progress to take relevant reports before the ICB Board for review and approval on 26th March 2025.

9.2 CL added that local partners were individually and collectively mapping out financial risk share, and the partners' finance directors were engaging each other to inform outcomes. CL outlined the accounting rules underpinning Specialised Commissioning and how this impacted risk share. CL explained that the determination of risk share included cross boundary mitigation. CL clarified that the principal commissioner was Somerset ICB.

9.3 DC presented the pre delegation checklist and reassured members that their team engaged the Associate Director of Corporate affairs, Christina Gradowski, and other colleagues in conducting due diligence ahead of submission. DC explained that the public facing dimensions of the Specialised Commissioning delegation were handled by the Communications department.

9.4 AJ discussed some structural issues associated with Specialised Commissioning and she highlighted what appeared to be weaknesses inherent in contractual relationship with providers. MW explained that there were governance arrangements in place to mitigate exposure. These included collaborative working arrangements such as Joint Specialised Services Committee which helped inform contractual decisions. MW reiterated that the

Specialised Commissioning team and partner organisations were seized with the mapping out of risk share within the System.

RESOLUTION: The System Resources Committee noted the Specialised Commissioning report.

10. ICS & ICB Performance Report

10.1 MW and KD presented the report. MW stated that despite the pressures experienced by the local System, Urgent & Emergency care showed improved performance in the month of January 2025. MW highlighted the national focus on elective recovery and stated that the appointment of Jim Mackey whose reputation in this area of work is respected brought some optimism. MW summarised local planning and ongoing activities designed to reverse long waits. MW stated that the 52-week performance relating to referrals showed a generally encouraging result, but he cautioned that Ear Nose & Throat (ENT) required more focus.

10.2 KD explained that diagnostic key performance indicators (KPIs) showed some level of performance deterioration in the 6-week waiting standard at the beginning of the year. KD explained that slippage was largely contributed by pressures associated with the Christmas season. KD described the pressures affecting performance in echocardiography and peripheral neurophysiology and reassured that the System was working on reversing slippage. KD highlighted that Category 2 Ambulance performance improved from 50.7 minutes in January 2025 to 35.5 minutes in February 2025.

RESOLUTION: The System Resources Committee noted the ICS & ICB Performance report.

11. ICS & ICB Finance Report

11.1 CL presented the System's 2024-25 Financial Savings Plan which pointed toward a Savings requirement of £93,240,000 and a forecast of £90,714,000. CL stated that the ICB and the System continued to target break-even, and several mitigations continued to be progressed. CL reiterated that the optimism derived from available evidence which pointed toward strong risk mitigation practices in the ICB and partner organisations. CL reassured that cash forecasts were under regular review.

11.2 CL stated that in addition to identifying both recurrent and non-recurrent Savings, partners aimed to flatten demand for future growth. JS raised the matter of the accumulated surplus of £21,000,000 and asked if there were avenues through which such surplus could be accessed. MH responded that in principle the surplus could be accessed, and extra steps would be taken to access such surplus as a last resort. CL stated that going forward, the system hoped to benefit from factoring Savings into the Joint Forward Plan and 2025/26 operational planning.

RESOLUTION: The System Resources Committee noted the ICS & ICB Finance report.

12. Any Other Business

12.1 There was no other business.

The meeting ended at 4:15pm

Date and Time of Next Meeting: 1st May 2025 at 09:00am

Minutes Approved by: System Resource Committee Signed (Chair): Prof Jo Coast Date: Thursday 1st May 2025

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NHS Gloucestershire ICB People Committee

