Extraordinary Gloucestershire Integrated Care Board Public Meeting

To be held at 2.00 – 2.30pm on Wednesday 18th June 2025

Ceremony Room, Ground Floor Shire Hall & MS Teams

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00pm	**Welcome and Apologies;** *Apologies: Mark Walkingshaw, Tracey Cox, Ann James, Mark Cooke,*	Information	**Chair**
2.		**Declarations of Interests** The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	**Chair**
		Items for decision		
3.	2.00 – 2.15pm	**Final Accounts 2024-25**	Approval	**Cath Leech**
4.	2.15– 2.30pm	**NHS Gloucestershire ICB Annual Report**	Approval	**Mary Hutton**
5.		**Gloucestershire Health Inequalities Information Review 2024/25**	Approval	**Douglas Blair & Siobhan Farmer**
6.	2.30pm	**Any Other Business**	Information	**Chair**
		Time and date of the next meeting		
		ICB Board meeting to be held on 30th July 2025		

Agenda Item 3

NHS Gloucestershire ICB Extraordinary Public Board Meeting

Wednesday 18th June 2025

Report Title	**Annual Accounts & Letter of Representation – 2024/25**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
			n/a				
Executive Summary	This report provides an overview of the key statements included within NHS Gloucestershire's accounts covering the period 1st April 2024 – 31st March 2025. The financial position as at 31st March 2025 was a small surplus of £187k.This position remains unchanged from the draft accounts and the auditors anticipate issuing an unqualified opinion on the accounts. The letter of representation is to the ICB external auditors providing assurance to them that the ICB has prepared accounts in accordance with all guidance, used income and expenditure in line with regulation and disclosed all relevant matters to the auditors. The letter will be signed by the Chief Executive once signed off by the Board. The ICB Audit Committee reviewed the accounts and the letter of representation on the 16th June 2025 and recommend approval of the accounts by the ICB Board.						
Key Issues to note	The 2024/25 and 2023/24 periods are for a 12 month period and so are a comparable in terms of time periods.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There was a risk to the accuracy of the accounts due to the tight timescales and additional work for the finance team that this entailed. Systems were in place to successfully mitigate this, even so, the impact on staff workload has been significant. (3x3) 9 (3x2) 6						
Management of Conflicts of Interest	• Who has been conflicted in the process / project ? n/a • How was this managed? n/a • Has it been logged on the declaration of interest register? n/a						
Resource Impact (X)	**Financial**	X	**Information Management & Technology**				
	Human Resource		**Buildings**				

Financial Impact	The ICB needs to ensure that accounts are prepared accurately and in a timely manner to ensure that the financial position for the organisation is understood and that an unqualified audit opinion is received from external audit.		
Regulatory and Legal Issues (including NHS Constitution)	There is a duty to prepare annual accounts for the initial period of the ICB's existence		
Impact on Health Inequalities	No impact on health inequalities as a result of this paper		
Impact on Equality and Diversity	No impact on equality & diversity as a result of this paper		
Impact on Sustainable Development	No impact on sustainability as a result of this paper		
Patient and Public Involvement	No impact on patients or the public as a result of this paper		
Recommendation	Recommendation was received from the Audit Committee on 16th June 2025 that the Annual Accounts and Letter of Representation should be approved by the ICB Board.		
Author	Shofiqur Rahman	**Role Title**	Interim Deputy CFO
Sponsoring Director (if not author)	Cath Leech, CFO		

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
POD	Pharmacy, Ophthalmic & Dental

Agenda Item 3

Audited 2024/25 Accounts Summary

Financial Summary	Programme Costs including primary care £000s	Running Costs £000s	Total £000s
Revenue resource limit	1,463,514	12,328	1,475,842
Total net operating cost for the financial year	1,463,497	12,158	1,475,655
Total Cumulative Surplus	**17**	**170**	**187**
Brought forward surplus			20,983
In year financial position			187
Cumulative surplus			**21,170**

Performance against key targets

Duty	Ref in Accounts	Target/Range	Actual	Within Target
Net Costs	Note 2	£1,475,842k	£1,475,655k	Yes
Cumulative Surplus	Note 2	£21,170k	£21,170k	Yes
Running Costs	Note 2	£12,328k	£12,158k	Yes
Cash Balance at 31/3/24	Note 8	£1,475k	£4k	Yes
Capital Resource Limit	Note 2	-	-	Yes
BPPC : Payments	Note 6.1	95% number & value	95% number & value exceeded	Yes

- The ICB receives Programme, Delegated Primary Care (including POD) and Running cost allocations; in the accounts programme and delegated primary care allocations are combined. Underspends against the Running Cost allocation (administrative expenditure) can be used to fund Programme Expenditure but not vice versa.
- Cash holdings at the end of the period were £4k and total cash drawings were within the Maximum Cash Drawdown limit set by NHS England; this is within the allowable limit.
- Performance against the Better Payment Practice code: the ICB achieved its 95% target in both value & volume of invoices

- Wherever possible rounding errors have been eliminated within the Annual Accounts.
- As per the Financial Reporting Manual (FReM), the ICB has removed the split between Programme and Administration costs from the accounts.
- The unaudited Accounts presented have been prepared in accordance with the ICB Annual Reporting Guidance and were submitted in accordance with the NHSE national timetable.
- Following the audit by Grant Thornton, the Audit Committee and Board will be notified of the final position and any changes from these drafts will be presented.
- The Annual Accounts show a position that is consistent with in-year performance reports presented to the Board.

1 Key Deadlines Annual Accounts and Report submission

Key dates are shown below with deadlines from the Department of Health are shown below.

25 April 2025 (9am)	Submission of the unaudited accounts to the Department of Health and External Auditors.
23 June 2025 (9am)	ICBs to submit: • full audited and signed April to March 2024/25 annual report and accounts, as approved in accordance with the scheme of delegation. These should be signed and dated by the Accountable Officer and appointed auditors, as separate documents (one for each statutory organisation during the period). • copies of final ICB Head of Internal Audit Opinion statements as issued by the local auditors. Note these should be submitted as separate documents. • Completed NAO disclosure checklist 2024/25 for final submission (to support regional final certification process).
4 July 2025 (5pm)	Regions to submit final certification documentation for ICB reports, to regional folders on SharePoint.
30 September 2025 (5pm)	ICBs to publish ICB annual reports and accounts in full on their public website.
By 30 September 2025 (5pm)	ICBs to hold a public meeting at which ICB annual reports and accounts are presented.

Key points relating to the accounts

2.1 **Prime Statements**

There are four prime statements in the ICB's Accounts. These are:

- **Statement of Comprehensive Net Expenditure (SoCNE)**
  This statement details the utilisation of resources in the period and highlights the operational net expenditure reported by the ICB during the period.

- **Statement of Financial Position (SoFP)**
  This statement provides a summary of the assets and liabilities of the ICB at a fixed point in time, the end of the financial period.

- **Statement of changes in taxpayers equity (SoCiTE)**
  This statement highlights all movements on reserves during the period. The movement is solely confined to expenditure incurred during the year when compared against cash drawn.

- **Statement of cash flows (SCF)**
  This statement shows the cash receipts and payments and is sub-divided into components relating to operating, investing (the ICB has no entries in this category) and financing (e.g. drawdown of cash) activities. This statement reconciles to the balance of cash at the period end.

The ICB accounting policies are based on a national template. In line with HM Treasury's Simplifying and Streamlining annual report and accounts, accounting policies and notes have been amended or removed completely where not relevant to the ICB.

2.2 **Accounting Policies**

The main text of accounting policies conforms to the NHS England standard approach. However, the areas below are relevant to the accounting period:

- **Going concern**
  The accounts have been prepared on a going concern basis. NHSE have recently issued the narrative in this note to encompass the recently announced national changes.

- **Key sources of estimation uncertainty**
  There are no known sources of estimation uncertainty in the production of the accounts

- **Adoption of New Standards**
  There are no new accounting standards in 2024/25.

2.3 **Other Operating Revenue (Note 3)**

Gross income of £55.6m was reported during in the period. This represents a small increase of 3.5% than the £53.7m in 23/24. Most of the income relate to contractual charges made to Gloucestershire County Council for their contribution to contracts where the ICB is the lead commissioner (i.e. GHC) and income received from the programmes such as the iBCF during the period.

2.4 **Employee Benefits (Note 4)**

Pay costs for the period were £28.6m, this is c1.9% of total gross expenditure which is the same proportion to the ICB operating expenditure. The movement in Staff costs on the Salaries and wages line is 6% and is in line with the 2024/25 pay award when compared to the prior year comparator.

2.5 **Operating Expenses (Note 5)**

Operating expenses of £1,503m were reported in 2024/25. This represents a £127m (9.2%) increase on 2023/24. The largest increase (c58%) in expenditure is with the two NHS Foundation Trusts within Gloucestershire ICS. Increases relate to the combined uplift factor, pass through payments from NHS England and some investments, including mental health. Purchase of health care from Non-NHS line has seen a large increase of 16%. This is driven mainly by inflationary costs plus increased activity in all areas including CHC and placements.

2.6 **Leases (Note 7)**

The note represents the Shire Hall ICB Headquarter lease from September 2023. The Shire Hall lease is for 10 years and is split into 2 component leases:

- Building lease for the rental of accommodation within the building itself and
- a land element for the rental of the staff car park at Castlemead.

Under IFRS 16 the ICB recognise a right-of-use asset representing the right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16.

2.7 **Property, Plant and Equipment (Note removed)**

This note has been removed as the ICB has fully depreciated its historic property, plant and equipment assets.

2.8 **Receivables (Note 8)**

Outstanding debts were £12.1m at the end of the accounting period. The £5.7m within the Non NHS not yet invoiced relates to the clawback of dental contract expenditure in 24/25.

2.9 **Payables (Note 10)**

At the end of the period trade and other payables stood at £77.5m compared to £64.6m in the 23/24 accounts. A large proportion of this increase is NHS accruals of which £5.4m relates to Gloucestershire Health and Care NHSFT. This accrual aligns the contract and includes an element of Gloucestershire County Council commissioned external care packages of £1.7m. The primary care prescribing accrual which is two months in arrears, totals c18.8m and is the largest accrual within the £51.9m Non NHS Accruals line in the note.

2.10 **Provisions (Note 11)**

The values of provisions has increased slightly to £5.4m for the ICB at the year end. This is mainly due to an increase in number of claims and costs relating to both adult and children CHC Claims.

2.11 **Losses and Special Payments (Note 15)**

There were two small losses in the 2024/25 accounts, as disclosed in the accounts these relate to a small book keeping loss relating to an unrecovered credit balance.

There were no special payments within the period.

2.12 **Events after the end of the reporting period (Note 16)**

This note has been updated to reflect the recent national announcement on the future of Integrated Care Boards. Most of the narrative for this note has been supplied by NHSE to enable a consistent message across commissioning organisations.

2.13 **Related party transactions (Note 17)**

Under IAS 24, related parties need only be disclosed where they have control or joint control of the related party. Board members in practices with more than two partners are not deemed to have control or joint control so are now excluded.

3.0 Recommendation

The Board is requested to:

- Approve the annual accounts and the signing of the letter of representation.

Data entered below will be used throughout the workbook:

Entity name:	NHS Gloucestershire ICB
	2024/25
Last year	2023/24
This year ended	31-March-2025
Last year ended	31-March-2024
This year commencing:	01-April-2024
Last year commencing:	01-April-2023

NHS Gloucestershire ICB - Accounts 2024/25

NHS Gloucestershire ICB - Accounts 2024/25

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024/25 £'000	2023/24 £'000
Income from sale of goods and services	3	(55,329)	(53,604)
Other operating income	3	(241)	(110)
Total operating income		**(55,570)**	**(53,714)**
Staff costs	4	28,627	26,490
Purchase of goods and services	5	1,495,954	1,373,670
Depreciation and impairment charges	5	256	435
Provision expense	5	2,873	1,005
Other Operating Expenditure	5	3,437	746
Total operating expenditure		**1,531,147**	**1,402,346**
Finance Expense		78	50
Net Operating Expenditure		**1,475,655**	**1,348,682**
Other Comprehensive Expenditure		-	-
Comprehensive Expenditure for the period		**1,475,655**	**1,348,682**

NHS Gloucestershire ICB - Accounts 2024/25

Statement of Financial Position for the year ended 31 March 2025

	Note	Closing Balances 31/03/2025 £'000	Closing Balances 31/03/2024 £'000
Non-current assets:			
Right-of-use assets	7	2,156	2,412
Current assets:			
Trade and other receivables	8	12,105	13,706
Cash and cash equivalents	9	4	59
Total current assets		**12,109**	**13,765**
Total assets		**14,265**	**16,177**
Current liabilities			
Trade and other payables	10	(77,543)	(64,622)
Lease Liabilities	7	(220)	(213)
Provisions	11	(5,381)	(4,698)
Total current liabilities		**(83,144)**	**(69,533)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(68,879)**	**(53,356)**
Non-current liabilities			
Lease Liabilities	7	(1,898)	(2,118)
Provisions	11	(110)	(110)
Total Non-Current Liabilities		**(2,008)**	**(2,228)**
Assets less Liabilities		**(70,887)**	**(55,584)**
Financed by Taxpayers' Equity			
General fund		(70,887)	(55,584)
Total taxpayers' equity:		**(70,887)**	**(55,584)**

The notes on pages 7 to 21 form part of this statement

The financial statements on pages 3 to 21 were approved by the Board on 18th June and signed on its behalf by:

Chief Executive Officer

NHS Gloucestershire ICB - Accounts 2024/25

Statement of Changes In Taxpayers Equity for the year ended 31 March 2025

	2024/25 General fund £'000	2023/24 General fund £'000
Changes in taxpayers' equity for 2024/25		
Balance at 01 April	(55,584)	(74,086)
Changes in NHS Integrated Commissioning Board taxpayers' equity for 2024/25		
Net operating expenditure for the financial year	(1,475,655)	(1,348,682)
Net funding	1,460,352	1,367,184
Balance at 31 March	**(70,887)**	**(55,584)**

The notes on pages 7 to 21 form part of this statement

The General Fund is the only reserve for NHS Gloucestershire ICB.

NHS Gloucestershire ICB - Accounts 2024/25

Statement of Cash Flows for the year ended 31 March 2025

	Note	2024/25 £'000	2023/24 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(1,475,655)	(1,348,682)
Depreciation and amortisation	5	256	435
Interest Received/(Paid)		78	50
(Increase)/decrease in trade & other receivables	8	1,601	(6,723)
Increase/(decrease) in trade & other payables	10	12,921	(11,614)
Provisions utilised	11	(2,190)	(1,147)
Increase/(decrease) in provisions	11	2,873	1,005
Net Cash Inflow (Outflow) from Operating Activities		**(1,460,116)**	**(1,366,676)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	**0**
Net Cash Inflow (Outflow) before Financing		**(1,460,116)**	**(1,366,676)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,460,352	1,367,185
Repayment of lease liabilities		(291)	(457)
Net Cash Inflow (Outflow) from Financing Activities		**1,460,061**	**1,366,728**
Net Increase (Decrease) in Cash & Cash Equivalents	9	**(55)**	**52**
Cash & Cash Equivalents at the Beginning of the Financial Year		**59**	**7**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**4**	**59**

The notes on pages 7 to 21 form part of this statement

Notes to the financial statements

Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.1.1 An explanation of the going concern

The ICB is required to explain its consideration of its status as a going concern. This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements. This is in addition to the Secretary of State direction that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.
On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.
As a result, the governing body of NHS Gloucestershire ICB has prepared its financial statements on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint Operations

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses. The pooled budget agreements that NHS Gloucestershire ICB holds with GCC (as mentioned in Note 1.4) are joint operations, with the exception of the Better Care Fund.

1.4 Pooled Budgets

The ICB has entered into a pooled budget arrangement with Gloucestershire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for integrated community equipment services and note 14 provides details of the income and expenditure.
The pool is hosted by Gloucestershire County Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.
Total net revenue expenditure for 2024/25 of £1,475,655k (2023/24 of £1,348,682k) is funded by in year revenue resource allocations from NHS England. The revenue resource allocation is accounted for by crediting the general fund, but this funding is only drawn down from NHS England and accounted for, to meet payments as they fall due. The total funding credited to the general fund during the year was equal to the revenue resource allocation (see Statement of Changes to Taxpayers Equity on page 5).

Notes to the financial statements

1.6 Cont'd

The ICB's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such, the ICB's income from other activities is limited. The most significant element of income is where the ICB commissions service level agreements (for Mental Health and Community Services) through liaison with the local authority. Where the ICB is the Lead Commissioner for service level agreements that include a contribution from the local authority, the ICB is acting as the principal in the relationship. The ICB provides all the administration to the contract, monitors performance, arranges the price and holds the provider to account. In such cases, all income is recorded in the ICB accounts as gross and shown within Other Operating Revenue within note 3.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7.3 **National Employment Savings Trust ("NEST") Pension Scheme**

The ICB has a small number of employees who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the ICB is taken as equal to the contributions payable to the scheme for the accounting period.

1.8 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Notes to the financial statements

1.10.1 Cont'd Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration. For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.12 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.14 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value. There are no contingent liabilities and contingent assets to disclose at their present value.

Notes to the financial statements

1.16 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified as Financial assets at amortised costs.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical accounting judgements in applying accounting policies**

There are no critical accounting judgements in the application of accounting policies.

1.20.2 **Sources of estimation uncertainty**

There are no sources of estimation uncertainty in the application of accounting policies.

1.21 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. The ICB is currently assessing the impact of this standard but it is not expected to be material.

● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The ICB does not have an Subsidiaries and so this is not expected to be applicable.

NHS Gloucestershire ICB - Accounts 2024/25

2 Financial performance targets

NHS Integrated Care Board performance against those duties was as follows:

	2024/25 Target £'000	2024/25 Performance £'000	Met (Y/N)	2023/24 Target £'000	2023/24 Performance £'000	Met (Y/N)
Expenditure not to exceed income	1,531,413	1,531,226	Yes	1,423,379	1,402,396	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	2,586	2,561	Yes
Revenue resource use does not exceed the amount specified in Directions	1,475,842	1,475,655	Yes	1,348,775	1,348,682	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	12,328	12,158	Yes	13,802	12,674	Yes

2.1 Performance against Resource limit	**2024/25**		**2023/24**	
	Revenue £000	**Capital £000**	**Revenue £000**	**Capital £000**
Notified Resource Limit	1,475,842	0	1,348,775	2,586
Total Other operating revenue	55,571		53,714	
Total Income	**1,531,413**	0	**1,402,489**	2,586
Employee benefits	28,627		26,490	
Operating costs	1,502,598	0	1,375,906	2,561
Total Expenditure	**1,531,226**	0	**1,402,396**	2,561
In Period Surplus	**187**	**Nil**	**93**	**25**
ICB Cumulative surplus brought forward	20,983		20,804	
Additional notified cumulative surplus brought forward	Nil		86	
Notified cumulative surplus brought forward	20,983		20,890	
In period surplus	187		93	
Cumulative surplus carried forward at 31 March	**21,170**		**20,983**	

The overall notified resource limit above includes specific funding for Primary Care Delegated Co-Commissioning of £131.489m (£120.763m for 23/24)
There is specific funding for delegated commissioning of pharmaceutical, general ophthalmic services and dentistry (POD) of £59.794m (£53.597m 23/24)

3. Other Operating Income

	2024/25 Total £'000	2023/24 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**1,272**	**1,099**
Non-patient care services to other bodies [(1)]	**38,496**	**37,866**
Prescription fees and charges	**8,011**	**7,596**
Dental fees and charges	**6,619**	**6,100**
Other Contract income	**931**	**943**
Total Income from sale of goods and services	**55,329**	**53,604**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**-**	**-**
Non cash apprenticeship training grants revenue	**106**	**79**
Other non contract revenue	**135**	**31**
Total Other operating income	**241**	**110**
Total Operating Income	**55,570**	**53,714**

[(1)] Non-patient care services to other bodies relates primarily to charges to Gloucestershire County Council.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

The majority of income from sales of goods and services (Contracts) relate to contracts with Gloucestershire County Council; the timing of the income for these contracts being over a period of time.

4. Employee benefits and staff numbers

	2024-25			2023-24		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	**20,924**	**653**	**21,577**	**19,722**	**571**	**20,293**
Social security costs	**2,322**	**-**	**2,322**	**2,325**	**4**	**2,329**
Employer Contributions to NHS Pension scheme	**4,638**	**-**	**4,638**	**3,749**	**8**	**3,756**
Other pension costs	**5**	**-**	**5**	**6**	**-**	**6**
Apprenticeship Levy	**85**	**-**	**85**	**105**	**-**	**105**
Termination benefits	**-**	**-**	**-**	**-**	**-**	**-**
Gross employee benefits expenditure	**27,974**	**653**	**28,627**	**25,907**	**583**	**26,490**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**27,974**	**653**	**28,627**	**25,907**	**583**	**26,490**
Less: Employee costs capitalised	**-**	**-**	**-**	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**27,974**	**653**	**28,627**	**25,907**	**583**	**26,490**

The ICB provided for 5 days of staff untaken annual leave at 31st March 2025. This equated to £635k (£453k in 23/24) and is included in staff costs

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**351**	**23**	**374**	343	57	400

4.3 Exit packages agreed in the financial year

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	2	40,373
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**2**	**40,373**

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	2	40,373
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**2**	**40,373**

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2024/25 Total £'000	2023/24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	2,404	2,048
Services from foundation trusts	928,076	845,101
Services from other NHS trusts	17,999	15,861
Services from Other WGA bodies	6	9
Purchase of healthcare from non-NHS bodies	200,873	173,488
Purchase of social care	9,768	10,520
General Dental services and personal dental services	26,004	21,868
Prescribing costs	113,169	112,924
Pharmaceutical services	23,842	21,728
General Ophthalmic services	6,215	5,913
GPMS/APMS and PCTMS	148,101	135,936
Supplies and services – clinical	1,281	1,308
Supplies and services – general	5,639	13,208
Consultancy services	125	165
Establishment	7,173	6,755
Transport	136	87
Premises	1,326	1,791
Audit fees [1]	234	228
Audit Other professional services [2]	44	42
Other professional fees [3]	442	832
Legal fees	440	302
Education, training and conferences	2,551	3,477
Non cash apprenticeship training grants	106	79
Total Purchase of goods and services	**1,495,954**	**1,373,670**
Depreciation and impairment charges		
Depreciation - Right of Use Asset	256	435
Total Depreciation and impairment charges	**256**	**435**
Provision expense		
Provisions	2,873	1,005
Total Provision expense	**2,873**	**1,005**
Other Operating Expenditure		
Chair and Non Executive Members	190	191
Grants to Other bodies	2,734	495
Research and development (excluding staff costs)	133	36
Expected credit loss on receivables	169	-
Other expenditure	211	24
Total Other Operating Expenditure	**3,437**	**746**
Total operating expenditure	**1,502,520**	**1,375,856**

[1] In Accordance with SI 2008 no 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, there is no limitation of auditor liability in respect of death or personal injury, fraud or fraudulent misrepresentation by it or its employees. In all other instances a total aggregate limit of £1m applies. The external audit fee is £233,520; representing a net spend of £194,600 together with irrecoverable VAT of £38,920.