Thursday 16th January 2025, 15.00 – 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
Tracey Cox	TC	Director of People, Culture and Engagement, ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, ICB
Participants Present:		
Deborah Tunnell	DT	Deputy Director for People & OD (deputising for Claire Radley)
Ruth Thomas	RT	Associate Director - OD, Learning and Development, GHC
Neil Savage	NS	Director of HR & Organisation Development, GHC
Christina Gradowski	CGi	Associate Director of Corporate Affairs, ICB
Sophie-Elizabeth Atkins	SEA	People Programme Manager, ICS
Zack Pandor	ZP	Strategic Workforce Transformation Programme Manager, ICS
Peter Wathen	PW	Head of Digital Transformation, ICS
Jenni Phillips	JP	Digital Communications Manager, ICB
In attendance:		
Dan Offord	DO	Head of Digital Transformation, ICB
Luke Rogerson	LR	Principal Data Analyst (Strategic Workforce), ICS
Dawn Collinson	DC	Governance Administrator, ICB
Michelle Allen	MA	Executive Business Manager, ICB
Vikki Walters	VW	Strategic Lead for Inclusive Employment, GCC
Charlie Presley	CP	We Want You Project Outreach Lead, GHC
Grace Booker	GB	Integrated Senior Commissioning Manager for Workforce, GCC
Riki Moody	RM	Chief Officer, Gloucestershire Care Providers Association
Lucy Blandford	LB	Head of Practice Education and Widening Access, GHC

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1 Introduction & Welcome

1.1 KC welcomed those present to the meeting.

2 Apologies for Absence

2.1 Apologies were received from Claire Radley (CR), Deborah Evans (DE), Marie Crofts (MC).

2.2 It was confirmed that the meeting was quorate.

3 Declarations of Interest

3.1 No new Declarations of Interest were noted for this meeting.

4 Minutes of the Previous Meeting

4.1 The minutes of the previous meeting held on Thursday 17th October 2024 were approved as an accurate record of the meeting.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **16.05.2024, Item 8.9** – **ICS Programme Priorities. January Update:** No further discussion. **Action to remain open.**

5.1.2 **18.07.2024, Item 7.15** – **Workforce Intelligence.** GHFT vacancy controls for corporate services and workforce controls circulated. Item is requesting closure. **January Update:**
Item to be closed.

5.1.3 **18.07.2024, Item 8.10** – **Apprenticeship Strategy. January Update:** Not discussed. **Action Open.**

5.1.4 **18.07.2024, Item 9.13** – **Workforce Planning.** To organise a follow up meeting to discuss the emerging risk of short term versus long term workforce planning. TC confirmed that this was on the future work plan for a board development session but would need to wait for a slot to be confirmed. **Action to remain open. January Update:** Ongoing. **Action Open.**

5.1.5 **17.10.2024, Item 6.2** – People Function Summary Report. **January Update:** On agenda today. **Item to be Closed.**

5.1.6 **17.10.2024, Item 6.8** – People Function Summary Report- - productivity tool. Definition and link to workforce productivity tool circulated in December 2024. Item is requesting closure. **January Update and Discussion:**

- **KC requested a follow up for a deeper dive on this given the amount of centre scrutiny.**
- It was unclear if tool had been helpful to GHFT.
- Clarification around oversight and which Committee this would come under. TC said Productivity was sitting between Finance and Workforce and a session was needed to clarify and articulate the productivity narrative for Gloucestershire next year. **Action: TC to facilitate a conversation around productivity with colleagues.** **TC**
- The tool favoured acute rather than Mental Health, Learning Disabilities and Community services. KC felt there should be a suite of measures that better reflected system working. Suggestion for operational discussion offline.
- SEA productivity would need to be reported into this year's Operational Plan; using the current tool but there may be a different tool introduced for next year. Simon Fuller had suggested that a South West discussion should examine what others were using for the Mental Health and Community aspect because the productivity tool had not been used in those workstream areas.
- KC said the goal was to agree on how the system could address this. The data was not telling a very good or accurate story likely due to some of the nuances around data not having been reflected. The data showed a large increase in non-clinical staff in GHFT which was unlikely, so ownership needed to be established if this tool were to be used for another year. **Action: Following long discussion, updates and the result of a deep dive on productivity, this should come back to a future People Committee meeting.** ***Date to be confirmed.***

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5.1.7 **17.10.2024, Item 9.1 – Review of Terms of Reference (ToR).** Survey circulated by ND. Not all responses received back. **Action to remain Open. January Update:** Limited response to feedback request on purpose of Committee. New deadline for feedback and format of meeting to be extended and this was agreed as Friday 14th February 2025. Following the meeting CGi recirculated the ToR to members. **Action Open.**