[2] Mental Health Investment Standard (MHIS) work was completed in 2024/25 in relation to the 2023/24 MHIS. The value of this work is £37,000 (£44,400 inclusive of VAT).

[3] Internal Audit services are provided by an external provider BDO LLP and fees totalled £68,400 net of VAT (2023-24 £68,400 net of VAT). This is included in Other professional fees.

6 Better Payment Practice Code

	2024/25		2023/24	
	Number	£'000	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,622	125,710	10,954	125,484
Total Non-NHS Trade Invoices paid within target	11,277	123,854	10,465	120,385
Percentage of Non-NHS Trade invoices paid within target	**97.03%**	**98.52%**	**95.54%**	**95.94%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	905	941,068	823	805,044
Total NHS Trade Invoices Paid within target	880	940,445	793	804,468
Percentage of NHS Trade Invoices paid within target	**97.24%**	**99.93%**	**96.35%**	**99.93%**

7. Leases

7.1 Right of Use Assets

The Right of use assets relate to the ICB's office accommodation. The ICB's lease commenced in September 2023.

	2024/25			2023/24		
	Land	Buildings excluding dwellings	Total	Land	Buildings excluding dwellings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 01 April	455	2,106	**2,561**	-	856	**856**
Additions	-	-	**-**	455	2,106	**2,561**
Disposals on expiry of lease term	-	-	**-**	-	(856)	**(856)**
Cost/Valuation at 31 March	**455**	**2,106**	**2,561**	**455**	**2,106**	**2,561**
Depreciation 01 April	27	122	**149**	-	570	570
Charged during the year	45	211	**256**	27	408	435
Disposals on expiry of lease term	-	-	**-**	-	(856)	(856)
Depreciation at 31 March	**72**	**333**	**405**	27	**122**	**149**
Net Book Value at 31 March	**383**	**1,773**	**2,156**	**428**	**1,984**	**2,412**

7.2 Lease Liabilities

2024/25	**2024/25 £'000**	**2023/24 £'000**
Lease liabilities at 01 April 2024	(2,331)	(286)
Additions	-	(2,451)
Interest expense	(78)	(50)
Repayment of lease liabilities (capital and interest)	291	457
other	-	-
Lease liabilities at 31 March 2025	**(2,118)**	**(2,331)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024/25	2023/24
	£'000	£'000
Within one year	(291)	(291)
Between one and five years	(1,164)	(1,164)
After five years	(994)	(1,285)
Balance at 31 March	**(2,449)**	**(2,740)**
Effect of discounting	331	410
Included in:		
Current lease liabilities	(220)	(213)
Non-current lease liabilities	(1,898)	(2,118)
Balance at 31 March	**(2,118)**	**(2,331)**

This relates to the right-of-use asset which is leased from Gloucestershire County Council

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024/25 £'000	2023/24 £'000
Depreciation expense on right-of-use assets	256	435
Interest expense on lease liabilities	78	50

7.5 Amounts recognised in Statement of Cash Flows

	2024/25 £'000	2023/24 £'000
Total cash outflow on leases under IFRS 16	291	457

8 Trade and other receivables

	Closing Balance 31/03/2025 £'000	Closing Balance 31/03/2024 £'000
NHS receivables: Revenue	297	840
NHS accrued income	623	4,692
Non-NHS and Other WGA receivables: Revenue	614	427
Non-NHS and Other WGA prepayments	1,528	402
Non-NHS and Other WGA accrued income	2,620	1,427
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	5,785	5,372
Expected credit loss allowance-receivables	(223)	(57)
VAT	628	603
Other receivables and accruals	233	(0)
Total Trade & other receivables	**12,105**	**13,706**
Total current and non current	**12,105**	**13,706**

8.1 Receivables past their due date but not impaired

	31/03/2025		31/03/2024	
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	100	64	38	127
By three to six months	-	54	-	3
By more than six months	-	25	-	49
Total	**100**	**143**	**38**	**179**

8.2 Loss allowance on asset classes

	31/03/2025 Trade and other receivables - Non DHSC Group Bodies £'000	31/03/2024 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2024	**(57)**	**(57)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(169)	**-**
Amounts written off	3	**-**
Total	**(223)**	**(57)**

9 Cash and cash equivalents

	2024/25 £'000	2023/24 £'000
Balance at 01 April	59	7
Balance on transfer under modified absorption		
Net change in year	(55)	52
Balance at 31 March	**4**	**59**
Made up of:		
Cash with the Government Banking Service	4	59
Cash and cash equivalents as in statement of financial position	**4**	**59**
Balance at 31 March	**4**	**59**

10 Trade and other payables	Closing Balance 31/03/2025 £'000	Closing Balance 31/03/2024 £'000
NHS payables: Revenue	**2,926**	3,054
NHS accruals	**7,776**	656
Non-NHS and Other WGA payables: Revenue	**9,064**	6,013
Non-NHS and Other WGA accruals	**51,909**	50,334
Non-NHS and Other WGA deferred income	**503**	-
Social security costs	**283**	282
Tax	**312**	275
Other payables and accruals	**4,770**	4,008
Total Trade & Other Payables	**77,543**	**64,622**
Total current and non-current	**77,543**	**64,622**

Other payables include £1,702k for outstanding pension contributions at 31st March 2025 (£1,656k at 31st March 2024)

11 Provisions

	Closing Balance 2024-25	Closing Balance 2023-24
Current	**£'000**	**£'000**
Continuing care	2,996	975
Other	2,350	3,688
Legal Claims	35	35
Total	**5,381**	**4,698**
Non Current		
Other	110	110
Total current and non-current	**5,491**	**4,808**

	2024/25				2023/24			
	Continuing Care	**Other**	**Legal Claims**	**Total**	Continuing Care	Other	Legal Claims	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Balance transferred at 01 July	**975**	**3,798**	**35**	**4,808**	**976**	**3,830**	**35**	**4,840**
Arising during the year	2,975	501	-	**3,476**	488	769	-	**1,257**
Utilised during the year	(954)	(1,236)	-	**(2,190)**	(489)	(659)	-	**(1,147)**
Reversed unused	-	(603)	-	**(603)**	-	(142)	-	**(142)**
Balance at 31 March	**2,996**	**2,460**	**35**	**5,491**	**975**	**3,798**	**35**	**4,808**
Expected timing of cash flows:								
Within one year	2,996	2,350	35	**5,381**	975	3,688	35	**4,698**
Between one and five years	-	-	-	**-**	-	-	-	**-**
After five years	-	110	-	**110**	-	110	-	**110**
Balance at 31 March	**2,996**	**2,460**	**35**	**5,491**	**975**	**3,798**	**35**	**4,808**

The continuing healthcare provision of £2,996k is for costs expected to be incurred in relation to backdated claims received since 1st April 2013 for continuing healthcare and which have yet to be settled. This has increased due to an increased number of potential high cost packages of care and rising costs and numbers of packages for Children's and Adult continuing healthcare. Claims are assessed for eligibility using the national guidance and toolkit.

NHS England held a provision for all backdated claims received prior to 1 April 2013. For NHS Gloucestershire, this has now been cleared and any appeal costs are within the ICB continuing care provision.

The claims outstanding at 31 March 2025 are expected to be paid within the 2025/26 financial year.

Provisions made under the 'Other' and 'Legal claims' categories relate to potential primary care costs relating to practice legal and contractual issues. During the period there were movements in the following categories

- a change in the provision relating to practices following a review of risks in this area.
- a reversal of provisions relating to dilapidation costs relating to the former headquarters of the ICB

12 Financial instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because NHS Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Integrated Care Board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the NHS Integrated Care Board and internal auditors.

12.1.1 Currency risk

The NHS Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Integrated Care Board has no overseas operations. The NHS Integrated Care Board and therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the NHS Integrated Care Board and revenue comes parliamentary funding, NHS Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.4 Liquidity risk

NHS Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Integrated Care Board is not, therefore, exposed to significant liquidity risks.

12.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

12.2 Financial assets

	Financial Assets measured at amortised cost 2024/25 £'000	Financial Assets measured at amortised cost 2023/24 £'000
Trade and other receivables with NHSE bodies	546	1,028
Trade and other receivables with other DHSC group bodies	374	5,313
Trade and other receivables with external bodies	9,252	6,418
Other financial assets	-	-
Cash and cash equivalents	4	59
Total at 31 March 2025	**10,175**	**12,818**

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024/25 £'000	Financial Liabilities measured at amortised cost 2023/24 £'000
Trade and other payables with NHSE bodies	665	366
Trade and other payables with other DHSC group bodies	10,067	3,412
Trade and other payables with external bodies	65,079	62,164
Lease Liabilities	2,118	
Total at 31 March 2025	**77,929**	**65,942**

13 Operating Segments

The ICB consider that they have only one segment: commissioning of healthcare services for the Gloucestershire population

14 Pooled budgets

NHS Gloucestershire ICB is party to a pooled budget with Gloucestershire County Council. Under this joint arrangement, funds are pooled under S75 of the Health Act 2006 for integrated community equipment services.

This service has been running for a number of years and buys, delivers, collects, maintains and decontaminates equipment for patients in their own homes. This service is jointly commissioned by the ICB, with Gloucestershire County Council, who are the lead commissioner for the service.
The NHS ICB share of the income and expenditure handled by the pooled budget in the financial year are:

	2024/25 £000	2023/24 £000
Income	(5,579)	(5,087)
Expenditure	5,579	5,087

15 Losses and special payments

15.1 Losses

There were two losses incurred by NHS Gloucestershire in 2024/25 totalling £3k (2 in 2023/24 totalling £1k). Both relate to a book keeping loss.

15.2 Special Payments

There were no special payments in 2024/25 or 2023/24

16 Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year. Gloucestershire ICB is working with NHS England and ICBs within the South West on the development of plans to take these changes forward.

17 Related party transactions

The Department of Health is regarded as a related party. During the year the NHS Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example NHS England, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust, South West Ambulance Service NHS Trust, NHS Litigation Authority,NHS Business Services Authority and West of England AHSN.

In addition, the NHS Integrated Care Board has had a number of material transactions with other government departments, universities and other central and local government bodies. Most of these transactions have been with Gloucestershire County Council in respect of joint commissioning of services.

The ICB Board includes Partner Member who are jointly nominated by the NHS Foundation Trusts and Primary Care which provide services for the purposes of the health service within the ICB's area. The relevant trusts are Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust and South Western Ambulance Service NHS Foundation Trust. As such, the Chairs and Chief Executives of Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust sit on the ICB Board and the Chair of South Western Ambulance Service NHS Foundation Trust. In addition, Gloucestershire primary care providers have nominated two representatives, Dr Emma Crutchlow (Lead GP at Gloucester Health Access Centre and Matson Lane Surgery and Clinical director for G-Doc primary care provider) as Board Participant and Dr Jo Bayley (Director for G-Doc primary care provider) as Partner Member.

In formulating this note the NHS Integrated Care Board has considered all declarations of interest for Board members.
Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:
a(i) have control or joint control of the entity
a(ii) having significant influence over the reporting entity or
a(iii) are a member of the key management personnel.

An entity is related to a reporting entity if any of the following conditions applies:
b(i) the entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others)
b(ii) one entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member)
b(iii) both entities are joint ventures of the same third party
b(iv) one entity is a joint venture of a third entity and the other entity is an associate of the third entity
b(v) the entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity
b(vi) the entity is controlled or jointly controlled by a person identified above
b(vii) a person identified in a (i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity)
b(viii) the entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity

The Declaration of Interest register can be found on our website.

NHS Gloucestershire
Shire Hall
Westgate Street
Gloucester
GL1 2TG
18th June 2025

Grant Thornton UK LLP
2 Glass Wharf
Temple Quay
Bristol
BS2 0EL

Dear Grant Thornton UK LLP

NHS Gloucestershire ICB
Financial Statements for the year ended 31 March 2025

This representation letter is provided in connection with the audit of the financial statements of NHS Gloucestershire ICB (the "ICB") for the year ended 31 March 2025 for the purpose of expressing an opinion as to whether the ICB's financial statements give a true and fair view in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2024/25 and applicable law.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities for the preparation of the ICB's financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2024/25 (the "GAM"); in particular the financial statements are fairly presented in accordance therewith.

ii. We have fulfilled our responsibilities for ensuring that expenditure and income are applied for the purposes intended by Parliament and that the financial transactions in the financial statements conform to the authorities which govern them.

iii. We have complied with the requirements of all statutory directions affecting the ICB and these matters have been appropriately reflected and disclosed in the financial statements.

iv. The ICB has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

v. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

vi. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include year end expenditure accruals. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative, methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the ICB ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a. there are no unrecorded liabilities, actual or contingent;

b. none of the assets of the ICB has been assigned, pledged or mortgaged; and

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have only accrued for items received before the year-end.

xii. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The ICB's financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xiii. We have considered the unadjusted misstatements schedule included in your Audit Findings Report and attached appendix. We have not adjusted the financial statements for these misstatements brought to our attention as they are immaterial to the results of the ICB and its financial position at the year end. The financial statements are free of material misstatements, including omissions.

xiv. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xv. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xvi. We have updated our going concern assessment. We continue to believe that the ICB's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

a. the nature of the ICB means that, notwithstanding any intention to liquidate the ICB or cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements

b. the financial reporting framework permits the ICB to prepare its financial statements on the basis of the presumption set out under a) above; and

c. the ICB's system of internal control has not identified any events or conditions relevant to going concern.

We believe that no further disclosures relating to the ICB's ability to continue as a going concern need to be made in the financial statements.

Information Provided

xvii. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the ICB's financial statements such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your audit; and

c. access to persons within the ICB via remote arrangements, where/if necessary, from whom you determined it necessary to obtain audit evidence.

xviii. We have communicated to you all deficiencies in internal control of which management is aware.

xix. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xx. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xxi. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the ICB and involves:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the financial statements.

xxii. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

xxiii. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiv. We have disclosed to you the identity of the ICB's related parties and all the related party relationships and transactions of which we are aware.

xxv. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Governance Statement

xxvi. We are satisfied that the Governance Statement fairly reflects the ICB's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

Annual Report

xxvii. The disclosures within the Annual Report fairly reflect our understanding of the ICB's financial and operating performance over the period covered by the ICB's financial statements.

Approval

The approval of this letter of representation was minuted by the ICB's Audit Committee at its meeting on 16 June 2025.

Yours faithfully

Name Dame Gill Morgan

Position Chair, NHS Gloucestershire ICB

Date 18th June 2025

……

Name Mary Hutton

Position Chief Executive Officer, NHS Gloucestershire ICB

Date 18th June 2025

Signed on behalf of the ICB

Detail	Statement of Comprehensive Net Expenditure	Statement of Financial Position	Impact on adjusted net surplus/deficit	Reason for not adjusting
In 2023/24 the value of the prescribing accrual for February and March 2024 was £19,033,653. Following the submission of the draft financial statements the actual February and March prescribing spend data was received by the ICB. The actual figures showed expenditure of £19,032,989, which identified an over accrual of £0.664m.	Cr 'Purchase of goods and services' £0.664m	Dr 'Current trade and other payables' £0.664m	Increase surplus by £0.664m	Immaterial difference and hence the estimate was materially accurate.
In 2023/24 the value of the pharmacy accrual for March 2024 was £2,722,982. Following the submission of the draft financial statements the actual March pharmacy spend data was received by the ICB. The actual figures showed expenditure of £2,361,153, which identified an over accrual of £0.361m.	Cr 'Purchase of goods and services' £0.361m	Dr 'Current trade and other payables' £0.361m	Increase surplus by £0.361m	Immaterial difference and hence the estimate was materially accurate.
As part of our testing of POD expenditure it was noted that the POD team had made a late posting to a control account that overstated the prescribing expenditure by £0.323m	Cr 'Purchase of goods and services' £0.323m	Dr 'Current trade and other payables' £0.323m	Increase surplus by £0.323m	Immaterial difference and will be adjusted in the 2024/25 financial year.

Agenda Item 4

NHS Gloucestershire ICB Extraordinary Public Board Meeting

Wednesday 18th June 2025

Report Title	**NHS Gloucestershire ICB Annual Report 2024/25**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					✓		
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
	Chair, Chief Executive and Chief Finance Officer review	23/4/2025	Gloucestershire Health & Wellbeing Board member virtual review via Chair re. Health & Wellbeing Strategy	17/4/25			
	Audit Committee	16/5/2025					
Executive Summary	This paper presents the NHS Gloucestershire (ICB) Annual Report 2024/25 to the ICB Board for approval. The Report highlights many of the achievements delivered by the ICB and system partners during the year, set out under the 3 ICS strategic priority pillars: 1. **Making Gloucestershire a better place for the future** - improving the health, wellbeing and care of our citizens - focus on early prevention and the wider impacts on health 2. **Transforming what we do** - locality integrated working that supports the needs of the local population, achieving equity - reducing unfair and avoidable differences in health, developing our workforce, improving quality and outcomes across the whole person journey and making the most of digital technology to support care 3. **Improving health and care services today** - improving access to care, reducing waiting times, supporting improvements in primary care and urgent and emergency care and improving mental health support. It also reflects the challenges, opportunities and risks facing the ICB, the wider health and care community (ICS) and progress made to address these.						

Key Issues to note	The ICB's objective is to produce a best practice Report and a public summary (Annual Review) to accompany it. The structure and much of the statutory report content for the full Report is determined by requirements set out in the Department of Health and Social Care Group Accounting Manual (GAM) 2024/25, the NHS England ICB Annual Report Template 2024/25 and the NHS England - ICB Annual Report - Working with People and Communities Guidance. As part of this, it is expected that the report should also describe how the ICB is delivering against eight specific duties for assurance: 1. The duty to improve quality 2. The duty to reduce inequalities 3. The duty to take appropriate advice 4. The duty to have regard for the effect of decisions 5. The duty to use and promote research 6. The duty to involve patients and the public 7. The financial duties 8. The duty to support local strategies and priorities. Whilst it is important to address these areas of focus in full for audit and assurance purposes, an annual highlights summary (Top 20) and news digest has been included at the front of the Report. The draft Report was submitted to NHS England and the auditors on 24 April 2025. NHS England provided their governance certification assessment on the Report. Only four areas were highlighted as providing 'partial assurance' and requiring more information, with one 'not met'. The Report has been updated accordingly. Given the need to meet the requirements of a diverse audience, a short public facing version of the Report (Annual Review summary) has also been produced. This includes the front end sections of the Report, together with a working with people and communities summary and a summary on 'how the money has been spent.' The Annual Report (and Annual Review summary) will be available online and a communication with links to the two publications will be sent to community partners. The news highlights included in the Annual Review summary form an integral part of ICB and ICS promotional plans. This includes blog, feature and video content which is communicated through a variety of channels, including media, social media, websites and the quarterly One Gloucestershire community partner/public e-bulletin.
Key Risks:	The Annual Report includes details of identified risks.

Management of Conflicts of Interest	This process is described in the Annual Governance Statement within the Report.		
Resource Impact (X)	Resource impacts are set out in the Report.		
Financial Impact	There is a Financial Performance section within the Report. The Annual Report will contain the summary Annual Accounts when published.		
Regulatory and Legal Issues (including NHS Constitution)	The ICB has produced its Annual Report in line with the annual Department of Health and Social Care Group Accounting Manuals (GAM) and The NHS England ICB Annual Report Templates. The ICB Annual Report (2024/25) has also been produced in line with NHS England - ICB Annual Report - Working with People and Communities Guidance.		
Impact on Health Inequalities	The Report promotes the partnership approach to tackling health inequalities and this includes a dedicated summary section.		
Impact on Equality and Diversity	The Report sets out the ICB's approach to promoting Equality and Diversity with links to additional/comprehensive online information.		
Impact on Sustainable Development	The Report includes an Environmental matters (Sustainability) section within the Performance Analysis Report.		
Patient and Public Involvement	The ICB Annual Report includes a detailed summary of the ICB's engagement, involvement and consultation activities (Working with People and Communities section). The Report (and Annual Review summary) has been produced in line with NHS England - ICB Annual Report - Working with People and Communities Guidance.		
Recommendation	The Board is requested to approve the NHS Gloucestershire ICB Annual Report 2024/25.		
Author	Anthony Dallimore	**Role Title**	Associate Director, Communications
Sponsoring Director (if not author)	Mary Hutton, Chief Executive Officer		

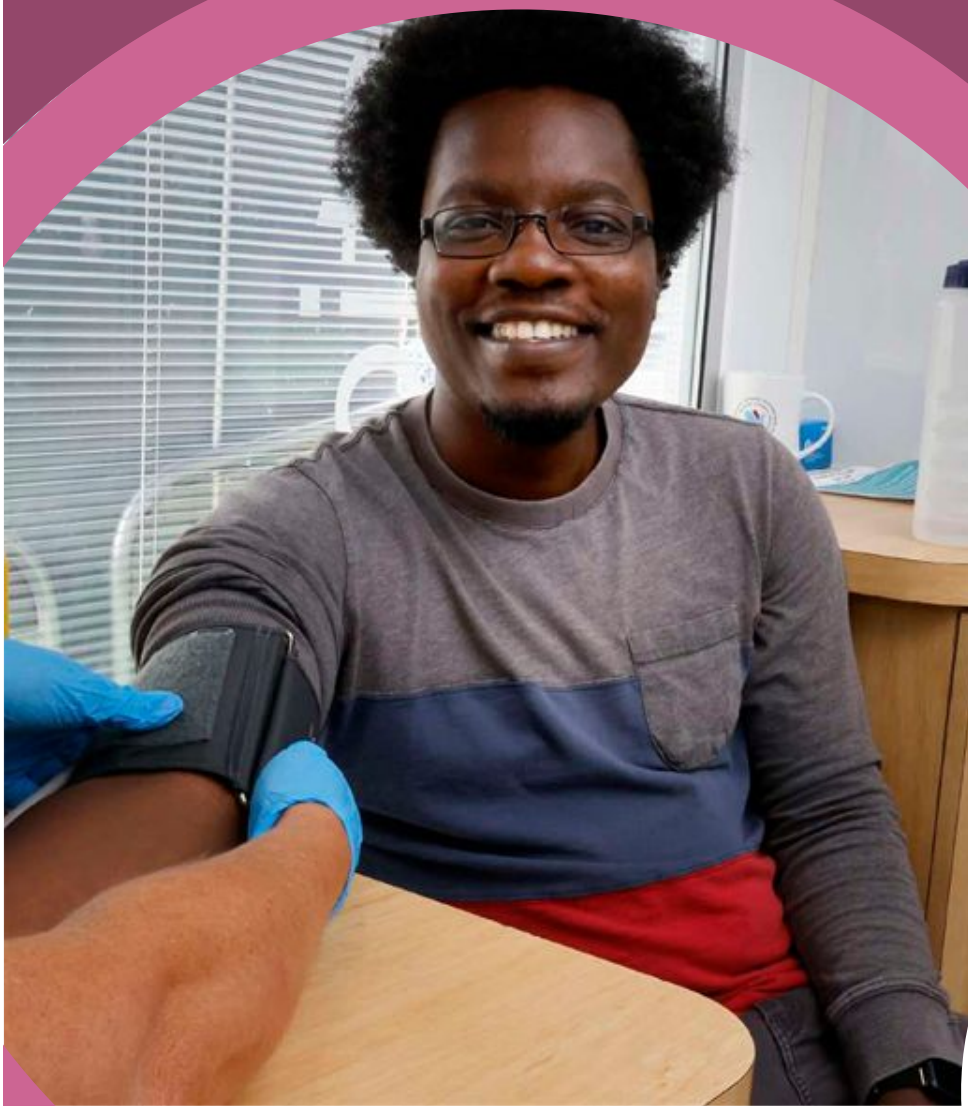
Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and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

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

Annual **Report**

A review of our year



2024/25

Contents

Dame Gill Morgan
Chair

Mary Hutton
Chief Executive Officer

2024/25

A message from

This is the third Annual Report for NHS Gloucestershire Integrated Care Board and an opportunity to reflect on our development as an organisation working hand in glove with the One Gloucestershire Health and Wellbeing Partnership.

This has been an extremely challenging year with recovery from the pandemic, the cost of living, industrial action and latterly the requirements of organisational change all placing significant pressure on our staff across the system and the people we serve.

During this period, we have seen unprecedented growth in people turning to the NHS and care services for support. Within this context, our local health and care professionals, supported by our fantastic partners, including local councils and other public, community and voluntary sector partners have responded magnificently.

The power of partnership (highlighted in our Annual Report) at neighbourhood, locality and county level is helping us to make real strides in improving health and wellbeing, care and services for local citizens and tackling long standing health inequalities.

Our Annual Report shows how working alongside local people and communities is integral to this, listening hard to ensure their priorities are at the heart of One Gloucestershire plans.

Our 5-year integrated care strategy and 5-year Joint Forward Plan for healthcare (refreshed this year) have created the blueprint for action and transformational change.

Both the strategy and the plan are underpinned by three key pillars for priority action:

- **Making Gloucestershire a better place for the future** - improving the health, wellbeing and care of our citizens over the longer term. Focus on early prevention and the wider impacts on health
- **Transforming what we do** - integrated working in neighbourhoods and communities supporting the needs of the local population, achieving equity - reducing unfair and avoidable differences in health, developing our workforce, improving quality and outcomes across the whole person journey and making the most of digital technology to support care
- **Improving health and care services today** - improving access to care, reducing waiting times and providing services that are sustainable and safe.

These strategic areas closely align to the national planning guidance priorities for 2025/26 and the emerging themes for the 10 Year Health Plan which we fully support, including a focus on the shift from sickness to prevention, further development of neighbourhood health services and the shift from analogue to digital.

With recent announcements on the substantial reduction in Integrated Care Board running costs and against the backdrop of intense service and financial challenges, we are taking a system wide approach to service transformation this year to ensure we continue to place the priority on patient care. We are also focusing on reducing waiting times, ensuring quality and safety across our services and achieving financial health.

We have an important responsibility to meet the priorities of local people in 2025/2026, whilst putting the building blocks in place for a health and care system that can meet the needs of future generations.

Thank you for your continuing support.

Top 20

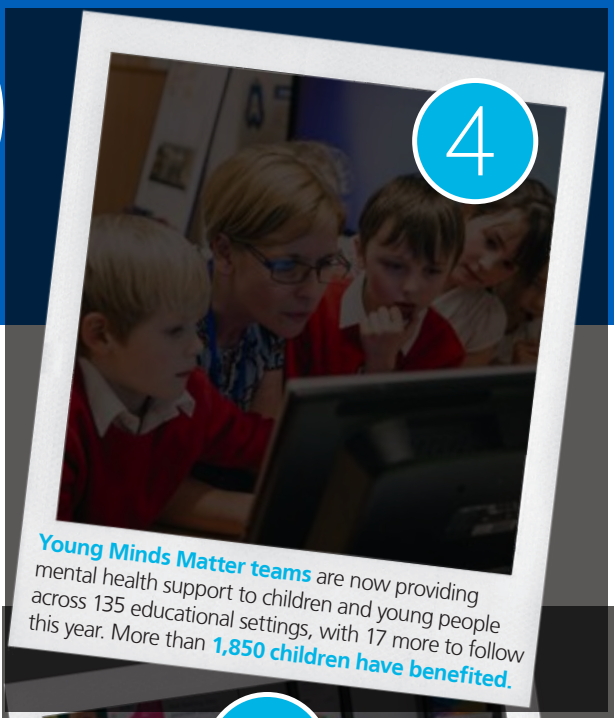
Highlights of the year

Making Gloucestershire a better place for the future

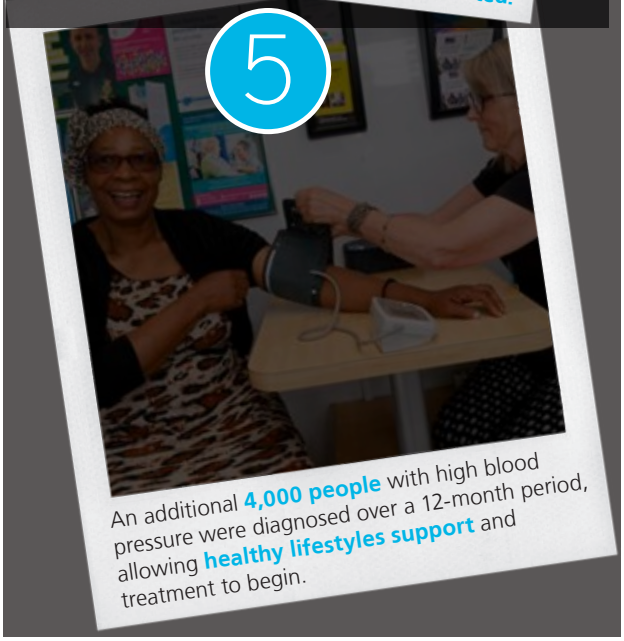
1. **34 grants ranging from £3,600 to £30,000** were made to voluntary, community and social enterprise organisations supporting health and wellbeing in our communities. Initiatives included healthy cooking courses and employment and skills development for individuals in recovery from addiction.

2. **Up to 150 people** with cold-sensitive health conditions who are at risk of fuel poverty received support to pay their energy bills through winter.

3. **Gloucestershire remains the best in England** for prescribing salbutamol inhalers with the lowest carbon footprint, reducing to an average of 12.45kg CO2e (carbon dioxide equivalent) per inhaler. Traditional aerosol inhalers contain propellants which are greenhouse gases.



4. **Young Minds Matter teams** are now providing mental health support to children and young people across 135 educational settings, with 17 more to follow this year. More than **1,850 children have benefited.**



5. An additional **4,000 people** with high blood pressure were diagnosed over a 12-month period, allowing **healthy lifestyles support** and treatment to begin.

6. **32 student nurses** were given the opportunity to gain first-hand experience of community nursing while 'on tour' with our information bus, performing health checks on more than 1,000 people.

Transforming what we do

7. **86% of people** with a serious mental illness have completed or been offered an annual physical health check, noticeably improving the physical health of those with SMI.

8. More than **50 staff including senior leaders** a cross maternity services have completed Black Maternity Matters training to improve their cultural knowledge and understanding.

9. Almost **1,800 people** at risk of developing Type 2 Diabetes have taken positive steps to improve their health and wellbeing by completing the 9-month National Diabetes Prevention Programme.

10 **More than 200 health and care staff** received support from the Wellbeing Line. A further 2,500 attended team and group sessions about things like mindfulness, neurodiversity and peer support for team leads and wellbeing champions.

11 **26 GPs** have been supported by Gloucestershire Primary Care Training Hub's 'Be a GP Partner' programme, with many more attending elements of the bespoke programme.

12 **More than 1,000 people with dementia** and their families were referred to The Alzheimer's Society Dementia Advisors for advice, support and signposting to services.

13

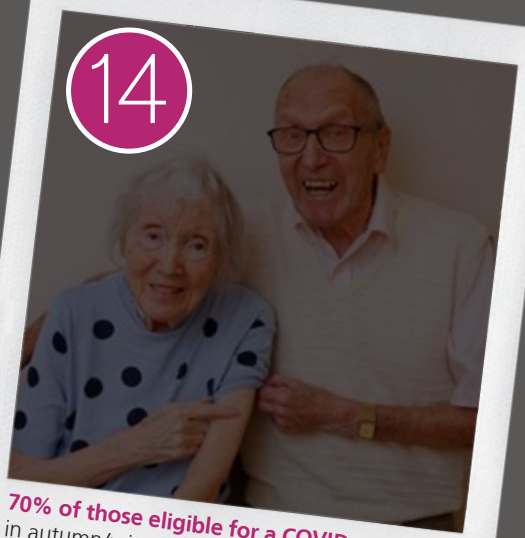
95 people living with dementia and their carers have been supported with personalised music therapy at home to support their wellbeing.

Improving health and care services today

15 Around **25% more diagnostic tests** are taking place than the previous year, reaching an all-time high three times, most recently in January 2025 where almost 26,000 tests took place.

16 GP practices are providing just **over 25% more appointments** with a range of professionals compared to the end of 2019.

14



70% of those eligible for a COVID vaccine in autumn/winter 2024 took up the offer, making Gloucestershire the highest for vaccine uptake in England.

17 More than **8,000 people each month** attend Gloucestershire's Minor Injury and Illness Units, who consistently meet and exceed the four hour waiting time targets for this type of service.

18 **More than 4,700 referrals** were made to the community Rapid Response service which operates 24 hours a day, 7 days a week. Over 87% of these people have been treated at home, avoiding an unnecessary hospital stay.

19 Around **75% of people** found out whether they have cancer within 28 days of being referred by their GP thanks to quicker access to diagnostic tests.

20

Each month the **NHS App** was used to book more than **4,000 GP practice appointments** and order around 56,000 repeat prescriptions.

News Digest

Stories from around the county

Making Gloucestershire a better place for the future

Increase prevention and tackle the wider determinants of health and care

Gloucestershire children given free access to Lumi Nova app

More than 1,500 children in Gloucestershire, aged between seven and 12, have now accessed the Lumi Nova app. The app offers anxiety support in a fun, safe and interactive environment, using a quest-based game.

Early data from the pilot suggests the service is easing pressure on local primary care and children's mental health services, with 70% of children in Gloucestershire who have used Lumi Nova as a first line intervention requiring no further support (based on survey feedback from 45 families in Gloucestershire as of December 2024).

Supporting children and young people to get active

More than 300 children and young people in primary and secondary education with mild to moderate mental health difficulties have been supported to access physical activity opportunities.

Children receive 12 funded sessions for an activity of their choice, including sports like fencing, horse riding and dance. This supports children to improve their wellbeing through becoming more active, developing new interests and hobbies, and building friendships.

Schools invited to sign up for new Asthma Safety Initiative

Over 50 primary and secondary schools across the county are working towards Asthma Friendly certification, with three schools fully certified, taking steps to ensure the safety of children and young people living with asthma.

It involves schools, Public Health and the NHS working together to ensure children and young people living with asthma have the best opportunities to live well and succeed as their fellow classmates.

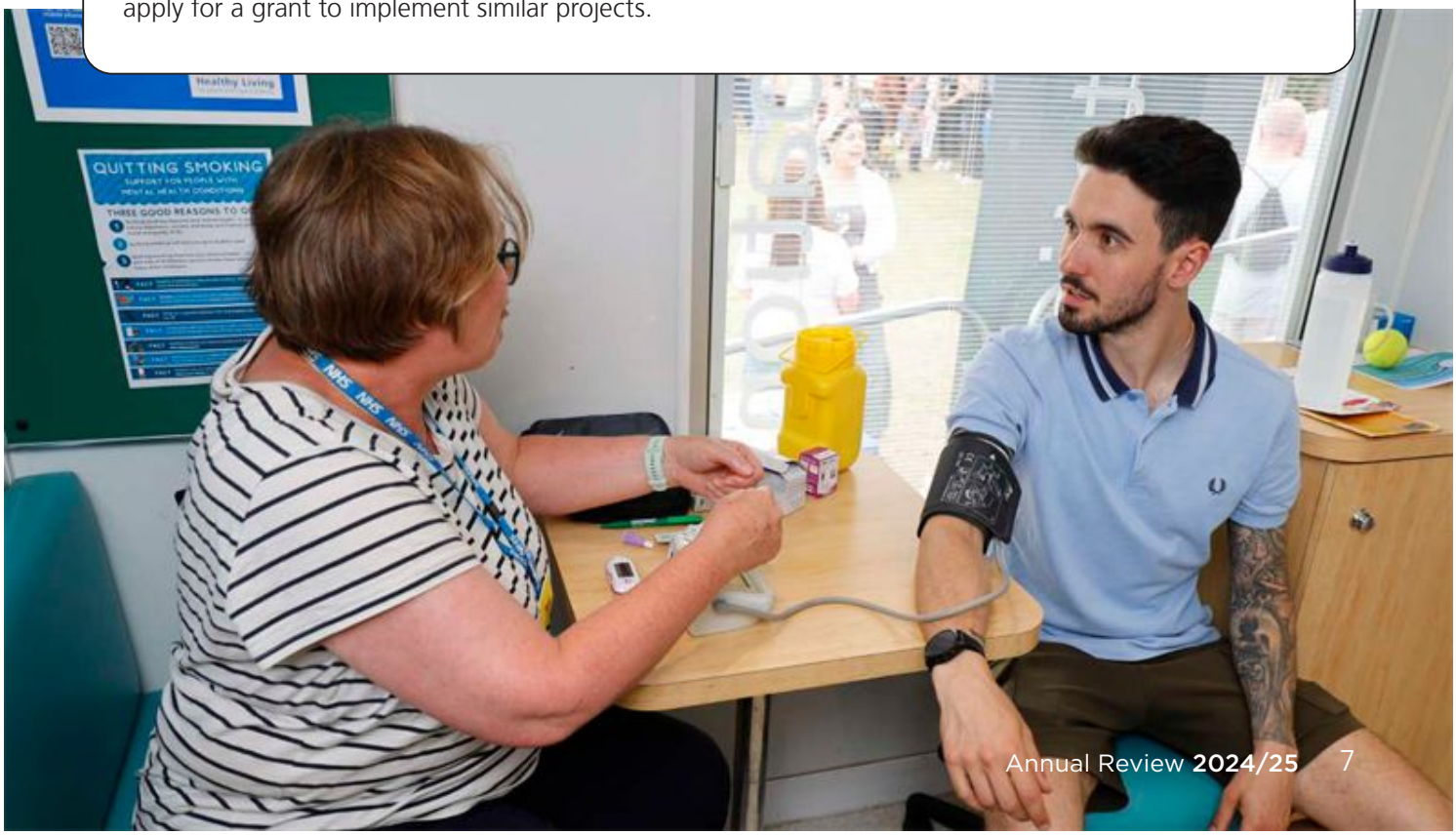
Along with nominated asthma champions, the schools develop an asthma policy, hold treatment plans for every child with asthma, and ensure emergency medication kits and plans are in place in every setting.

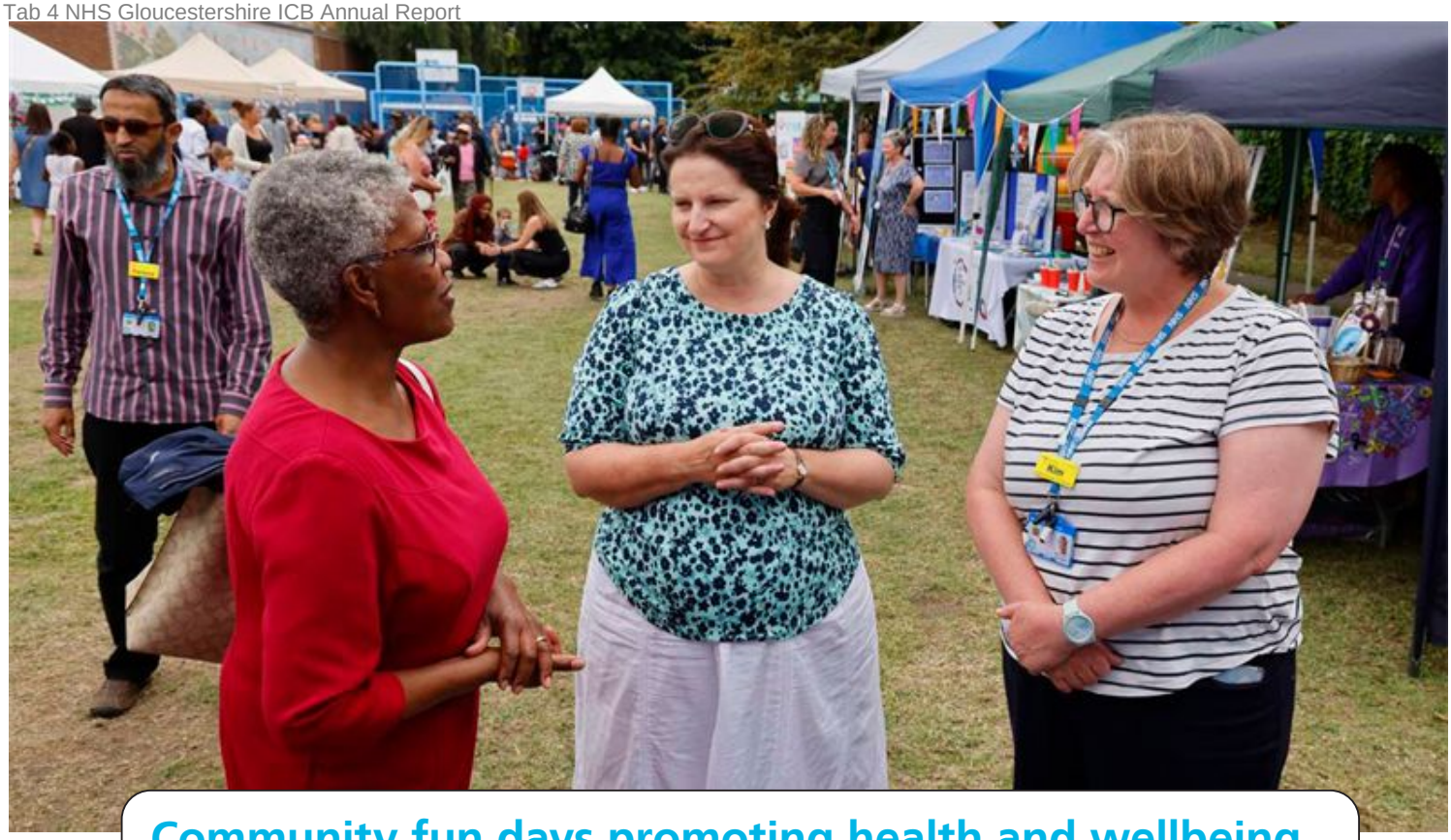
Working with the voluntary and community sector to offer blood pressure checks

GL11 Community Hub in Stroud and Berkeley Vale offered almost 700 blood pressure (BP) checks as part of a pilot scheme to increase checks outside of traditional health settings.

Some people reported finding it embarrassing to check their BP in GP waiting rooms and were less anxious being tested in a non-health setting. Staff at GL11 were able to combine giving the BP check with wider wellbeing support, for example advice about loneliness and isolation or financial advice.

The scheme is being expanded in 2025/26 with VCSE organisations being offered the opportunity to apply for a grant to implement similar projects.





Community fun days promoting health and wellbeing in the Cotswolds

1,800 people were able to make connections, try out new things and explore options for help and support at a series of community health and wellbeing events in the Cotswolds.