6 Integrated Care System (ICS) People Function Summary Report

6.1 TC highlighted:

- **Independent Review & Regulation of Physician Associates and Anaesthetic Associates.** Results from a regional questionnaire had been shared with colleagues who had participated in this across the system. It was noted a high number of graduates from the latest cohort had not been able to secure employment due to challenges around the perception of these roles.
- Whilst the General Medical Council (GMC) were reviewing their roles, the ICB had been reminded of existing guidance around ensuring those within certain roles had the right capabilities and practice in place.
- **Report on Labour Workforce Supply.** This report reinforced the national Workforce Strategy about the forthcoming challenges regarding the level of growth required across the health sector in coming years to meet demographic demand.
- **NHSE People Promise Site Visits.** GHC's visit took place on 29th November 2024 and included representatives from the national NHSE HR Team. GHFT's site visit had to be rearranged due to the Critical Incident having been declared.
- **Health, Work and Skills Integration Funding.** The ICB had put a request for this funding as part of these grants. The ICB had been given just under £90k in 2023/24, which was carried forward this year, with an additional £90k having been allocated. Plans for using the funds would be developed.

6.2 TC said that HRD colleagues would be aware that by 31st January 2025, there had been a request to sign off a national Memorandum Of Understanding (MOU) that would operate between NHS organisations for the passporting of Statutory and Mandatory training which was positive. Further engagement for staff would be following in early February.

6.3 KC queried whether the Staff Survey results had come in. TC said all organisations should have received them and there would be more detail known at the time of the next Committee meeting.
Action: Updates on the Staff Survey results were requested for the next Committee meeting. **TC/CGi**

6.4 AR said that the obesity service had informed him that there appeared to be a number of roadblocks around oversight of clinicians where some were employed with GHFT and some within GHC. It was queried whether a pilot could be conducted on a way of trying to work through this, and whether the ICS could tackle this systemwide problem.

6.5 ZP said that NHSE had published a new Staff Movement toolkit which contained sample contracts for arrangements between NHS organisations to share staff which would cover some of the points mentioned by AR. If some of the specialties wished to start using this toolkit, then ZP said he would be happy to facilitate this.

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https://www.england.nhs.uk/publication/enabling-staff-movement-a-toolkit-for-sharing-staff-safely-and-efficiently/

6.6 NS said this had been discussed within GHC having a People Framework which was designed to support and aid cross-organisational working, It was planned for a review in tandem with the new national document referred to by ZP.

6.7 **Action: AR to explore and discuss models around passporting staff across different organisations and bring an update to a future Committee meeting.** ***Date to be confirmed.*** **AR**

RESOLUTION: The People Committee noted the content of the ICS People Function Summary Report.

7 Workforce Intelligence and Programme Highlight Report

7.1 SEA explained that since the last meeting, two bids had been placed, one of them being around the Step Into Work programme and another one for First Stage Careers. Unfortunately, the funding was withdrawn due to late application, but confirmation had been received this week that £3k had been received for a systemwide Stay and Thrive event to be hosted for overseas colleagues.

7.2 The Operational Planning Guidance was expected for 27th January 2025 and there was a deadline of 3rd April 2025 for the first submission. A final submission (if requested) would be due 24th April 2025. Priorities would be around productivity and finances. Workforce Key Lines of Enquiry were available and there was a focus on temporary staffing. Nothing had been requested on EDI, Health and Wellbeing or Leadership and Development that had been previously part of the workforce narrative.

7.3 Plans on a Page had been worked on and the Joint Forward Plan. These may need to change when the Operational Planning Guidance was received.

7.4 The Business Cases for Oliver McGowan and the ICS Lead Roles had been submitted to the 2025-2026 strategic delivery priorities process. There had been a positive systemwide event "Countywide Circle to Success," with statistics shown in the report. There had been good engagement from all system partners.

7.5 A Health and Wellbeing Survey was being undertaken with results to be circulated in February. ZP said that there was access to good data, and he would be pulling together a first draft of a report his would then be brought back to future meetings to examine what the future was for Health and Wellbeing services.

7.6 SEA said the We Want You project had been busy and another Support Worker Appreciation systemwide event being implemented, with a focus on assisting and demonstrating career development for Support Workers. There was also funding available for Professional Midwifery Advocates (PMAs) training.