More than 25 agencies joined forces to promote health and wellbeing activities, advice and support in areas of the Cotswolds where people face challenges.

From providing advice on blood pressure, diabetes, diet and exercise through to showcasing sports such as trapeze and circus workshops, the events were well received by attendees who appreciated the opportunity to connect with their local community.

Monthly 'Action Days' Raise Dementia Awareness Across Communities

Health and care teams have been working with local organisation Dementia Action Alliance to take information to the heart of communities in a bid to raise awareness of dementia.

Visiting a different part of the county each month, the team have conversations about the signs and symptoms of dementia and how to access diagnosis, treatment and support.

They also talk to people about how healthy lifestyles in mid-life (aged 45-65) can reduce the likelihood of getting dementia by up to a third.

Supporting veterans to access healthcare

More than 5,500 armed forces personnel, veterans and their families are better able to access the healthcare and support they need thanks to an ambitious partnership project in Gloucestershire.

GP practices in the county are receiving support from the ICB to sign up to the Royal College of General Practitioners (RCGP) Accredited Veteran Friendly Practice scheme, increasing their understanding of the health needs of veterans and the services available to them. They are able to appoint a clinical lead who is trained to act as a champion for issues relating to veteran healthcare.

So far, 80% of practices have signed up to the scheme, with more currently in the process.

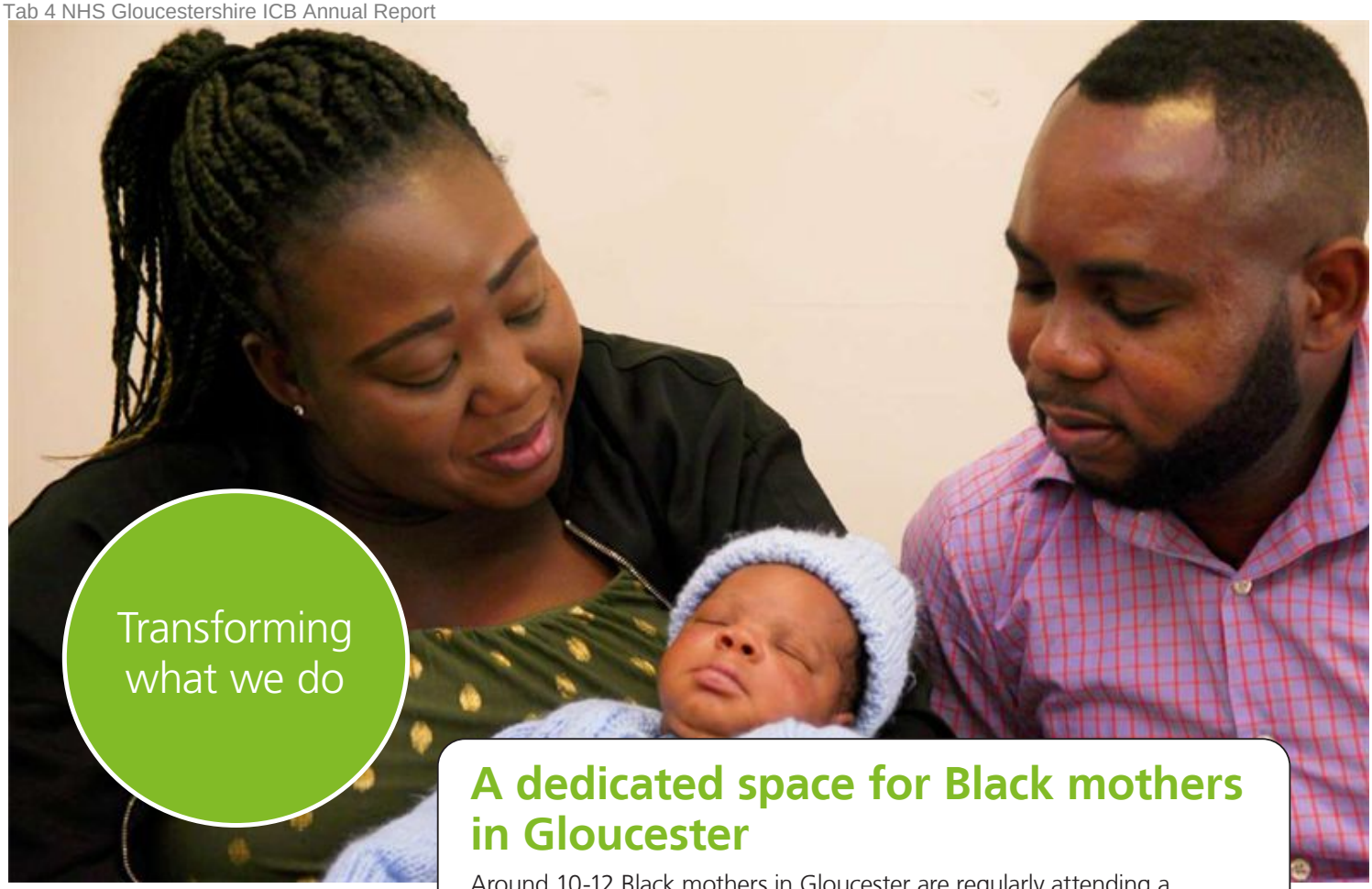
Award winning music charity helping young people to reach their full potential

The Music Works, one of our five partners in the Creative Health Consortium, have supported more than 8,500 people in the Forest of Dean and Gloucester.

The charity, who use music as a powerful tool to help young people reach their full potential in learning and life, offer a variety of programmes and events for people facing isolation, disability, physical or mental health illness.

Their health inequalities programme also provides targeted outreach, music mentoring and after school clubs in areas where people face disadvantages or who might be navigating things like youth justice, the care system or being a refugee.

Following a nomination by Forest of Dean MP, Matt Bishop, The Music Works won the regional Health Equalities Award at the 2024 Parliamentary Awards.



Transforming what we do

Take a community & locality focused approach to the delivery of care

A dedicated space for Black mothers in Gloucester

Around 10-12 Black mothers in Gloucester are regularly attending a dedicated space to meet others and find support, and they're considering finding a larger meeting space so they can expand.

The peer support group is run by Black Mothers Matter, a Community Interest Company which first started in Bristol.

In addition to creating friendships and offering peer support, the group enables vital signposting. One mother who attended was encouraged to speak to her health visitor about her concerns around her baby's weight, meaning advice and support could be given.

Specialist support helping people to stop smoking in Gloucester

A group of GP practices in inner city Gloucester have been reaching out to their 800 Polish, Czech and Slovak speaking patients with specialist support in their own language to stop smoking.

Data revealed that after English patients, the largest number of smokers within the patient population at Gloucester Health Access Centre (GHAC), Severnside Medical Centre, Partners in Health and Kingsholm were from Eastern Europe.

Their in-house Smoking Cessation Coach, who speaks Polish, Czech and Slovak, has contacted over 350 patients with more than 100 accepting support.

Popular strength and balance classes come to Cheltenham

Around 75 older adults in Cheltenham are attending one of six strength and balance classes available across the town each week. Around 20% of the town's population are aged over 65 and the Integrated Locality Partnership identified a need for people to be linked with activities in the community that could help them stay well for longer at home.

Since launching in March 2024, the popular award-winning exercise classes have been helping people to maintain independence, resilience and wellbeing in addition to strong bones, muscles and better mobility. Classes offer a variety of standing and seated exercises for all abilities.

Community Wellbeing Hub promoting health and wellbeing in Gloucester

A Community Wellbeing Hub on Stroud Road in Gloucester is helping to create a healthy, happy, successful and thriving local community.

Established in June 2024, the hub is providing a number of important support initiatives for local residents and patients at the local GP practices. Activities have included gardening, crafting, a choir for people with dementia as well as support groups for veterans and people with Parkinson's.

In addition to encouraging friendships and support, the hub has helped people develop confidence and improve their health wellbeing.

Older patients at Aspen Medical Practice benefiting from specialist frailty care

Around 700 people registered with Aspen Medical Practice have been supported by an innovative project which aims to help older people to live safely at home for longer.

The practice identified which of their 31,000 patients were living with dementia, housebound or have high levels of frailty and would benefit from a specialised, holistic approach.

The team work alongside hospital and community services to monitor and support patients, a collaborative approach which has led to a reduction in unplanned hospital admissions and urgent appointment requests.

The practice also work with patients and their carers to develop personalised care plans and think about 'what matters to me' before working together to achieve those goals, supporting people to live independently for as long as possible.

Stay Well this Winter (SWTW) campaign supported people to have a healthy winter

Fifteen of our health, social care, voluntary and community sector partners were at the heart of our innovative SWTW campaign, using their expertise to encourage people to take practical steps to support their health and wellbeing during winter.

Working with these local experts, we created 24 videos with advice on topics ranging from eating well, staying warm, looking out for others and prioritising mental health to advice on cost of living.

The campaign was well received, with more than 600,000 post and video views across NHS Gloucestershire social media channels alone, and a 32% year on year increase on visits to the campaign hub.

People's Panel seeking views of local population

The One Gloucestershire People's Panel seeks out the opinions of a representative sample of over 1,000 people living and/or accessing services across the county.

Panellists' anonymous feedback is used at a county and a more local level to shape health and care services and support. Subjects covered this year have included non-medical support for health and wellbeing to inform our approach to working with VCSE organisations and communities, and a localised survey focused on the development of the 10-Year Plan for Health.

Person-centred support for carers in Stroud and Berkeley Vale

More than 1,000 new unpaid carers have been identified by GP practices in the Stroud and Berkeley Vale area thanks to a joint project with Gloucestershire Carers Hub.

A high number of carers in the area have frailty, or care for people who have frailty. Reaching out to them proactively means support can be built around their needs.

Once registered as a carer, people can access to information, guidance and support. It can also help them meet and interact with other carers in similar situation, reducing isolation.

GP practices in Tewkesbury using innovative ways to share information with patients

A series of innovative livestreams, organised by the Tewkesbury, West Cheltenham, Staunton and Newent (TWNS) Primary Care Network, have helped share vital health information with thousands of patients.

The events, hosted on Facebook Live, have covered topics including prostate health, menopause, women's health and how to manage respiratory conditions in winter.

The livestreams have reached more than 17,000 people across the PCN and beyond. Further events are planned for the coming year covering new topics including bowel cancer.

Health and wellbeing project to Enrich the lives of people in Cheltenham

A one-stop health and wellbeing offer has been developed for people living in the St Marks area of Cheltenham, where residents have a life expectancy 10 years lower than the least deprived areas of the town.

Run by Cheltenham Borough Council on behalf of the Integrated Locality Partnership, more than 140 people have engaged with the Enrich project in the first year, having input into the programme themselves, combining initiatives like exercise, nutrition and the importance of making sustainable lifestyle changes to prevent illnesses such as diabetes.

Ensure that care is accessible when it is needed most

Nurse-led heart failure service secures funding for a further year

Almost 550 patients with worsening symptoms of heart failure have been supported by a pilot nurse-led inpatient heart failure service at Gloucestershire Royal Hospital.

The service developed a 'virtual ward' to help people avoid hospital stays and recover at home after a hospital stay, in addition to treating patients through Same Day Emergency Care.

Over a six-month period, the service saw an 11% reduction in people being hospitalised with heart failure.

Funding has been secured to continue the pilot for a further year.

Acute Respiratory Infection (ARI) Hubs benefit local patients

ARI hubs have provided over 11,500 appointments to patients at risk of a hospital stay with respiratory illness (e.g. chest infections or 'flare-ups' of lung conditions).
Adults and children across Cheltenham and Gloucester can be offered same-day face-to-face assessment and treatment within 'hubs' at Rosebank GP Practice and St Paul's Medical Centre, seven days a week.

Evaluation has shown that the areas with ARI hubs have continued to maintain a lower rate of ED ARI attendances compared to other localities.

The service has received excellent feedback, with over a quarter of patients saying they would otherwise have attended A&E with their symptoms.

Current and ex-smokers in Gloucester offered lung health check

Around 5,000 current or former smokers aged 55 to 74 have been invited for a Targeted Lung Health Check since January 2025.

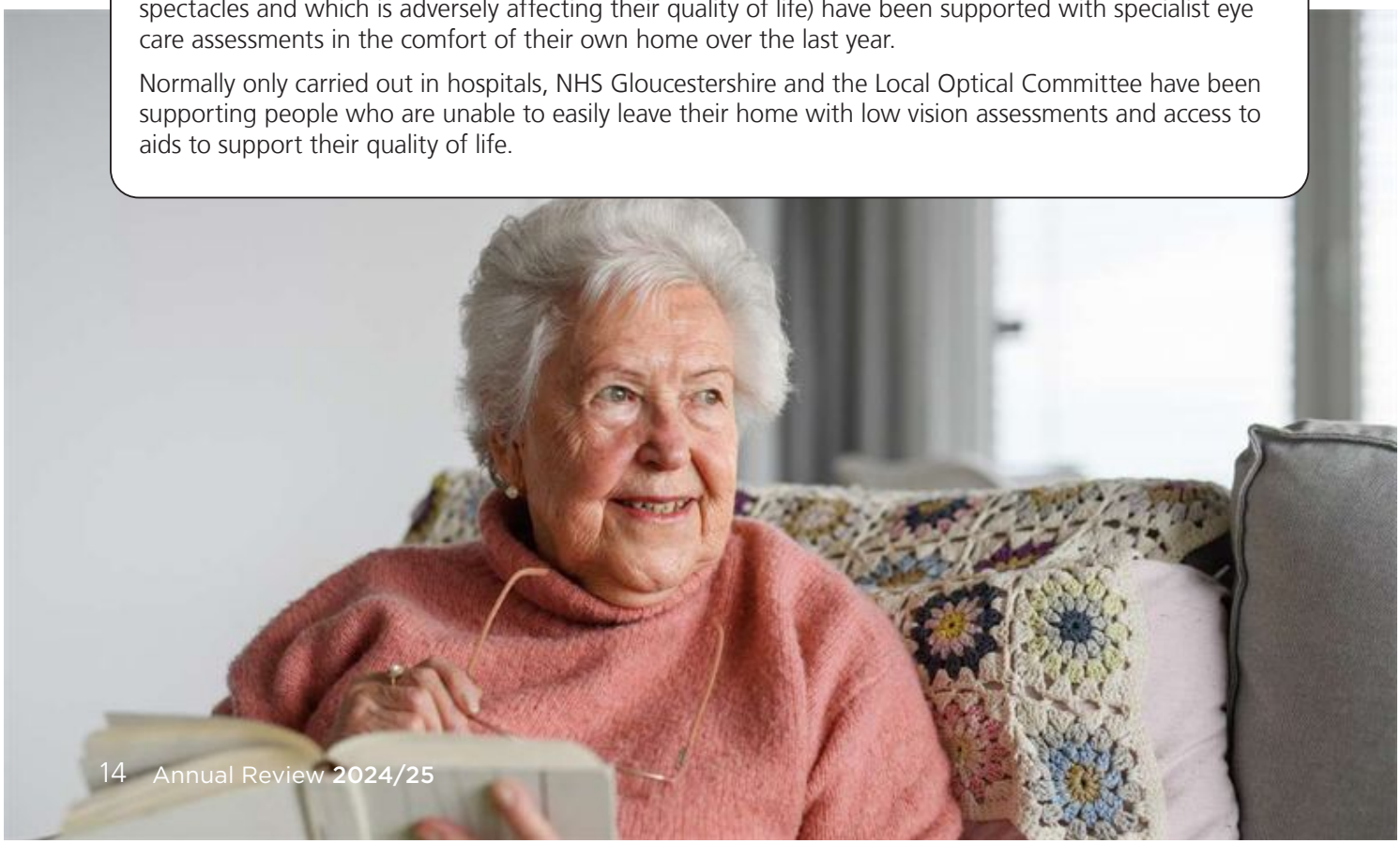
The initiative being piloted in Gloucester Inner City Primary Care Network aims to detect lung cancer at an earlier and more treatable stage by looking at how well a person's lungs are working. This marks a significant step forward in addressing health inequalities and providing targeted support to our communities, with the initiative set to be rolled out at further PCNs over the next year.

So far, more than 1,800 people have attended a check, with 13 being referred to the hospital for investigations into potential lung and other cancers. Almost 800 people have had additional assessments in primary care for other lung and some heart conditions.

Providing eye care to vulnerable people at home

Around 175 people with low vision (an impairment of visual function that cannot be corrected with spectacles and which is adversely affecting their quality of life) have been supported with specialist eye care assessments in the comfort of their own home over the last year.

Normally only carried out in hospitals, NHS Gloucestershire and the Local Optical Committee have been supporting people who are unable to easily leave their home with low vision assessments and access to aids to support their quality of life.



Transforming Adult Community Mental Health Services across the Integrated Care System

Gloucestershire Health and Care NHS Foundation Trust have continued their transformation of community mental health services with partners from across the voluntary and community sector (VCS) and experts by experience. The aim is to provide easier access to support, shorter waiting times, and provide more personalised care for people with serious mental illness (SMI).

Locality Community Partnerships, bringing together local statutory and voluntary partners to provide more joined up support to people with SMI, have now reviewed over 800 individual cases.

An Open Access Therapy service was established in February 2024 and is showing promising results. The service, co-delivered with Kingfisher Treasure Seekers, offers peer therapy for people who experience overwhelming emotions, facilitated by a specialist team who are supervised weekly by the Lead Psychologist, adhering to therapeutic community principles. There are now 149 people enrolled and data suggests a 30% reduction in GP visits and a reduction of 70% in crisis team contacts for regular attendees.

Improve quality & outcomes across the whole person journey

Improving care for people with learning disabilities and autistic people

More people with learning disabilities and autistic people are being supported to live safely at home with improved community-based support.

The Transforming Care Programme, established following the Winterbourne View review, is focused on better supporting people in mainstream services and identifying those who are at risk of developing challenging behaviour or mental health problems to provide earlier support. Where specialist assessment and treatment are needed, so far as possible, this is provided closer to home via local services.

The NHS in Gloucestershire is recognised as one of the best areas in the country for our creative, bespoke and person-centred approach to supporting people with learning disabilities and autistic people through their Dynamic Support Approach.

Maternity and Neonatal Independent Senior Advocate provides support for families

Families who have experienced a range of adverse outcomes during their maternity and/or neonatal care have been supported by a new Maternity and Neonatal Independent Senior Advocate.

The Independent Senior Advocate helps ensure that the experiences of women, birthing people and families are listened to and acted upon by care providers.

The new role is being piloted in response to the recommendations in the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust.

Supporting people in care homes to live and age well

Almost 400 health and care professionals attended learning and development sessions to better equip them in providing high quality, personalised care to individuals living in residential, nursing and independent living facilities.

More than 80% of care homes for older people now have a 'Falls Champion' in place, who is trained in falls awareness, prevention and response.

Gloucestershire's award winning joined-up approach to eye health

Community optometrists are able to access hospital eye care records and make thoroughly informed clinical decisions thanks to the Community Ophthalmic Link, developed by BlueWorks OIMS.

Accessed more than 10,000 times this year, the system has reduced e-referrals to hospital by 14% and users have reported being better able to support patients in the community in 95% of cases.

The first system of its kind in the country, the project recently won 'the Most Impactful Use of Technology on Clinical Practice' at the HSJ Partnership Awards.

Quicker diagnosis for people with dementia

People in Tewkesbury, West Cheltenham, Newent and Staunton have been receiving a timelier diagnosis of dementia as part of a 'co-diagnosis' project. Those with clear and obvious signs of dementia can now receive a diagnosis without a referral to the Memory Assessment Service (MAS).

GP practice staff and community colleagues can review patients at weekly multi-disciplinary meetings with other health and care professionals including dementia specialists. This frees up capacity at the MAS for people with less clear complex symptoms.

The rate of diagnosis of people thought to have dementia in the area has increased from just under 62% to over 71%.

Other areas have also been trialling similar projects and it is expected to be extended countywide over the next twelve months.

What matters to you? The personalised care approach

Personalised care helps people experience and access healthcare and community support in a way that matters to them. The aim is to give people choice and control over the care they receive.

Patients are able to hold their own personalised care and support plans within orange folders which have been given out to around 6,000 individuals across the county.

Two main documents are included in the plan - a Me at My Best form (giving professionals key information about a patient) and ReSPECT plans, which create recommendations for a person's care/ treatment in a future emergency in which they are unable to make choices.

There are now 82 in every 1,000 people over the age of 65 in Gloucestershire currently holding a ReSPECT plan. This compares to 71 in every 1,000 at the same point last year.

Create One Workforce for One Gloucestershire

25,000 young people explore health and social care careers with 'We Want You'

The We Want You team has engaged over 25,000 young people across Gloucestershire, inspiring interest in health and social care careers. Developed with input from young people, the project offers interactive in person workshops, careers coaching and digital resources.

In addition to offering workshops aligned with Gatsby Benchmarks for all secondary schools, tailored workshops are also available for SEN schools, home-educated students, care leavers, refugees and asylum seekers, and DWP/JCP initiatives, ensuring inclusive, impactful, and personalised guidance.

Information about options for higher education at the University of Gloucestershire as well as T Levels, apprenticeships and NHS Cadets is accessible for young people, with employers benefiting from the development of emerging talent.

A new Arts, Health and Wellbeing Centre for University's City Campus

We have continued to work with the University of Gloucestershire on the development of the new Arts, Health and Wellbeing Centre which will be part of the new City Campus in Gloucester, due to open in September 2025.

Ahead of the opening, funding has already been provided for six PhD studentships who began their studies in February 2024 and February 2025. To date 45 places have been taken up on a new Research, Audit and Evaluation course, along with training places for primary care staff to complete an accredited master's module in Independent and Supplementary prescribing.

Transform care through technology and effective use of our estate

Updated Digital Shared Care Record improves patient care

More than 6,500 health and care professionals have been using the latest version of Joining Up Your Information, a software system that allows instant, secure access to patient health and social care records.