7.7 **Key Issues:**

- Workforce Metrics (January 2025 IPR report but reflecting data to end November 2024 for Trusts and end September 2024 for Social Care)
- Overall, the current leaver rate was 12.3% across the ICS which had slightly increased since the last reporting period This remained below the Operational Plan's forecast for GHC (11.4%) and above for GHFT (11.2%).

- Vacancy rate across the ICS was 8.5% (9.6% for GHC, 7.4% for GHFT and 9.8% across Adults & Children's Social Care) against the Operational Plan's implied vacancy rate of 9.6% for GHC and 4.8% for GHFT in 2024-2025.
- Sickness rates had slightly reduced from the last reporting period to 4.7% across health and social care. Both Trusts' sickness rates were as the assumed Operational Plan rates for November or lower
- Further reduction in agency usage across the system since the last report with GHC at 44.2wte, GHFT 82.3wte and social care 139wte.

Operational Plan Metrics

Performance data against operational plan requirements.

- At M7, year to date agency spend for both providers had reduced slightly to 2.5% of total pay expenditure, with GHFT down to 2.7% and GHC remaining steady at 2.1%.
- By 1st July 2024, all providers were required to remove all off-framework agency usage. In M6 there were 68 off-framework shifts and M7 86, both second highest in the region.
- For November, the ICB were slightly below the agreed substantive head count forecast (11,798wte) for Trusts at 11,751wte, but slightly over the total worked forecast, (staff in post plus bank and agency - 12,682wte) at 12,798wte.
- GHC's Integrated Urgent Care (IUC) contract commenced 17th November 2024.

7.8 KC mentioned total workforce versus the Operational Plan where this was now red as a system level, which equated to 116 full time equivalent (FTE) staff over the Operational Plan assumption for total. NS said this related to workforce controls in both GHC and GHFT. There would be another internal audit this year to ensure that roles were not being recruited to that were not funded.

7.9 KC said she did not think that this would have affected data, as numbers had risen steadily rather than showing as having peaked. KC thought that NS was just on target around the Operational Plan numbers for GHC, rather than being above them in this latest report. SEA said this would come through in the next reporting period, as had not been included in the workforce numbers in the latest report.

7.10 DT said this was a continuing focus particularly due to the NHSE performance baseline of Month 7 for 2023-2024. DT was working to examine actions for the rest of the financial year to get back into a good position. It was about understanding what had driven growth and what was driving the month-on-month worked position.

7.11 Work would continue to bring things to a satisfactory position for 2024-2025 with a focus on whether anything over and above what had already been done, could be accelerated. Tools that had worked effectively this year could be taken over into next year.

7.12 SEA confirmed accurate processes needed to be in place ready for next year, as there had been some discrepancies in terms of the forecast plan. If there were to be an issue around forecasting from this year to the next, then this aspect would need to have a very consistent and concentrated approach.

Action: SEA to send the workforce metrics file to DT as well as PWR data information from Chris Buttery. **SEA**

RESOLUTION: The People Committee noted the performance position in the Workforce Intelligence & Programme Highlight Report.

APPROVED

8 **People Committee Risk Register and Board Assurance Framework (BAF) Update**

8.1 The workforce risk on the BAF remained at a score of 20. As per last the last reporting round, improvements continued around overall vacancy rates, performance relating to agency spend and general workforce controls in line with this year's Operational Plan requirements. The strategic risk relating to the failure to deliver EDI improvements across the system remained at a risk rating of 15.

8.2 **High Rated Risks**

In line with the ICB's risk framework and policy, all risks rated 12 and above were shared with the People Committee. These included

1. Learner Capacity Utilisation, 2. Oliver McGowan training and 3. Reduction in externally recruited apprenticeship starts at level 2-4 within NHS organisations due to financial constraints. 4.System OD capability & 5.. Lack of Progress on ED&I.

8.3 The Committee noted and discussed the contents of the People Function Risk Register and reviewed current BAF risk ratings. It was agreed that no changes would be made to this prior to this being presented to the ICB Board for their approval at the end of January 2025.

RESOLUTION: The People Committee approved the People Committee Risk Register and Board Assurance Framework which would go forward to the ICB Board for their approval at the end of January 2025.

9 **Gloucestershire ICS Digital Workforce Strategy**

9.1 With an increasing reliance of staff on digital technologies to undertake their roles in health and social care, a clear digital workforce strategy was needed. This strategy was setting out national, regional, and local context in areas pertinent to digital workforce, including policy, skills, transformation, and existing work undertaken.