The record combines key information from Gloucestershire Health and Social Care services, such as GP practices, hospitals, ambulance, community and mental health services and social care. This information combines into a single, shared digital record, making care safer, more efficient and joined up.

The system has been used more than 130,000 times since the new version was launched in January 2025.

Digital tool supporting GP practices to identify people at risk of deteriorating health

14 of Gloucestershire's 16 Primary Care Networks are now using a digital tool known as a personalised proactive whiteboard to identify and support 24,000 people at risk of health deterioration.

After identifying at risk groups, the aim is to provide a proactive approach to coordinating care, with a purpose of providing 'personalised care' and avoiding a crisis.

Initial evaluation has shown the rate of unplanned hospital admissions for this group of people has decreased by almost 20% in the last six months.

Investing in the GP surgeries of the future

Minchinhampton's new surgery opened in February 2025 and we are continuing to progress another five new surgery buildings that will serve 65,000 patients.

Building work on new premises in Tetbury is due to get underway late spring 2025 and subject to planning permission, work on a new Hucclecote surgery could commence in autumn 2025.

There is additional investment for the Coleford and Lydney developments, with construction work in Lydney anticipated to start by late 2025.

Meanwhile, the focus for a new Brockworth surgery is on finalising planning requirements, with a view to building work also starting late in 2025.

Improving health and care services today

Community Diagnostic Centre opens

The new £15m facility at Quayside in Gloucester has delivered 75,000 diagnostic appointments this year, giving patients across Gloucestershire access to potentially lifesaving checks more quickly, without having to go to hospital.

Quayside has also facilitated one stop clinics for lung cancer, complex breathlessness, and early detection of liver disease.

Plans are in development to provide a wider range of diagnostic tests including audiology and neurophysiology over the coming year.

Improve the timeliness of care and treatment

NHS in Gloucestershire reduces long waits by almost two thirds

Significant progress has been made in reducing the longest waits for treatment planned care operations and procedures), 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 just over 1,000 at the end of March 2025.

We continue to work hard to meet the ambitious 18-week target (the government target is to reach 92% by March 2029), with 67.4% of patients being treated within this timeframe in January, compared to 58.9% nationally.

The total size of the waiting list is now at just under 77,500, reduced by 3,600 from its highest levels in 2023.

Providing support to patients waiting for treatment

Almost 40,000 patients who are waiting for treatment have been contacted by the Elective Care Hub over the last twelve months, offering them support to manage their condition and provide reassurance that they haven't been forgotten.

Around 4.5% of patients contacted have been escalated to the relevant speciality team due to increasing health needs. About 1,250 patients were removed from the list because they no longer required an appointment.

Integrated Urgent Care Service playing a key role in joining up care

A new Integrated Urgent Care Service launched in November 2024, providing the NHS 111 service (both telephone and online), a local doctor led clinical assessment service and out of hours primary care service for when GP surgeries are closed.

Via 111, the public can access a range of services including pharmacy first, GP services, including the Gloucester Health Access Centre, Community Minor Injury and Illness Units across Gloucestershire, other community services and mental health support.

On average, the service receives more than 550 calls per 24-hour period - Monday to Friday and more than 700 per 24-hour period at weekends. The service is providing between 30 to 40 out of hours appointments on week days and just under 150 per 24 hours at weekends.

Joined up care helping people to leave hospital more quickly

Around 300 people each month have been supported to leave hospital more quickly when appropriate to do so thanks to the Integrated Flow Hub located at Gloucestershire Royal Hospital.

Staff from across health, social care and the voluntary and community sector, work together to support timely care, improve decision making and significantly reduce the time it takes to get people out of hospital, when appropriate.

Ensure the services we deliver today are sustainable and safe

New vaccine against Respiratory Syncytial Virus (RSV) protecting older adults and babies

A new vaccine against Respiratory Syncytial Virus (RSV), which protects older adults and babies from pneumonia, has been made available to women over 28 weeks pregnant and people when they reach their 75th birthday.

Around 67% of those who were aged between 75 and 80 on 1 September 2024 have also been vaccinated against RSV following a 'catch up' campaign.

Pharmacy First having a positive impact in Gloucestershire

All 105 pharmacies across Gloucestershire have expanded the range of healthcare services they provide under Pharmacy First. They now also offer assessment, treatment, and when appropriate, some prescription medicine, for seven common conditions, without patients needing to see a GP.

Our highly trained pharmacists can assess and treat patients for sinusitis (age 12+), sore throat (age 5+), earache (age 1 - 17), infected insect bites (age 1+), impetigo (age 1+), shingles and uncomplicated urinary tract infections in women (age 16 – 64).

Backed by a local campaign run by NHS Gloucestershire, over the past 12 months, their expertise has helped over 35,000 local people with the seven conditions and other minor illnesses.

Increasing access to NHS dentistry

We are working hard to secure additional NHS dental places. There are currently 60 urgent care appointments available on average each week at clinics across the county, including weeknight and weekend clinics, and we are continuing to increase this number. Around 230 appointments to support patients by stabilising their dental care needs are also provided each week.

First Dental Steps offers parents oral health advice at the baby's 9- and 12-month reviews whilst the Big Brush Club has so far seen 3,726 children in reception and Year One classes brushing their teeth twice a day during school time.

Only order what you need campaign encouraging people not to stockpile medicine

More than 50% of the population in Gloucestershire are on a repeat prescription for multiple medications each month, with an estimated 1.4 million medicine items wasted each year.

The Only Order What You Need campaign was promoted across GP practices and pharmacies to encourage patients to check what medicines they have before they order repeat prescriptions.

As part of our commitment to a greener and more sustainable NHS, people were also reminded about how they can safely dispose of medicines they don't need to avoid polluting our rivers and seas.

Performance report

Performance Report – an overview

This overview provides a summary of:

- the organisation and where the Integrated Care Board sits within the Gloucestershire system
- our priorities
- key risks to achieving these priorities
- how we performed over the past twelve months.

NHS Gloucestershire Integrated Care Board (ICB)

NHS Gloucestershire ICB was established on the 1 July 2022.

We are responsible for developing and implementing plans to meet the health needs of the Gloucestershire population (c670,000 people), managing the NHS budget for our area and arranging for the provision of health services in line with the plan.

How we work

The ICB Board is made up of Non-Executive Directors with a range of expertise plus representation from Gloucestershire County Council, Gloucestershire Health and Care NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, Primary Care and Executive Directors.

Representation from the County Council includes the Director of Public Health and the Director of Adult Social Care, Wellbeing and Communities.

NHS Gloucestershire Integrated Care Board (ICB) is a core member of the One Gloucestershire Health and Wellbeing Partnership alongside NHS providers, primary care, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations. The partnership strategic priorities are:

- **Making Gloucestershire a better place for the future** - improving the health, wellbeing and care of our citizens - focus on early prevention and the wider impacts on health.
- **Transforming what we do** - locality integrated working that supports the needs of the local population, achieving equity - reducing unfair and avoidable differences in health, developing our workforce, improving quality and outcomes across the whole person journey and making the most of digital technology to support care.
- **Improving health and care services today** - improving access to care, reducing waiting times, supporting improvements in urgent and emergency care and improving mental health support.

The partnership has developed a five-year interim integrated care strategy which can be found here: **https://www.onegloucestershire.net/wp-content/uploads/2022/12/Interim-Integrated-Care-Strategy-v1.1.pdf**

The Gloucestershire Joint Forward Plan (JFP) is a statutory document, covering the 17 legislative requirements. It describes how we will stay on course, through our ten strategic objectives, to deliver the three core aims and ambitions of the Integrated Care Strategy. It is refreshed annually, though the publication of the 10-year health plan later this year will lead to a larger refresh of the plan in March 2026.

The JFP is developed in collaboration with our partners across the health and care system, from agreeing the approach to reviewing the draft and approving the final version.

Within Gloucestershire, we have one main acute provider (Gloucestershire Hospitals NHS Foundation Trust), one community and mental health services provider (Gloucestershire Health & Care NHS Foundation Trust), 64 GP practices, one County Council and six District Councils.

A key part of our work together is through Integrated Locality Partnerships (ILPs): these are non-statutory partnerships of local government, NHS, Voluntary Community and Social Enterprise (VCSE) sector, housing and increasingly communities, people and wider partners such as police, education etc.

ILPs working with the 16 Primary Care Networks are in a good position to collectively understand the needs of their population and work together in partnership to provide care and support closer to home.

We also draw on expertise from a range of other organisations, such as West of England Academic Health Science Network and various universities, to engage in research and innovation related to our activities and ensure that we are using best practice within our services. We use this engagement to help develop and improve our services.

Our Constitution

The ICB's constitution, sets out the arrangements the ICB has put in place to meet its responsibilities for the people of Gloucestershire. It describes the governing principles, rules and procedures which ensure integrity, honesty, and accountability. It also commits the ICB to taking decisions in an open and transparent way and places the interests of patients and the public at its heart.

Our constitution can be found on our website: **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/icb-constitution/**

Decisions made by the ICB consider the likely impact on relevant organisations and the local population. All service changes are underpinned by relevant impact assessments and engagement and consultation as required, so that the Board and its sub-committees can take informed decisions.

The NHS is offering more and more options to enable patients to make choices that best suit their circumstances and give patients greater control of their care.

Patients can review the choices available in the NHS Choice Framework. If a GP needs to refer a patient for a physical or mental health condition, in most cases people have the legal right to choose the hospital or service they would like to go to. This will include NHS as well as private hospitals if they provide services to the NHS. The ICB has patient information relating to patient choice on our website **https://www.nhsglos.nhs.uk/your-health-services/community-and-hospital-care/patient-choice/**

Performance

Our performance is measured across a range of local, regional and national performance measures.

The performance of the system during 2024/25 is set out in the following summary. We have focused on key national targets that are set out in the wider NHS constitution, as well as performance against local strategic milestones we committed to in our Joint Forward Plan: **https://www.nhsglos.nhs.uk/wp-content/uploads/2024/07/Joint-Forward-Plan-2024.pdf**

Performance Overview

The table below shows our performance assessment against system plans in 2024/25 by programme area.

Programme area	2024/25 Outturn	2025/26 Forecast
Urgent and Emergency Care	Amber	Amber/Green
Elective Care	Amber/Green	Green
Cancer	Amber	Amber/Green
Mental Health	Green	Green
Community Care	Green	Green
Primary Care	Green	Green
Diagnostics	Amber	Amber/Green

We have seen improvements in several programme areas over 2024/25. The Working as One transformation programme has contributed significantly to maintaining stable performance in Urgent and Emergency Care waiting times throughout a challenging year.

The system has collaborated to enhance the Urgent Care pathway, with a particular focus on minimising discharge delays to ensure patients can return home promptly.

Additionally, we have achieved further reductions in the number of patients waiting over a year for elective (planned) care, while our diagnostic activity has increased to support both cancer and elective pathways.

Our primary and community care services have consistently met planned expectations for activity and waiting times in 2024/25, and we anticipate continued success into 2025/26.
Further detailed performance analysis is provided in the Performance Analysis section.

Key risks

The approach taken by the ICB around the management of risk is set out in the annual Governance Statement (see Corporate Governance Report section of this Annual Report).

The key issues and risks that the ICB have been managing during 2024/25 have been included in the Board Assurance Framework which included several principal risks linked to the achievement of organisational strategic objectives as set out below:

- The failure to promote and embed initiatives on health inequalities and prevention.
- The risk 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.
- 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.
- 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.
- The 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.
- The risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.
- 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.
- Failing to deliver increased productivity requirements to meet both backlogs and growing demand.
- Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes.
- Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity.
- 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.
- Emergency Preparedness, Resilience and Response (EPRR) - Failure to meet the minimum occupational standards for EPRR and Business Continuity.
- Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.

The Board Assurance Framework (BAF) is supported by the Corporate Risk Register with regular reporting of the BAF to the Board and Audit Committee and the risk register to the Audit Committee and ICS Operational Executive meetings.

In addition to managing the risks identified as a threat to the delivery of the strategic objectives, during 2024/25, NHS Gloucestershire ICB has been monitoring and managing the risks and issues relating to the delivery of priority operational issues of Planned Care, Urgent and Emergency Care including Ambulance and Discharge, Cancer, and specific quality issues in provider organisations.

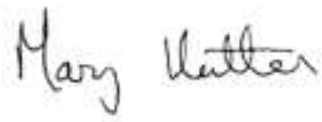
Full details of the most significant risks are detailed in the Governance Report within the Risk Management Section.

An explanation of the going concern

The ICB is required to explain its consideration of its status as a going concern. This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

This is in addition to the Secretary of State direction that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result, the governing body of NHS Gloucestershire ICB has prepared its financial statements on a going concern basis.



Mary Hutton

Chief Executive Officer

June 2025

Performance Report – performance analysis

Introduction and context

NHS Gloucestershire Integrated Care Board (ICB) monitors how our services in Gloucestershire are performing in terms of quality, timeliness, and safety.

We evaluate performance against national NHS targets and our operational and strategic plans, including the Joint Forward Plan.

We regularly assess system performance with system partners in the ICB board, focusing on service quality, performance, activity, finance and workforce in our Integrated Performance Report. Latest reports are available in our board papers: **https://www.nhsglos.nhs.uk/category/board-meetings/**

National priorities for the operational plan throughout 2024/25 were focused on the performance recovery of our core services and improvements to productivity following the COVID-19 pandemic. In particular, waiting times for Urgent and Emergency Care services, Elective (planned) treatment, cancer diagnosis and treatment and Diagnostic tests were all highlighted for specific improvement.

We have seen significant improvement in many of these areas, but challenges remain - particularly during the winter season as increased illness and demand for acute care impacts our population and staffing.

Primary care access, including dental provision has been of significant concern to patients nationally and was a key deliverable in the 2024/25 national strategy.

We have continued to deliver record numbers of general practice appointments, while working with our local NHS dentist providers to increase activity delivered and availability of urgent and stabilisation appointments to those without a routine dentist.

Patient satisfaction with general practice services in the county continues to benchmark well nationally and we have delivered the highest uptake of the COVID-19 booster vaccine to eligible patients in the country during the Autumn campaign for 2024/25.

Access to mental health services was the third area to be specifically identified in the operational planning priorities for 2024/25, and we have continued to deliver high access rates for perinatal mental health services, Children and Young People's services and transformed community services for people with Serious Mental Illness. We know how important holistic care is for those with a Serious Mental Illness so have continued to work to improve the uptake of physical health checks in this population and expanded the offer of support through services such as Individual Placement Support (IPS) to help people with benefits counselling and make a return to work more achievable with individualised support to find the right role.

Post the global pandemic, productivity across the NHS was affected and reduced as a consequence. This also applied to Gloucestershire, coupled with the additional challenge of higher demand and more complexity from our ageing population.

Gloucestershire has been and continues to focus on achieving the best outcomes for its residents whilst also securing value for money and meeting key performance standards and targets.

This targeted approach on doing the best for the people of Gloucestershire has resulted in a renewed focus upon improving productivity across all health services in the county, which is essential to fully recover our service performance within our financial means. Examples include initiatives on outpatient productivity and efficiency; this year, our acute provider implemented a patient portal to facilitate communication with patients, resulting in fewer unattended appointments and late cancellations and has continued to focus on maximising the use of resources, for example ensuring maximum use of our theatre space and optimising theatre lists to minimise downtime.

Following the publication of the Darzi review in 2024, the government announced the development of a 10-year Health Plan to respond to the challenges faced by the NHS. Engagement has been taking place throughout 2024/25 - focusing on three shifts: Moving more care from hospitals to communities; Making better use of technology in health and care; and focusing on preventing sickness not just treating it.

These aims are in line with the three pillars of our ICS Strategy (**https://www.onegloucestershire.net/wp-content/uploads/2024/12/Interim-Integrated-Care-Strategy-v1.1.docx**) and we have reviewed our performance throughout 2024/25 with this in mind, considering the specific performance commitments we made in our JFP refresh for 2024/25 (***https://www.nhsglos.nhs.uk/wp-content/uploads/2024/07/Joint-Forward-Plan-2024.pdf**) as we look to the future of our services in Gloucestershire.

Performance analysis - Pillar One: Making Gloucestershire a better place for the future

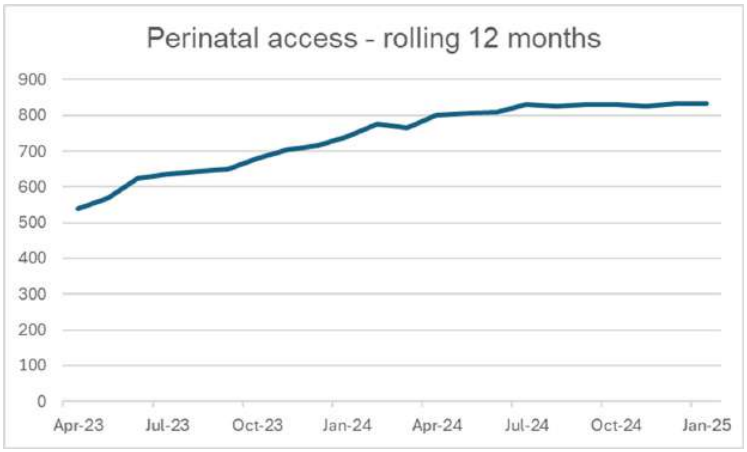
Objective - Increase prevention and early intervention

Alongside working with Public Health and partners across the county to prioritise prevention, for example expanding tobacco dependency support, we are investing in specific services that have an impact on wider determinants of health or support people at an early stage. This aims to prevent more intensive use of health services at a later stage and keep people in a positive state of health and wellbeing.

This is particularly the case with our mental health services where we have seen expansion of support throughout 2024/25:

Perinatal mental health support

Ensuring perinatal support is available helps parents cope with anxiety, depression, and stress, fostering a healthier environment for both the parent and baby. Early intervention can prevent long-term mental health struggles and improve overall well-being.



We have seen access grow across Gloucestershire perinatal mental health services to exceed our target for 2024/25 (672 people receiving perinatal mental health support in the year), which also includes support for those with mental health needs planning a pregnancy. We are aiming to maintain this access in 2025/26.

Individual Placement and Support (IPS)

Having seen the IPS offer grow throughout 2023/24, in 2024/25 we have maintained access to this service, helping people with severe mental health problems find paid employment which has been shown to reduce people's symptoms, improve quality of life and enable financial independence.

Performance analysis - Pillar 2: Transforming what we do

Objective - Take a community & locality focused approach to the delivery of care

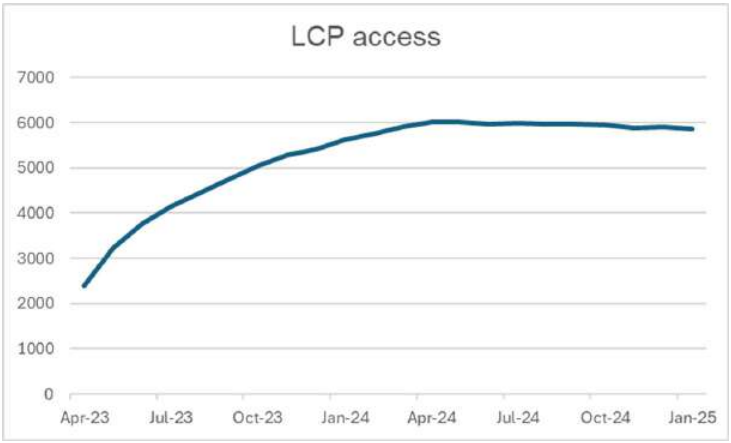
Pillar 2 sets out our aim to transform health and care delivery in Gloucestershire using a community and locality approach to ensure quick and early diagnosis and provide support closer to home. This approach involves integrating services across different providers to deliver joined-up care as well as providing alternatives for some services to support timely and easy access.

Frailty

During 2024/25 we have piloted Integrated Neighbourhood Teams which have specifically worked to proactively identify and support people with frailty. This has contributed to the improving performance for dementia diagnosis in the county, with the percentage of the estimated dementia population with a formal diagnosis increasing by 2% at the highest point in 2024/25 compared to the previous year.

Serious Mental Illness

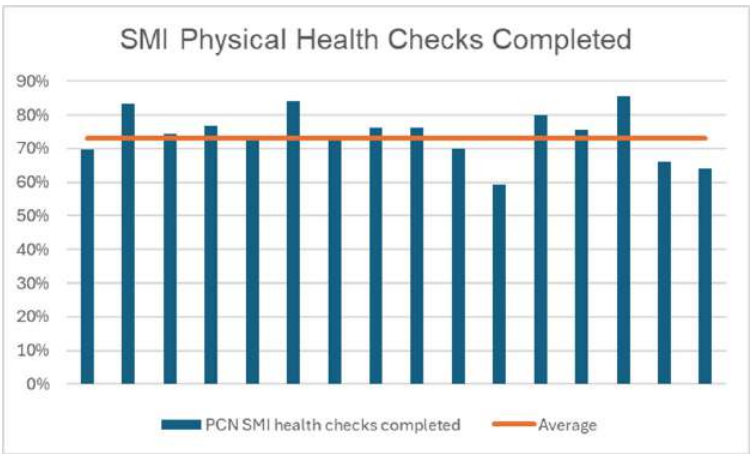
Work has continued to embed Locality Community Partnerships to support those with severe mental health needs and these have now been rolled out across the county. We have seen steady increases in the number of people with severe mental health needs accessing these transformed services throughout 2024/25.



Across the Primary Care Networks (PCNs) we have seen good continued uptake of physical health checks by people with Serious Mental Illness (on the register in primary care) - all bar one PCN achieved above 60% (national target) with the average across the system at 73%.

This gives clinicians the opportunity to support health interventions for people which will prevent worsening physical health and help to contribute to decreasing the gap in life expectancy between those with serious mental illness and the rest of the population.

In our county, lower areas of uptake of health checks tend to be in higher areas of deprivation and we are actively working across primary and secondary care to improve this position and reduce this inequality.

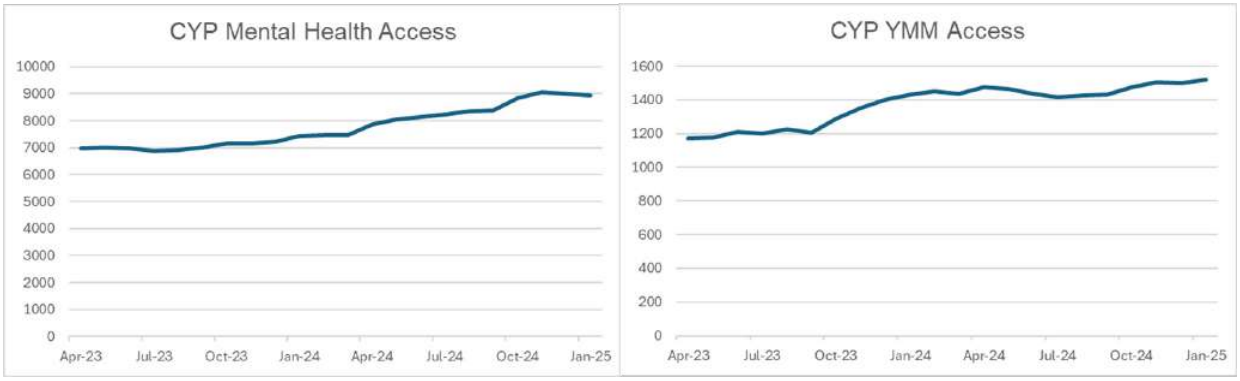


Children and Young People's mental health access/Young Minds Matter

We have continued to roll out Mental Health Support Teams (known locally as 'Young Minds Matter') in our schools in a phased approach - prioritising areas of highest deprivation and greatest need.

These teams offer online or in-person support to children and young people suffering from anxiety, low mood and poor sleep or similar concerns. This not only offers young people the most appropriate support for their circumstances but helps to reduce demand for more intensive mental health support.

Overall, Gloucestershire offers good access to children's mental health services, with access in 2024/25 increasing compared to 2023/24:

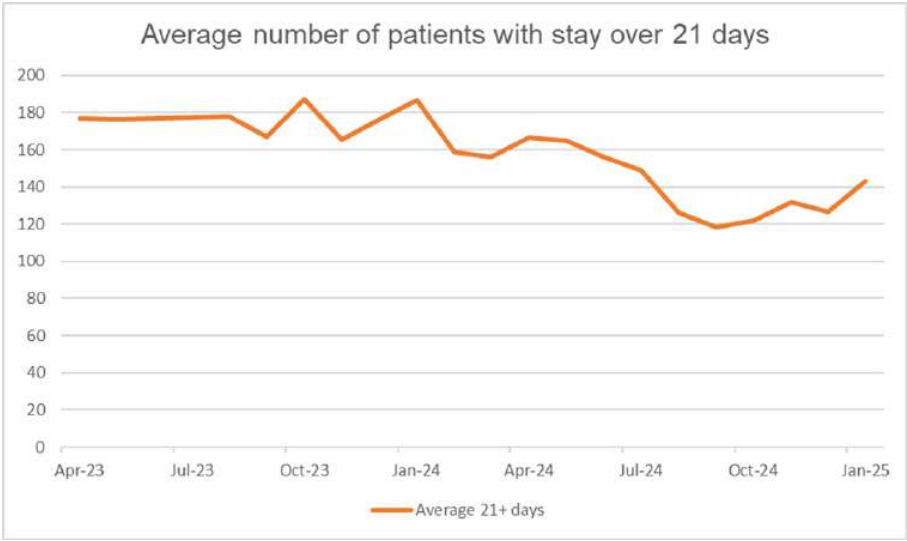


Objective: Providing the right care in the right place, when it is needed most

Urgent and Emergency Care

Throughout 2024/25 we have continued to implement our 'Working as One' programme for Urgent and Emergency Care (UEC). Aims included helping to avoid admission to hospital when possible, improving the care pathways (flow) across the whole UEC system and expanding our offer of technological support to care, such as through our virtual wards.

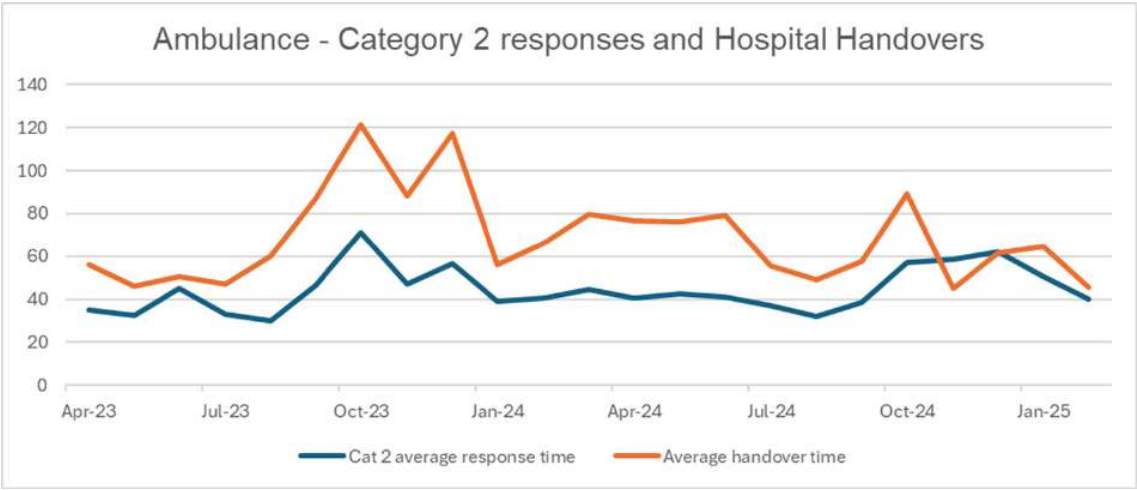
By optimising hospital flow, the length of stay in acute hospitals has been reduced by 14%, making it easier to ensure space for patients needing admission. Additionally, there has been a consistent reduction in patients staying in hospital for more than 21 days throughout the year, although this trend faced challenges during the winter months due to increased flu and norovirus incidence.



Ambulance response times

A key area of focus for the system has been shortening ambulance response times, which during 2024/25 have improved on the longest times seen in 2023/24 but have not reached the aspiration of improving to a 30-minute average for Category 2 incidents.

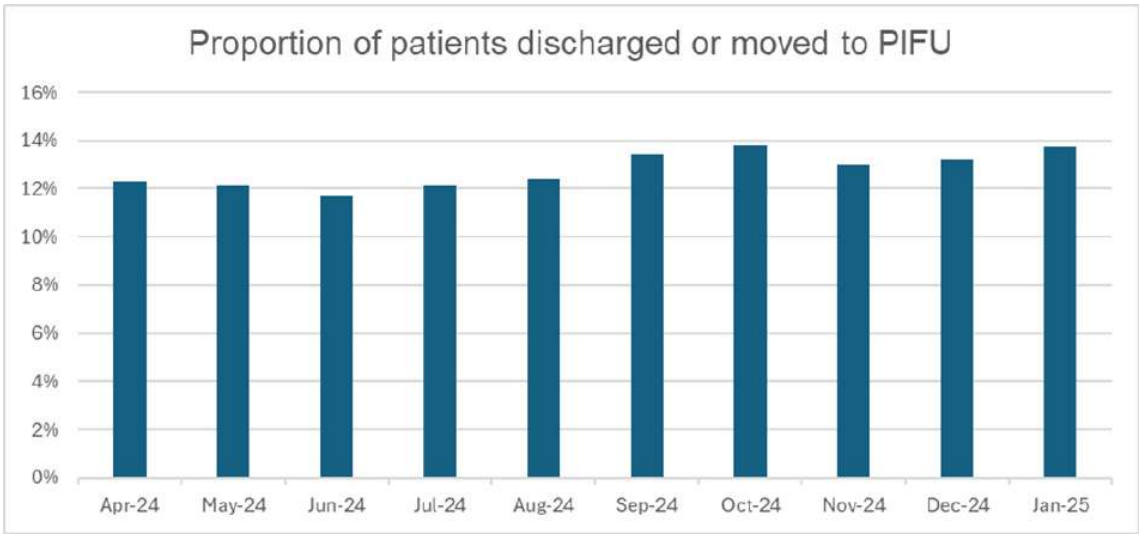
Seasonality impacts response time performance, with the winter months particularly challenging due to increased demand and more serious illness in patients. Time lost to handover at acute hospitals has been reducing in 2024/25, and the association between handover delay and Category 2 performance has not been so strong in the latter part of the year:



Elective (planned) Care

PIFU

Patient Initiated Follow Up (PIFU) enables patients to manage their condition and supports shared decision-making and self-management, by allowing them to request follow up care as and when is appropriate to them. We have maintained good levels of PIFU which helps the system to manage the volume of people on the waiting list and prioritise those needing care the most.

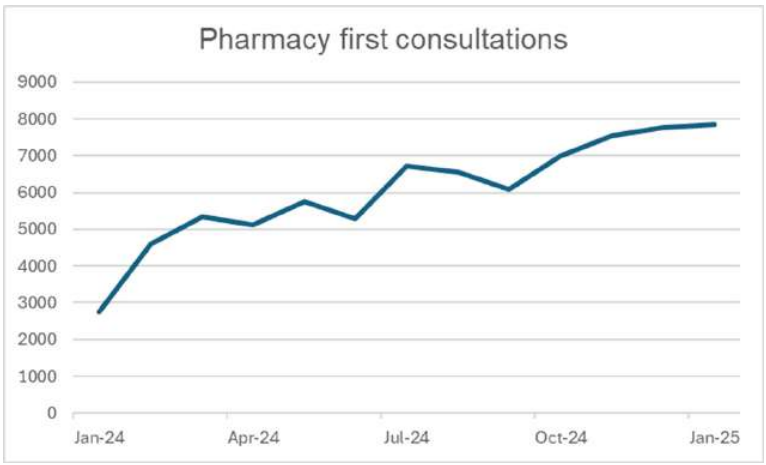


Community

Pharmacy First

To assist with access to general practice, nationally the Pharmacy First offer has been developed to allow patients to get certain prescription medications directly from a pharmacy, without a GP appointment.

In Gloucestershire, 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 and we have seen good progress in increasing consultations throughout the year:



Objective: Equity of service provision

Challenges remain in providing equitable healthcare access and addressing health inequalities that impact our population's outcomes.

Many of these areas we have reviewed countywide performance for are broken down by demographic groups in our review of Health Inequalities in Gloucestershire (**LINK in next cut**), in line with NHSE's statement on Health Inequality **https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities-duty/**

Performance analysis - Pillar 3: Improving health and care services today

Objective: Ensure the services we delivery today are sustainable and safe

Primary Care - General practice access and Dental access

Demand for primary care, in particular General Practice (GP surgery services) and dental provision, has continued to grow.

We continue to prioritise the sustainability of General Practice and Dental services supporting resilience and demand pressures for these essential services.

During 2024/25, general practice delivered the highest number of appointments on record and continued to expand the offer to patients through additional roles such as social prescribers, care coordinators, paramedics, and physiotherapists.

Performance in Gloucestershire against the 'Appointments booked within two weeks' target is lower than the national average, however due to the volume of appointments carried out in general practice, the system ranks 3/41 for appointments delivered per head of population, and 10/41 systems for volume of appointments booked within two weeks.

General Practice appointment activity

Efforts are being made to improve NHS dental access by expanding and supporting the local dental workforce and enhancing oral health promotion in collaboration with system partners.

Current performance shows that we are delivering around 70% of the contracted activity in the county, and we are working to increase this in the coming year, including committing to the national target for increasing urgent appointment availability in 2025/26.

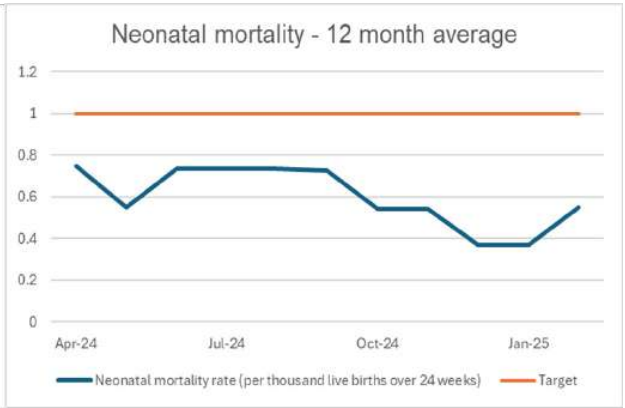
Maternity Services

Maternity services remain a key priority for our system, particularly in light of the national focus on maternity care during 2024/25.

Our Local Maternity and Neonatal System (LMNS) oversees the monitoring of safety and quality in maternity services, aligning with the national Maternity and Neonatal Delivery Plan.

We aim to improve outcomes for babies and mothers in line with national ambitions, particularly stillbirth and neonatal mortality rates. In 2024/25, we met the ambition for neonatal mortality, with mortality below 1/1000 live births throughout the year, and are actively working towards reducing stillbirth rates by supporting expectant mothers in quitting smoking and ensuring high-quality integrated care.

Additionally, we have maintained our support for the Continuity of Carer model in antenatal care within our most deprived neighbourhoods, recognising the higher risk of stillbirth in these areas.



Objective: Improve the timeliness of care and treatment

Providing timely care is essential for patient outcomes across all services, as longer waits can result in patient harm.

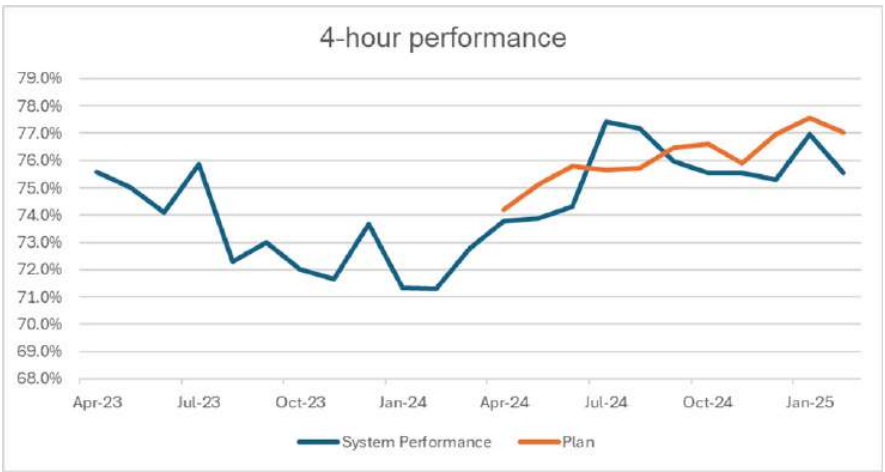
Throughout 2024/25, wait times have improved for many services, however some remain above our goals, and further focus is required on recovery of these targets moving into 2025/26.

Urgent and Emergency Care

With rising demand for acute care, an ageing population with more complex needs and challenges in ensuring people have access to the right care following a hospital admission, our 'Working as One' transformation programme has been coordinating system efforts to improve Urgent and Emergency Care pathways currently in place as well as maximising the opportunities to provide care away from acute hospitals. A key indicator for the success of these initiatives is the timeliness of urgent care delivery:

Emergency Department (ED) waiting times

The system plan for 2024/25 aimed to improve waiting times in the Emergency Department (ED) to meet national recovery targets, with 78% of patients seen, treated, admitted, or discharged within four hours across our acute and community ED and Minor Injury and Illness Units (MIIU). Although performance has improved compared to 2023/24, there has been difficulty maintaining this improvement in the last quarter of the year due to the impact of winter pressures. MIIU performance remains strong, with over 99% of patients attending our MIIU settings meeting the 4-hour target.



There has been good overall progress in the reduction of 12-hour waits in the ED, with 12-hour delays in ED from decision to admit reducing by more than a third compared to the 2023/24 average in 2024/25:

Community Urgent Care

To support hospital attendance and admission avoidance, our Urgent Community Response team have been attending more referrals, with the 2-hour target for responses met in every month over the last two years:

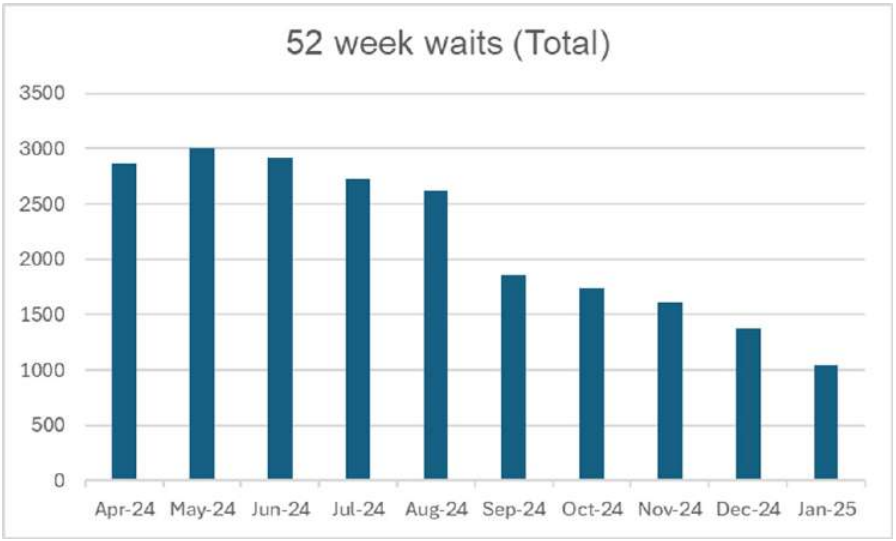
Elective (Planned) Care

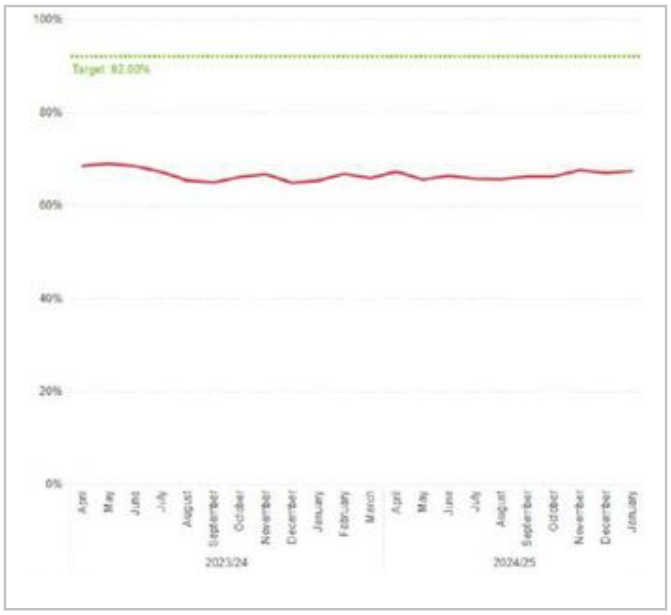
Due to the substantial increases in waiting lists for elective treatments, diagnostic tests, and cancer care, along with the deterioration of waiting times worsened by the COVID-19 pandemic, the recovery of elective services has become a significant concern for the entire NHS. This focus continued throughout 2024/25 while we remain in the performance recovery phase, with an emphasis on enhancing productivity to reduce waiting times and maintaining a sustainable size for the waiting list.

We are making services more efficient by expanding Advice and Guidance and improving secondary care pathways to ensure clinicians access specialist care effectively. We are following the 'Getting It Right First Time's Further Faster' programme - which identifies opportunities for improvements to support our recovery by ensuring only the right patients are referred, effective management of referrals, reduction in non-attended or cancelled appointments, best use of clinic capacity, and appropriate follow up (including use of PIFU).

Referral to Treatment

During 2024/25, a government pledge to restore performance to the NHS constitutional target (92% of patients waiting less than 18 weeks for elective treatment) by 2029 was made. Gloucestershire has seen significant progress made in reducing the longest waiting times for planned operations and procedures as we continued to focus on improving efficiency and increasing the capacity of our services in 2024/25.





Patients waiting more than a year for treatment have reduced to their lowest levels since prior to the pandemic, while overall performance against the 18-week target has remained stable. Specific additional capacity has been procured during the year to support specialties with the longest waits or largest numbers of patients waiting – for example additional Ear, Nose and Throat clinics and Oral Surgery theatre lists. We have also continued to expand the offer of treatment through the independent sector where appropriate to support waiting times and increase patient choice.