9.2 The strategy defined these themes in greater detail and outlined the delivery approach via the ICS Digital Workforce Programme Board. The agreed project for the 2024/2025 financial year had been documented, with the ambition currently scaled with available resources.

9.3 PW explained that Topol Review had suggested that by 2039, 90% of jobs within the NHS would require some element of digital skills. It called for staff to be supported to develop digital skills and provided a significant number of recommendations for a digital workforce. This had led to the creation of NHS Digital Academy, and many other changes. This was the key policy document around which much of recent work had been based. https://topol.hee.nhs.uk/

9.4 Slide 15 demonstrated that failure was not just about the inability to deliver a product, but also failure of a product to deliver the stated benefits of the change, despite the changes having been undertaken. Research had shown that 63% of failure was down to mindset and capability reasons and not due to lack of funding or insufficient technology being in place.

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9.5 The ICS has agreed four key strategic themes which encompassed the ICS digital workforce strategy. These were:

- Development of Digital Skills and Education offer for all staff to develop and enhance digital literacy
- Support and develop digital specialists (including clinical informaticians) across the ICS
- Delivery of Technology Enhanced Learning (TEL) as a key enabler for training both digital skills required and innovative methods of education
- Development and optimisation of current workforce systems for the ICS.

9.6 PW explained the oversight and delivery of the strategy, the involvement of partner organisations and said a good example of such a project was the Digital Staff Passport work being undertaken within NHS providers in the 2024/2025 financial year. Reporting would be both to the ICS Digital governance structure via the Digital Delivery Group and ICS People governance structure via ICS Workforce Group. Updates are also provided to ICS Education and Training Group.

9.7 The themes for the 2025/2026 delivery plan were:

1. Implementation of Recommendations from 2024/2025 Discovery Work (TEL and LMS)
2. Implementation of Fundamental Digital Skills tools and resources across the system (either from discovery or NHS Digital Academy work ongoing)
3. Support for MS Suite to all users, in conjunction with GHFT roll out of N365 and Windows 11.

There were also additional topics which could be covered and were extremely relevant and important to the digital workforce, including AI and Data Literacy for all staff and supporting the strategic direction for workforce systems, however, there were not currently any programme resources to support these appropriate areas of work.

9.8 TC said she agreed with the four themes but was concerned that the level of resources did not match the strategy ambition. TC suggested acceleration in this space via the Health Innovation Network and opportunities with NHSE. A more purposeful discussion should be held with the University's Arts, Health and Wellbeing project to think about the potential for earmarking funds to be able to do this. PW said that further support would be appreciated from those organisations.

9.9 After discussion and thanks to PW for his work on this, it was recognised that the strategy had been written and aligned with resources available. KC said the Committee were in full support and wanted to help PW find ways to support delivery. NS said that there were likely soon to be more national directives on digital and AI.

RESOLUTION: The People Committee approved the Digital Strategy and Delivery Plan in principle but asked for this to be brought back again within a six month timescale for review.

10 <u>Policy Updates</u>

10.1 a) Social Media Policy 2024-2025
b) Flexible Retirement Policy 2024
c) Apprenticeship Policy 2024

10.2 The policies were discussed. CGi had refreshed some of the historical wording in them and they would be placed on the staff portal shortly. The portal would be

changing in the near future and CGi would be in discussion with HR around this. The Committee agreed to approve all three policies.

RESOLUTION: The People Committee approved the Social Media, the Flexible Retirement and the Apprenticeship Policies.

Seminar Session

11 Connect to Work Update and Linking Employment And Health (LEAH) Project

11.1 TC explained the purpose of bringing this topic to the meeting included a growing expectation that the NHS would step in to support the broader social and economic development and help to get people back into employment which had big impacts on both physical and mental health outcomes. The aim today was to highlight the new programme to ensure people were cited on this and to note the work to try to link people into employment that were presenting in other parts of the health service.

11.2 VW explained that the Connect to Work programme was aimed at people who were at risk from health inequalities to ensure they had opportunities to be able to work. This was part of the Government's "Back to Work Plan" to support 100,000 people with disabilities or other health conditions, or complex barriers to entering the labour market, into paid employment.