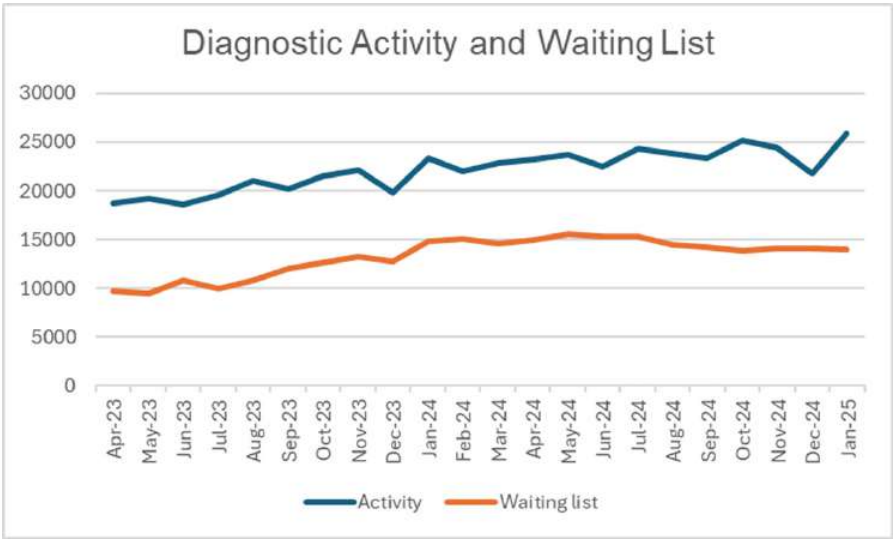
Diagnostics

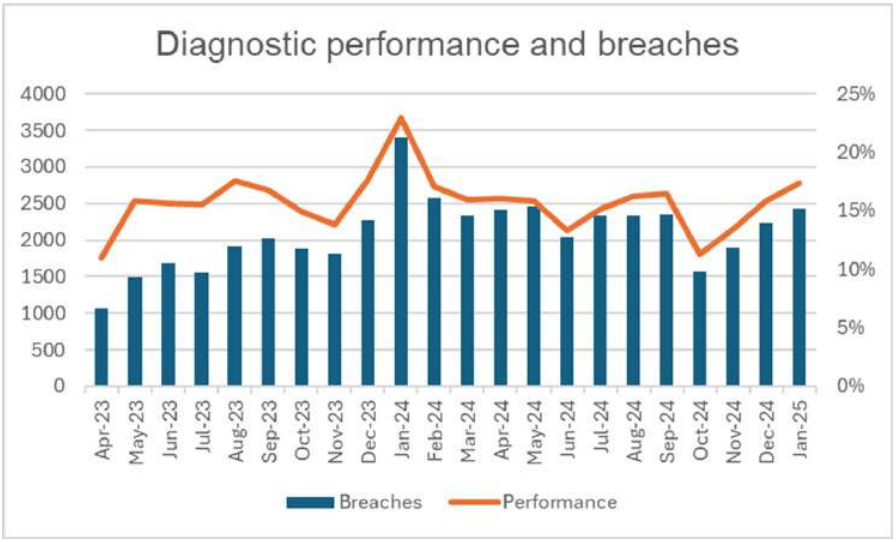
The system has continued to build on the success of the newly opened Community Diagnostic Centre throughout 2024/25, with the overall volume of diagnostic tests delivered across the year the highest on record.

We have been aiming to reduce the number of patients waiting more than six weeks for diagnostic tests, in line with the national ambition that no more than 1% of people on the waiting list should have been waiting over 6 weeks.

The COVID-19 pandemic significantly impacted performance in diagnostics - with some modalities particularly affected by infection control measures, such as Endoscopy.

With system focus on performance recovery from the pandemic, additional capacity and pathway improvements have significantly reduced both the overall waiting list for endoscopic investigations and the number of people waiting more than 6 weeks for an endoscopy. Some areas have remained challenging, such as provision of Echocardiograms within the six-week target - this is primarily due to workforce challenges with substantive staff difficult to recruit.



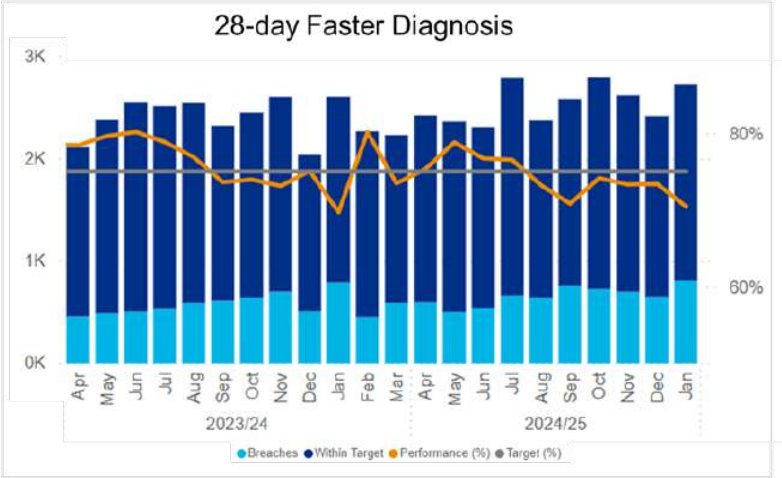


Cancer

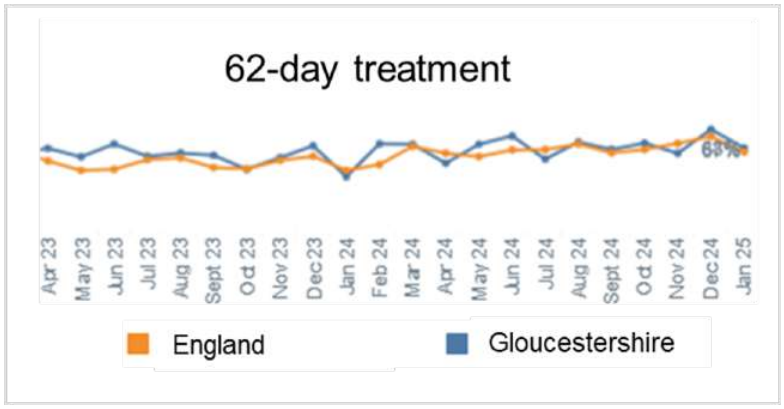
Performance against headline cancer targets has been challenging in 2024/25 due to capacity constraints within pathology services, which has particularly impacted large specialties such as skin.

The Faster Diagnosis Standard (FDS) (aim - 75% of people should have cancer ruled out or receive a diagnosis within 28 days) has not been met since July 2024 due to these issues.

However, there are system wide plans in place to address pathology recruitment and capacity and we are expecting performance to recover and meet the new ambition for FDS of 80% by the end of next year.

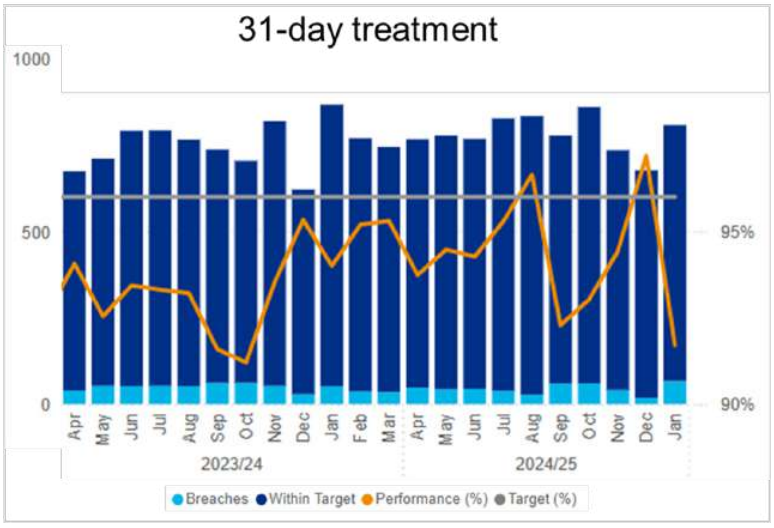


Treatment times in Gloucestershire have generally been consistent with the national average, with the year-to-date 62-day treatment performance (% of people beginning their cancer treatment within 62 days of referral) averaging just under the national interim recovery target of 70%.



Most breaches of the treatment target have been for Sin, Lower Gastroenterological and Urological cancers, and we have committed additional capacity in these specialties to improve performance. The time spent on diagnosing these cancers in particular is impacting the ability to meet the 62-day treatment targets, so work has been carried out in 2024/25 to optimise the pathway from referral to treatment, reducing delays.

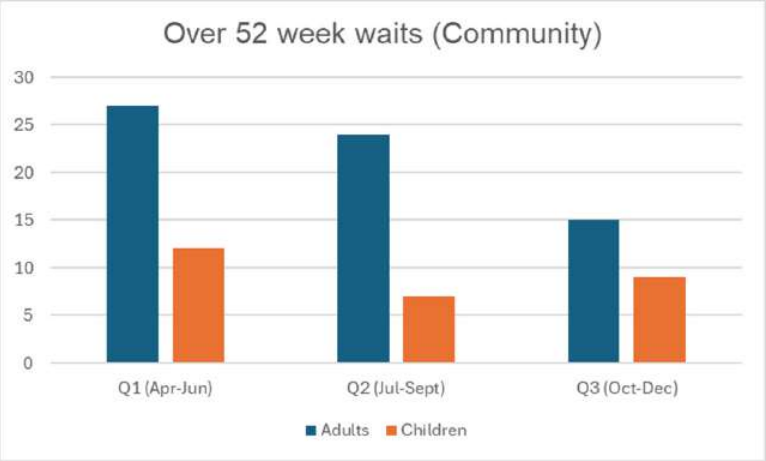
This is demonstrated by our strong performance against the 31-day treatment target (for patients to receive treatment or surgery within 31 days of a decision to treat), which has remained above 90% all year:



Community services waiting times

Focus is not only on acute hospital services, but timely delivery of care across all settings.

We have continued to see very small numbers of people waiting over 52-weeks for care in community services, which have reduced over the year, and we are planning to eliminate these in 2025/26:



Talking therapies in stage waits

Our talking therapies service has been focused on improving waiting times once people have commenced treatment - seeing significant reductions in the number of people waiting more than 90 days between first and second appointment in the latter part of 2024/25:We have continued to see very small numbers of people waiting over 52-weeks for care in community services, which have reduced over the year, and we are planning to eliminate these in 2025/26:

Working in partnership to safeguard our population from abuse and neglect

NHS Gloucestershire Integrated Care Board (ICB) has a statutory duty to put in place appropriate arrangements to safeguard children and adults at risk.

As per the 'Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework' (SAAF), ICBs are responsible in law for the safeguarding elements of the services they commission.

This includes:

- ensuring that the ICB internal safeguarding arrangements are sufficient, and that safeguarding is embedded in practice.
- being assured that the safeguarding arrangements of all commissioned services are appropriate.
- co-operating and providing strategic health leadership within statutory local multiagency safeguarding arrangements.
- securing the expertise of Designated and Named Professionals for Safeguarding adults, children, and children in care.

We set out how we have achieved this in more detail within our published annual report: **https://www.nhsglos.nhs.uk/wp-content/uploads/2024/01/NHSGlos-Safeguarding-Annual-Report-22-23.pdf** (2024/25 currently in draft)

Our comprehensive teamwork plan reflects our local, regional, and national safeguarding priorities and how we have sustained and enhanced partnership working and strengthened safeguarding collaboration across the health system. This includes our continued work with primary care (including delegated services within Pharmacy, Optometry and Dentistry and additional responsibilities alongside the NHSE Central Commissioning Hub).

We have contributed to the ICB Joint Forward Plan and outlined our areas of current focus which includes:

- the ICB Safeguarding team's commitment to supporting people who use health services to live in safety. Through our work with partners, we are helping to prevent people from experiencing harm due to abuse and neglect. This includes continued strategic health safeguarding leadership alongside our partners in the Gloucestershire Safeguarding Children Partnership, Safeguarding Adult Board and Safer Gloucestershire Board. The ICB Chief Nursing Officer (CNO) and Associate Director, Safeguarding continue in their leadership roles for the health system at the GSCP Executive.
- undertaking a review of the health system safeguarding children dataset to ensure it is focused, not onerous and meets our collective needs to ensure we collect information to inform our work going forwards across all health services. The aim is to incorporate both health safeguarding children and adults' data.
- effective succession planning to ensure the ICB meets the statutory requirements for key safeguarding and children in care roles in the future and expand the safeguarding and children in care team to meet statutory Designated and Named Nurse and Doctor resource requirements for our increasing population need.
- embedding learning from statutory safeguarding reviews where we provide health safeguarding leadership as panel members, to ensure we prevent further harm to our most at risk. ICB Designated Professionals have developed a combined health action plan to track progress of all health actions resulting from safeguarding reviews. We have regular progress meetings, with monitoring via our bi-monthly ICB led health safeguarding strategic group. Learning from local reviews is explored in more detail within our safeguarding annual report and disseminated via 7-minute briefings, training and updates, GP safeguarding forums etc.
- Health safeguarding leadership in the development of a multi-agency local process for health input and information sharing for https://www.gloucestershire-pcc.gov.uk/how-we-can-support-you/supporting-you-our-public/anti-social-behaviour-asb/anti-social-behaviour-asb-case-review/ to ensure the ICB can comply with their statutory duties in relation to anti-social behaviour. This includes obtaining GP information. An ICB safeguarding led project is underway to explore streamlining health information sharing requests for Multiagency Risk Assessment Conference (MARAC) (high-risk domestic abuse) as the demand has increased pressure on provider safeguarding teams and GPs.

- Designated Doctor and Nurse Safeguarding Children have led on Gloucestershire Safeguarding Children Partnership multiagency protocols and practice guidance and continue to chair and lead on the work within its sub-groups.
- Designated Nurse and Doctor for Children in Care have continued to lead on various workstreams and priorities for Children In Care (CiC) and Care Leavers, as set out in our annual report https://www.nhsglos.nhs.uk/wp-content/uploads/2024/01/NHSGlos-CiC-Annual-Health-Report.pdf (currently in draft for 24-25) and our workplan. Gloucestershire's care experienced population (young people who are in or have been in care) continues to grow year on year, therefore increasing demand on the specialist CiC health services.
- Supporting GP practices in complying with the safeguarding element of the Primary Care Offer including forums, supervision drop ins and practice support visits and the development and analysis of the annual safeguarding assurance audit. Our statutory Named GP Safeguarding Adults and Children is key to this ongoing work.
- Further understand how the safeguarding team can support the ICB commissioning and contracting arrangements and how to seek robust assurance for safeguarding elements for all services we commission. This includes embedding the new GSCP Safeguarding Standards for Commissioning and Procurement Document in our wider ICB commissioning work.

2023 saw the introduction of the Serious Violence (SV) duty, where specified authorities, including the ICB, must work together to prevent and reduce serious violence (set out in the Police, Crime, Sentencing and Courts Act 2022 and accompanying statutory guidance).
The definition of 'serious violence' includes domestic abuse and sexual offences.

The ICB's Designated Nurse Safeguarding Adults is our lead for the SV Partnership strategy and associated health development work alongside the Associate Director, Safeguarding.

During 2024/25, the ICB Safeguarding Team continued to deliver our statutory duties and developed as a team despite an increased demand for safeguarding services and an increase in wider statutory responsibilities.

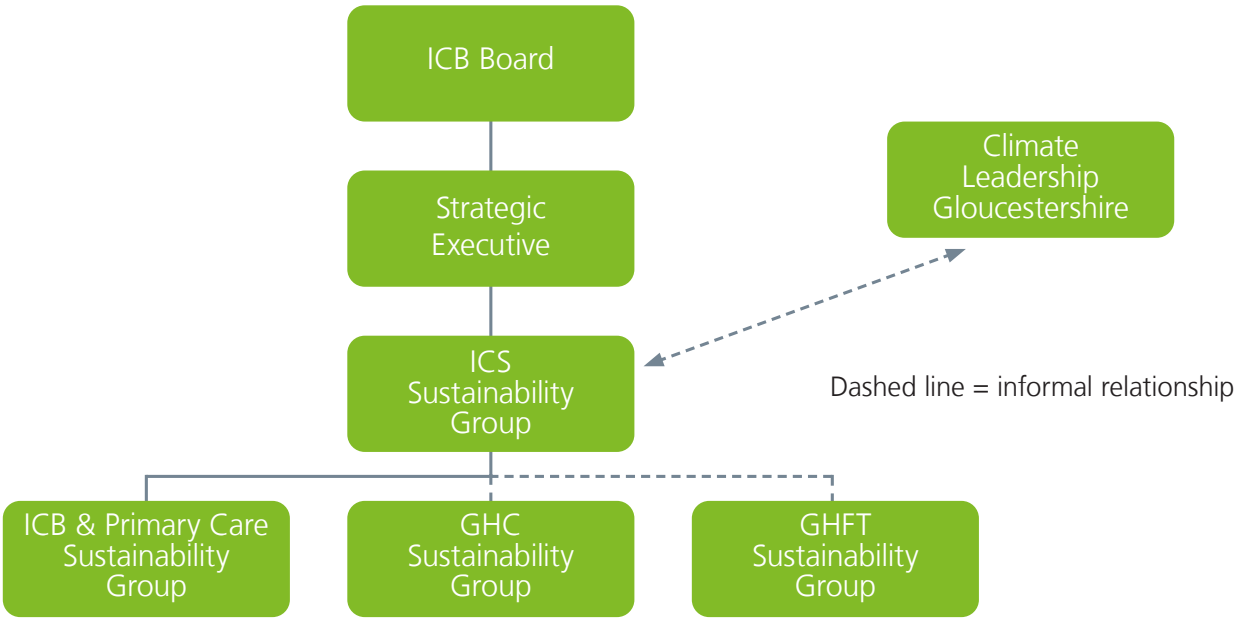
Taskforce on Climate-related Financial Disclosures (TCFD) - A sustainable and green NHS

The 'Delivering a net zero NHS' report provides a national-level framework for action on climate change and sustainability.

It is now widely recognised that Climate Change places the biggest impact on human health. NHS Trusts, Primary Care Networks, and ICSs must do all they can to mitigate the effects from an ever-changing climate.

Every NHS organisation has an essential role to play in meeting this ambition. In Gloucestershire, NHS Gloucestershire Integrated Care Board (ICB) and our partner organisations have been working together to plan how we can meet this NHS ambition together. We have produced a One Gloucestershire Integrated Care System (ICS) Green Plan: **https://www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/publications/**
The Green Plan is currently being refreshed and this will be published later in 2025/26.

The governance structure for sustainability is shown below. Membership of the ICS sustainability group is drawn from the ICB, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospital NHS Foundation Trust (GHFT) and Gloucestershire County Council, with reporting into Strategic Executives. In addition, the ICB Chief Executive is a member of the Climate Leadership Gloucestershire Board, ensuring the join up between health and Local Authorities within the county.



The ICB's Chief Finance Officer (CFO) takes responsibility for Sustainability at Board level.

Sustainability is seen as key across all programmes within the ICS, with sustainability featuring within a growing range of dedicated meetings, including the Local Health Resilience Partnership (particularly looking at the long-term impacts of climate change - Adaptation) and Estates including Primary Care.

In addition, all Board and Committee papers are required to outline the impact on Sustainability. The Green Plan is currently being refreshed and the April Board development session will include this item.

The organisation is involved in the NHS England Green agenda.

Reporting against sustainability within Gloucestershire ICS is developing.

Risk management

Climate related risks are identified by teams throughout the organisation and feed into the ICB risk registered through the ICB risk processes, all risks are assessed and managed in line with the ICB risk management approach. Risk management is described in more detail in the governance report. Work will take place in 2025/2026 as part of the refresh of the ICB Green plan to review sustainability and climate related risks more broadly and embed this within our risk management processes.

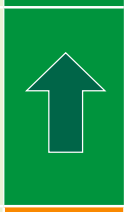
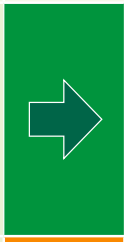
In addition, the Climate Leadership Gloucestershire partners, which include the NHS, is currently undertaking a climate risk and vulnerability assessment. The aim of this programme of work is to strengthen the understanding of climate risks across the county, and provide the evidence needed to identify priority projects and areas of work that are needed in order to reduce climate impacts.

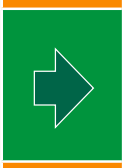
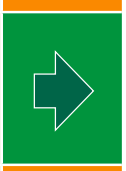
Metrics and target pillar

Key metrics for 2024/25 are set out in the ICS Green Plan across the following areas: travel & transport, estates and facilities, climate adaptation, sustainable models of care, medicines and procurement and Workforce and System Leadership. Delivery of a number of these is through our partner organisations, Gloucestershire Health and Care NHSFT and Gloucestershire Hospitals NHSFT and specific information is included in their annual reports.