11.3 People were expected to be on this programme for 12 months and job outcomes would come from the HMRC system. There were a whole range of people who were disadvantaged in the employment market and the Connect to Work programme was also for people who had real barriers around finding employment. This included victims of domestic abuse, forces veterans, carers and the homeless.

11.4 The Gloucestershire Employment and Skills Hub would remain, of which around 100 people a month came through and this was available for any resident. A number of programmes would operate. The Hub would be redesigned so that anyone not eligible would be picked up, so that people who did not get through via Connect to Work, could have access to other programmes and support to move them into jobs. Referrals would start to come in from April to June 2026 and delivery would be implemented thereafter.

11.5 VW explained that this programme would benefit the whole county and whilst GCC might be the accountable body and responsible for delivery, it did not belong to GCC and there were a number of stakeholders who would become involved, including Health, DWP, the voluntary and community sector, district councils, employers and residents. There were a number of ways that people could become involved to support the programme; referrals, training and jobs by encouraging employers to participate and open up their recruitment processes to become more inclusive and employ some of those from the different participant groups.

11.6 MA presented the LEAH project.

- Utilising a grant from DHSC, the LEAH project had been developed jointly by the Health & Wellbeing Partnership and Gloucestershire County Council's Employment & Skills Hub. The project responded to the Health & Wellbeing Partnership where Employment was one of its Exemplar Themes.
- There were hundreds of thousands more people out of work due to long-term sickness since the pandemic. The Government was focusing on what it called the 'greatest employment challenge for a generation,' looking at a new approach to economic inactivity.

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- Economic inactivity meant that people (aged 16-64) were not involved in the labour market – they were neither working nor actively seeking employment.

11.7 NHS data had revealed that 10,901,086 fit notes were issued in England between March 2023 and April 2024. and in Gloucestershire 94,886 fit notes were issued between March 2023 and April 2024. The two diagnoses were for mental health and musculoskeletal (MSK) disorders. 21,539 people were claiming Universal Credit with no work requirement as of November 2024.

11.8 The LEAH project had commenced in October 2024 with the aim to strengthen the links between employment and health and to make employment part of the non-clinical intervention for patients.

- It had been decided not to have a fixed model with individual approaches being offered within health settings. Areas targeted were those areas with the highest deprivation and where high numbers of fit notes were being issued.
- Settings included Gloucester Health Access Centre (GHAC) and Rosebank, linking in with their Occupational Therapy Quality Improvement project.
- Links had also been made with Cheltenham Central Primary Care Network (PCN) and with the MSK Clinical Programme Group (CPG).

11.9 It was not the intention to ask health staff to do yet more work but when someone had been identified with a need for employment support, they could just send an email into the Inbox that had been created. An employment drop-in service had started at GHAC whereby an on-site presence had proven beneficial for patients and staff alike.

11.10 *Positive Outcomes:*

- In 3 months 29 referrals had come into the Employment and Skills Hub from new health settings where there had been engagement with LEAH
- One person referred to the 50/50 initiative and had started a placement in GCC Highways, two others were now in paid employment
- Main referrers were social prescribers, occupational therapists and mental health nurses
- Positive engagement of Health staff who were now starting to think about employment and ask about their patient's employment situation, which had previously not been discussed
- Promotion of the LEAH project including attendance of Integrated Locality Partnerships (ILP's), CPG's and a Personalised Care Away Day.

11.11 *Next Steps:*

- Work with ILPs to identify a "system-wide" approach – to include community-based health care settings
- Work with PCNs in high need areas to:
  - Drive referrals, raise awareness of employment provision & establish employment as a viable non-clinical intervention to aid recovery
- Identify areas to open more employment 'drop-ins' e.g. GP surgeries or community-based settings
- DHSC have offered Year 2 funding - working through plan to continue
- Evaluate findings to help inform local strategies and programmes including a work and health strategy, Connect to Work etc.

11.12 CGi asked if good benefits advice were available sitting alongside employment advice, as it was a huge risk if someone had a disability and were in receipt of

Employment and Support Allowance (ESA) and Personal Independence Payment (PIP) and the employment did not for whatever reason, work out, which could potentially lead to financial difficulties.

11.13 VW said she was currently looking for a provider who could deliver that advisory service in Gloucestershire. This would then become an integral support mechanism for the Connect to Work programme.

11.14 NS asked VW whether she and her team linked into the IPS Employment Service at Pullman Court within GHC as there was a service that supported people specifically with secondary mental health services who were experiencing various difficulties around getting into employment and there seemed to be some similarities between what was being done by VW's team and what they could offer. VW confirmed she chaired the Steering Group for the IPS Service and had been involved with the transformation so knew them very well and worked closely with them.

11.15 TC spoke about a case study https://youtu.be/ARIziOxC2NY and there were some questions to consider:

- How could we identify and reach people who are not accessing services?
- How could the system do more as employers to recruit and support potential employees identified through Connect to Work and LEAH?
- How could we be more open-minded and challenge our perceptions to modify our criteria for recruitment?
- What were the practical next steps to make this a reality?

11.16 *Discussion:*

- A more open selection criteria
- Better recruitment processes, was it always necessary to have NHS experience?
- Complex and long application forms were off-putting
- A less strict interview process, where more types of people could flourish
- Could the project help recruitment panels who may not have the time and capacity given that this was a long term programme.

VW said she would be happy to work with ZP on these aspects and said this could be a work in progress with sustainable outcomes which could be future-proofed.

Other comments:

- Word of mouth and Facebook were still the best forms of advertisement for Adult Social Care.
- Our NHS job application process are a barrier, job descriptions and person specifications expect candidates to come forward with a ready-made set of skills and experiences. We need to be braver and allow new entrants into the workplace and help them to develop into their role.
- KC also suggested a softer recruitment process where someone could perhaps help the applicant with their forms without convening any NHS rules or regulations.

11.17 CGi said that there had been many sessions on the ICB being a Disability Confident Employer with Lunch and Learn sessions about taking on those with different disabilities. CGi felt that the only thing to be done around this would be to set some targets to ensure that people would come through this route.

11.18 LB asked what success looked like in fulfilling the employment criteria. VW said participants would go through the HMRC system which would generate the job start.

The job outcome for lower rates would be calculated on a financial value and not number of hours. The threshold was equal to the national minimum wage x 8 hours x 13 weeks. 40% of participants were expected to reach that within the 15 months and the higher rate which was 29% was equivalent of 18 hours x national minimum wage x 26 weeks. The target could be reached earlier should someone be earning more. This was in line with Universal Credit which was triggered by wages earnt and not by hours worked.

11.19 VW said that people could return to the programme even though they were in employment. Transitioning into work was vital to ensure that the job suited the candidate with a Task Analysis undertaken. Working with the employer to ensure that there was a support mechanism in place or buddying was also considered. Access to trained job coaches was available, so there was a range of offers dependent upon needs of the individual. Even when off the Connect to Work programme the employee would remain with the Hub

11.20 DT observed that a lot of initiatives had been seen over the years and there were still so many barriers to recruitment. The NHS should have a focus on one or two things that would make a difference rather than trying to tackle many things at once.

11.21 KC said that clarity and regulations would need to be paramount for recruiting managers about where they could hire from a more diverse pool than they would do normally

11.22 VW said she would welcome taking this to the next stage and talking to recruitment teams which had been mentioned in the Widening Participation Network.

11.23 KC felt that many issues could be tackled at once when examined more closely. KC said that there had been some incredibly positive feedback about We Want You and how well we had been doing in reaching out to young people from disadvantaged backgrounds and really connecting with them in a way which had made them want to come and work for us.

11.24 This needed to have a very action-orientated group to be able to do just that. NS said that some of the operational people needed to be involved as there was a real risk that in 12 months' time that nothing had changed to support this.

Action: Further session/reflective practice or Lunch and Learn (initial session) to build on some of the momentum and make connections across the system to take this work forward. **TC/VW/MA**

RESOLUTION: The People Committee noted the Connect to Work and Linking Employment And Health (LEAH) Project updates.

12 Any Other Business

12.1 There was no other business to discuss. The meeting ended at 5.00pm.

Date and Time of next meeting: Thursday 17th April 2025 at 2pm in Shire Hall.

Minutes Approved by: People Committee
Signed (Chair): Karen Clements
Date: 17th April 2025

APPROVED