Progress against the green plan is shown below:

Priority Areas	Short/Medium term objective	Objective	Progress	
Transport & Travel	Short term	Each organisation to reduce business mileage by 20%	Business mileage: reduction achieved against 19/20 baseline. ICB 24/25 mileage 54% of 2019/20 level	
	Medium term	Green travel plan including cycle to work	Green travel plans in progress aligned to NHS green travel plan • Green Travel Plans in development • Cycle schemes in place in each organisation • Lease car scheme in place for either hybrid or fully electric vehicles • Joint plan in development with GCC and NHS partners on EV charging	
	Medium term	At least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions)	Joint programme of work started across the system including GCC, development of joint plan for EV charging in progression GHC installed 30 EV charging points	

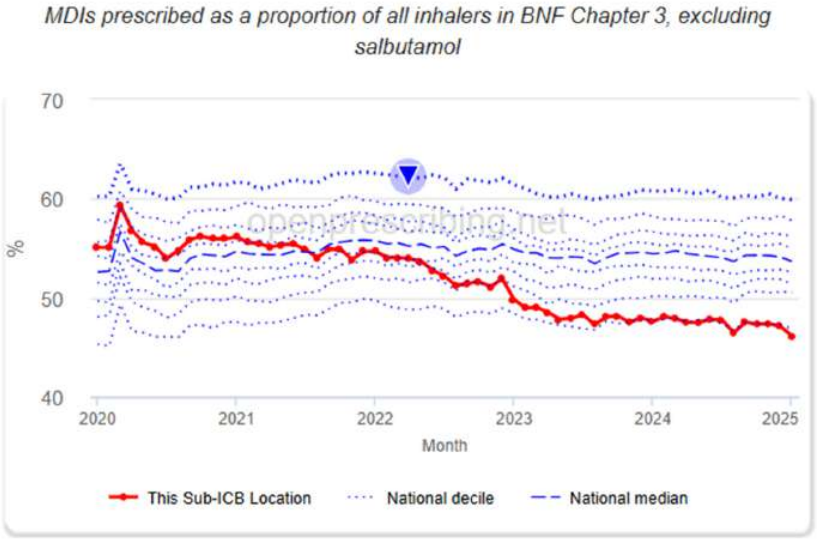
Estates & Facilities	Short term	Each organisation purchases 100% of its electricity from renewable sources	Organisations purchase from renewable sources	
	Medium term	Implementation of detailed plans	ICB head quarters move Sept 23, halving office space used Gloucestershire Health & Care NHSFT: New Forest of Dean Hospital opened April 2024, built to be net zero	
			GHFT & GHC: Salix funded projects at completion 2024/25 Carbon calculations reported through Greener NHS dashboard for Trust estate Sustainability requirements includedi in the ICS Infrastructure draft strategy	
Climate Adaptation	Medium term	Undertake a risk assessment to highlight risks to continuity and resilience of supply	Climate adaptation work across Gloucestershire jointly with Local Authority & the NHS in progress. Project started January 2025, due to complete in 2025/26	
		Develop a Climate Change Adaption Plan outlining interventions and action to mitigate the risks	not started, will follow on from the climate risk assessment	
Sustainable models of healthcare	Short term	Ability to refer patients from primary care to the nature-based prescribing opportunities in conjunction with the VCSE sector	Nature based social prescribing scheme in place, eg Glos Wildlife Trust (programme of activities for children & young teens who are struggling with mental health issues), Wilde Earth Journeys and Tewkesbury Nature Reserve which run community activities and walks	
	Medium term	Increase access to green space and biodiversity on site	In progress	
	Short term	Increase remote consultations	Remote access consultations available for clinicians across the county including primary care 2024/25 non face to face outpatient appointments 17.58% of total outpatient appointments (April -Feb)	
	Medium term	Further rollout of virtual wards	In progress	
	Short term	Digital literacy programme jointly with GCC to enable better access to digital services by a wider range of the population	Digital literacy programme in place jointly with Gloucestershire County Council since 2023, next steps development where this becomes self-sustaining. Total participants 5,037 of which 2,258 new and 2,579 returning. Support areas: internet (20.58%), employability (16.83%), on line services (13.39%), devices (10.3%), e-mail (10.18)	
	Short term	Patient portal in implementation within Gloucestershire Hospitals NHSFT	In progress	

Medicines and procurement	Short term	Reducing the proportion of desflurane to volatile gases used in surgery to 10%.	Gloucestershire Hospitals NHS FT Reduction in nitrous oxide use	
	Medium term	Plans for clinically appropriate prescribing of lower carbon inhalers & how to encourage service users to return their inhalers to pharmacies for appropriate disposal Reduce meter dose inhalers prescribed by 25%	Low carbon inhaler prescribing progressed (see graph below)	
	Short term	A minimum weighting of 10% of the total score for social value should be applied in all procurement (PPN 06/20)	In place	
	Medium term	Stop use of single-use plastic cutlery, plates or cups made of expanded polystyrene or oxo degradable plastic	In progress	
	Medium term	100% of food waste recycled	Glos Royal Hospital: Food waste recycling introduced in main kitchens GHC: Food waste recycling introduced in main kitchens	
	Medium term	Reduce in appropriate use of plastic gloves	Programme on reducing inappropriate use of plastic gloves in progress	
Workforce and System Leadership	Short term	Every Trust and the ICS to ensure a board member is responsible for their net zero targets and their Green Plan (SC)	In place for all Gloucestershire NHS organisations. For the ICB this is the Chief Finance Officer	
	Medium term	Communication approach in place to ensure all staff understand the importance of sustainability for the future of health All staff understand that acting sustainably brings co-benefits to health	Varying progress across organisations	
	Short term	All GP Practices to sign up to the Green Impact Award Scheme	93% of practices signed up to Gloucestershire improvement scheme in 2024/25	

Within the ICS, medicines management teams are working to reducing the environmental impacts of medicines (that account for 25% of emissions within the NHS). Work locally is focused on anaesthetic gases and inhalers where emissions occur at the point of use.

Reduction in nitrous oxide use at Cheltenham General and Gloucestershire Royal Hospitals has saved c. 430 t/CO2 per annum. Progress with the work on inhalers is shown below with the ICS having made significant progress in reducing the use of metered dose inhalers which are the single biggest source of carbon emissions from NHS medicines prescribing.

Environmental impact of inhalers – Prescribing of Metered Dose Inhaler (MDI) (excluding sabutamol)



The ICB continues to use a sustainable approach when commissioning healthcare services, considering the social and environmental impact of all its procurement and commissioning activities with sustainability included as a factor within procurements.

Gloucestershire Hospitals NHS Foundation Trust

The Trust Green Plan 2021-25 (sustainability strategy) commits the Trust to a range of actions, initially between 2021-2025, but also longer term, which will help move us forward on our pathway to net zero by 2040. GHFT is keen to be a leader in climate action, helping and encouraging others to make a positive long-term shift towards sustainable behaviour.

During 2024/25 the replacement of the Tower Block façade together with the installation of triple glazed windows. Combined, both projects should contribute to a 3,105 tCO2e reduction in scope 1 and 2 emissions.

The trust has also taken forward initiatives in waste management which have delivered a reduction of 15% in carbon emissions compared to 2023/24, a significant proportion of this relates to a reduction in chemical waste.

Initiatives within the Trust have also included changes within clinical settings, some example are given below:

- Endoscopy: reductions in the use of CO2 during colonoscopies through adoption of changed valves
- Endoscopy: introduction of point of care testing for coeliac disease, to reduce unnecessary duodenal biopsies for some patients
- Maternity: Central Destruction Unit installed in GRH Birth Unit to capture exhaled Entonox gas from birthing mothers. Entonox is nitrous oxide and oxygen, nitrous oxide has a global global warming potential 265 times more than CO2 so enormous environmental impact and workforce health risk due to long and regular exposure.

Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Health and Care NHS Foundation Trust's carbon footprint Plus covers emissions outside of the organisation's direct control including supply chain, staff and service user travel and commissioned health and social care, the supply chain is the largest component of these emissions.

Improving the quality of services

The Health and Social Care Act 2012 S26(14R) sets out that Integrated Commissioning Boards (ICBs) have a duty to continually improve the quality of services.

The System Quality Committee (SQC) has been delegated responsibility on behalf of NHS Gloucestershire Integrated Care Board (ICB) for ensuring these responsibilities are discharged.

Quality and clinical governance have been driven and overseen using the three pillars of Quality - Safety, Effectiveness and Experience through our System Quality Group (SQG) and System Quality Committee (SQC), which is our board led committee.

These governance processes aim to highlight good practice, identify gaps and drive improvement. As the ICB develops and matures, so to do our processes which have been reviewed during 20204/2025 and strengthened.

Patient Safety and Mortality

During the last year, the ICB and our providers transitioned to the Patient Safety Incident Response Framework (PSIRF). This moves our responsibility from a position of formal oversight to that of system convener to support improvement.

Over the last year our weekly Patient Safety Insight Huddles have matured, and we are about to commence quarterly System Safety and Learning Groups. Through these groups we will continue our focus on promoting learning and improvements to patient safety in Gloucestershire.

Our System Mortality Group has also matured over the last year and has supported the system to improve the Summary Hospital-Level Mortality Indicator (SHMI). At the start of the year, this was outside of control levels. Through a Quality Improvement Group, the system has made dramatic improvements with the indicator expected to return to being within control levels in May 2025.

Our focus now moves to sustaining the improvements made, enabling all partners to hold each other to account and focusing on system level information, linking to population health management data, particularly at Primary Care Network level.

Migrant health

Alongside the work with Asylum Seekers living in Gloucestershire, the ICB Migrant Health team are working extremely hard to support Entitled Persons (EPs) residing in Reception, Staging and Onward Movement (RSOM) sites and Transitional Service Families Accommodation (TSFA) sites in Gloucestershire.

EPs are Afghan nationals who have the legal right to remain in the UK due to their contribution to UK objectives in Afghanistan. This work has taken a collaborative approach with the Ministry of Defence ensuring that the NHS legal obligation for the provision of healthcare is met.

The team continue to work very closely with Gloucestershire GPs and Public Health to provide health screening and GP registrations for vulnerable children and adults achieving minimal disruption to existing health care services.

Infection, Prevention and Control

We have continued to work closely with all our colleagues in Infection Prevention and Management (IPM) benefiting from excellent relationships across organisational boundaries. Along with continuing COVID and flu outbreaks, we are now seeing infections that we have not seen for many years such as measles, and as a system we respond quickly and effectively for our patients and local communities.

The NHS England regional Infection Prevention strategy was published last year, and we have spent time scoping our workforce, training and governance structures, along with our improvement projects to support our local strategy, which was approved by the ICB's Quality Committee in 2025. This is led by our Infection Prevention Management Group which supports the delivery of our local priorities.

Local Maternity and Neonatal System (LMNS)

The ICB continues to monitor all aspects of Quality in Maternity through our System Quality Group and the System Quality Committee. Our Chief Nursing Officer is the chair of the Local Maternity and Neonatal System (LMNS) which is working to support the local provider after another challenging year.

Through LMNS partnership working, the provider continues to improve its midwifery vacancy rate and strengthen its leadership in midwifery and governance structures. As a system we work alongside our NHSE regional colleagues to support improvements and sustainability.

In addition, the local provider continues to receive support from the national Maternity and neonatal support programme as well as from the ICB through the Quality Improvement Group (QIG) which is overseeing the specific improvements related to the latest CQC inspection and its findings.

Medicines Optimisation

The ICBs Medicines Optimisation (MO) team continues to prioritise initiatives which reduce the risk of harm associated with medicines. This includes leading on the local response to national medicines safety alerts, reviewing medication incidents reported to the ICB, proactively informing clinicians working in GP practices and community pharmacies about safety issues and managing local medication shortages to reduce the likelihood of patient harm.

A priority this year has been to work with prescribers in GP practices to help patients with chronic pain reduce higher doses of medication likely to cause significant side effects. To this end, a prescribing community of practice has been initiated to encourage prescribers to discuss any challenges they are facing and share ideas to support their patients. There has also been an initiative to ensure the appropriate dosing of oral anticoagulants (DOACs) in patients with reduced renal function.

The team has been regularly updating the MO digital tools which support prescribers to prescribe safely and identify patients who would benefit from a medication review or change in medication. This work includes developing and promoting the use of the medication safety risk stratification system Eclipse and also the quality messages in the real time prescribing recommendations system Optimise Rx. The team has also been working with Clinical Programme Groups (CPGs) to advise on medication-related issues (including choice of medicines, availability and pathways to ensure patients receive their medicines efficiently).

Our Appliance Ordering Service and Medicines Optimisation Field team have been working directly with GP practices and patients to support appropriate product and medicine choice and cost-effective prescribing.

We continue to work to promote good antimicrobial stewardship to reduce the likelihood of antimicrobial resistance in the future. Initiatives this year have included an audit on broad spectrum antibiotics, a project to reduce the course length of antibiotics, a project to help clinicians ensure that patients documented as having a penicillin allergy are reviewed and allergy status changed if appropriate, and an initiative looking at alternatives to antibiotics for patients with chronic urinary tract infections. Pharmacy teams in the acute trust have also been working to reduce the number of intravenous antibiotics prescribed.

The MO dietician has been working to promote "Food First" across the county which supports patients with malnutrition to have access to healthy nutritional drinks. He has also been promoting good practice associated with prescribing vitamins and minerals in the county.

Our project team has been working on several projects, including one to ensure nurses in the community have immediate access to a range of dressings so that patients are treated with the right dressing at the right time. This will reduce the number of dressings needed, improve outcomes for patients (wounds heal more quickly), and reduce the number of wounds that become infected.

We have also initiated an 'Only Order What You Need' campaign and a patient facing campaign to encourage patients to order before bank holidays to reduce the likelihood of them running out of medicines over a holiday period.

Our COVID Medicines Service continues to assess eligible patients (those at higher risk if they contract COVID), and when appropriate prescribe medicines to reduce their risk.

The MO team continues to support the updating of the Gloucestershire Joint Formulary and the development of associated prescribing guidelines to support high quality, safe and clinically effective prescribing e.g. recent guidance on how best to prescribe metolazone according to MHRA guidance.

We are also working closely with the ICBs' Primary Care Clinical Audit Team (PCCAG) to develop a range of medication quality driven prescribing audits across Gloucestershire's GP practices which are then made directly available to practices via their practice prescribing systems (System One) as well as in summary form in the prescribing dashboard available on the ICB Intranet.

Working with people and communities

Sharing the Power - the One Gloucestershire Research Engagement Network steering group and community Research Champions celebrating Cultural Competency Training at The Music Works in Gloucester this spring.

What is "Insight"?

We believe that insight is: Listening to people's experiences and to the views of staff and volunteers involved in providing a service. Using insight is a crucial part of codeveloping and delivering support and services that are effective, safe, and continually improving.

Insight Network

Local people's voices are heard across the One Gloucestershire ICS from the Boardroom to Integrated Locality Partnerships; through facilitated working with groups and 1:1 conversations with individuals.

People's and communities' views are considered alongside those of clinicians and managers, when we are planning, developing, procuring, evaluating, and monitoring services.

We aim to be clear about what people and communities can and cannot influence, explain where there is scope for local decision making, or where we must follow actions mandated by others. We have a well-established insight network to enable the voices of local people and communities to be heard within the ICB and ICS-wide to inform planning, commissioning and decision making: **https://www.nhsglos.nhs.uk/have-your-say/working-with-you/strategy-and-insight/**

The impact of Insight

We regularly report themes from insight to the ICB System Quality Committee and the Primary Care and Direct Commissioning Committee and ICB Board. Here are some examples of ways in which we gather and use insight:

- we collate and review national and locally collected patient experience data e.g. national GP Patient Survey
- we review the information collected by the ICB's Patient Advice and Liaison Service (PALS), which also includes details of complaints
- we look at Providers' Friends and Family Test results and national survey data; we share storied and respond to them at every Board meeting
- we look at studies carried out by key community partners such as Healthwatch Gloucestershire (HWG)
- we reflect on what matters to individuals who are part of underserved communities, considering the best methods for working with them, gaining trust, and encouraging their involvement in research
- we record the views the One Gloucestershire People's Panellists.

Working with people and communities Strategy

The ICB has a comprehensive Working with People and Communities Strategy **https://www.nhsglos.nhs.uk/have-your-say/working-with-you/strategy-and-insight/**

The approach set out in our Strategy ensures we meet our duty to involve people and communities in our work and supports our legal duties with regards to public involvement as set out in the ICB Constitution.

The ICB Strategy adopts the ten principles set out by NHS England for working in partnership with people and communities **https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/** but has adapted these into five key areas of focus for us locally:

1. Involving people and communities (see **Accountability**)
2. Involving you
3. Working with people and communities to tackle inequalities
4. Working with Healthwatch Gloucestershire and with voluntary and community organisations and groups
5. Communicating with you.

Involving you

https://getinvolved.glos.nhs.uk/involving-you

10 Year Plan for Health, National and Local Engagement

During the autumn/winter 24/25 the ICB Engagement Team facilitated a series of workshops with local people and ICS partners to provide feedback into the national conversation, co-hosted by the Department of Health and Social Care and NHS England, to support the development of a 10 Year Plan for Health.

Gloucestershire was specifically invited by the national team to deliver two targeted workshops with Trans and Non-Binary individuals and Asylum Seekers and Refugees to ensure diversity of voices were heard to influence the plan. The One Gloucestershire People's Panellists were also invited to complete a survey relating to the 10 Year Plan for Health development.

One Gloucestershire People's Panel

Two years ago, we launched the One Gloucestershire People's Panel; with the purpose of seeking out the opinions of a representative sample of people living and/or accessing services across Gloucestershire. The Panellists' anonymous feedback is used at a county and a more local level to shape health and care services and support.

Panellists are sent links to online surveys (postal on request) about a wide range of topics relating to health and wellbeing. Examples of survey subjects promoted this year include non-medical support for health and wellbeing to inform the ICB's approach to working with VCSE organisations and communities and, to complement the national conversation, we created a survey focusing on the development of the national 10 Year Plan for Health to inform our local response to the Plan when it is published later in 2025.

Surveys

Surveys are one of the more traditional methods we use for gathering insight from people and communities. We also use surveys to obtain feedback from the people who work across the ICS.

During the last year, we have co-created numerous surveys which have resulted in plenty of quantitative and qualitative data for analysis.

We produce bespoke survey reports recording the feedback received which are shared with ICS and ICB programmes and projects. Some of this work is targeted towards particular communities of interest or patient groups, but other surveys are shared more widely on the public-facing Get Involved in Gloucestershire pages. Topics for surveys we have created this year have included:

- Personalised Care - this survey received over 10,000 responses!
- End of Life Care services and support
- Respiratory Services development
- Know Your Numbers - Hypertension awareness
- Patient Participation Group (PPG) member recruitment
- GP patient experience, coproduced with a PPG
- Children's mental health and wellbeing
- Managing Memory Together.

After the success of our coordination of the regional COVID-19 experience survey in 2020/21, NHS Gloucestershire ICB hosted a South-West Region Hypertension Survey in 24/25, creating individual surveys, and feedback reports for each ICB in the Region.

Information Bus

We have continued to make every effort to reach out to people who might not have accessible opportunities to engage with us. Our Information Bus supports events all week, including weekends and bank holidays, frequently attending the county shows and community events as well as regular visits to high streets, supermarkets, and garden centres.

In 2024/25 our Information Bus has been out and about all over the county - here are some of the highlights:

- Bowel cancer awareness
- Fairer contributions consultation with the Local Authority ICS partner
- Maintaining strong links with the farming community through regular visits to Livestock Markets
- Heart failure awareness
- Biker Meet at a local supermarket
- Nurse on Tour, facilitating the training of student nurses
- Know Your Numbers - blood pressure testing supported by GHC
- Regular visits to a local Traveller site following extensive insight work to gain trust.

Supporting GP practices and Patient Participation Groups (PPG)

We work with practices and PPGs in several ways:

- Supporting the recruitment of new PPG members
- Supporting individual PPGs with information and advice
- Running a Gloucestershire PPG Network of PPG representatives
- Involving PPG representatives in shaping and developing strategies and services.

We respond to a wide range of enquiries from practices and PPGs, offering information and advice on engaging effectively with the wider community, and sharing good practice in PPG management and activity.

The PPG Network brings together representatives from PPGs across the county **https://getinvolved.glos.nhs.uk/ppg-network**

Members hear about new initiatives and developments and share their experiences and views with NHS teams to shape and influence the development of strategies and services and seek guidance from, or offer support to, other PPGs. There are six meetings of the Network a year, which are hybrid so people can attend virtually or in person. This year we have had approximately 40 people attending each meeting. This year agendas have included:

- Support for Carers at Gloucestershire Royal and Cheltenham General Hospitals
- 10-Year Plan for Health
- Gloucestershire Talking Newspapers
- The NHS Federated Data Platform, introduced by Claire Clements, Rebecca Leahy and Nirav Patel from NHS England.

- Primary Care update, including management of collective action
- Dentistry in Gloucestershire
- Pharmacy in Gloucestershire
- Sustainability and environmental practice in primary care
- Translation and Interpretation in the NHS
- Digital Inclusion Gloucestershire Initiative.

Tackling inequalities

https://getinvolved.glos.nhs.uk/tackling-inequalities

Insights

The ICB's Insights Manager regularly visits a wide range of communities across Gloucestershire. She listens to people without an agenda and frequently gets hands on involved in the planned activities of the groups, such as crafting, joining exercise classes and volunteering in a local community café in Gloucester.

We believe that open, honest conversations and being seen regularly in the same places often help to establish trust. Through our open approach we have found people are more willing to reveal unique concerns and needs relating to their health and wellbeing and that of others in underserved communities.

The proactive collection of individual and group experiences is shared with relevant teams across the ICB and wider system, to ensure this data informs service development, delivery, and evaluation of reducing health inequalities programmes.

Health Inequalities Engagement Framework

ttps://www.cqc.org.uk/news/new-self-assessment-and-improvement-framework-integrated-care-systems

The ICB was selected by the CQC, working with the Point of Care Foundation and National Voices, as one of four ICBs to pilot a framework codesigned to help ICSs measure how well they listen to the experiences and needs of people and communities to reduce health inequalities (launched 12 Feb 2025). Further detail about the Framework can be found in the Reducing Health Inequalities section of this report.

Joining Up Insight in Gloucestershire (JIG)

In December 2024, the ICB launched 'Joining up Insight in Gloucestershire' (JIG) on the NHS Futures platform at Gloucestershire Data Day **https://future.nhs.uk/Joining_upInsightGloucestershire/groupHome**

We know there is a lot of insight data, especially qualitative data, being gathered from people in Gloucestershire by a wide range of health, care, statutory and voluntary organisations, and groups. JIG provides a central hub for collating and storing this insight, so that people making decisions about service development can access it. As well as insight collected by the ICB we also welcome reports and other insight from statutory, voluntary and community organisations and groups in Gloucestershire.

This workspace is easily accessible to a wide range of people working (or volunteering) in health and care, to inform decision-making. It is open, giving wide access with the aim of increasing understanding and reducing duplication.

Working with local partners

https://getinvolved.glos.nhs.uk/involving-local-healthwatch-and-vcs-partners

Healthwatch Gloucestershire (HWG) and Patient Stories

Throughout the year, we have continued to receive, respond, and act upon reports and patient stories produced by HWG. For instance, HWG 's report focusing on access to primary care prompted the co-development of a new information resource for local patients.

Healthwatch Gloucestershire (HWG), the ICB and the LMC came together to develop an information resource for local people to help them to make the most of their GP practice. This will be available soon; we plan to promote it widely and will take the advice of PPGs in developing our communications plan.

Patient stories are shared with system-wide Clinical Programme Groups (CPG) to ensure themes are identified and used to inform their work. HWG present a Patient Story bi-annually to our ICB Board. An example from this was a collection of stories curated by HWG about people's experiences of being diagnosed and living with Parkinson's in Gloucestershire.

The full HWG Parkinson's patient story and our response can be found in the January 2025 Board Papers on the ICB website: **https://www.nhsglos.nhs.uk/wp-content/uploads/2025/01/NHS-Gloucestershire-ICB-Board-Papers-Public-Session-Weds-29th-Jan-2025.pdf**

Get Involved in Research in Gloucestershire

In 2023/24 and 24/25, the ICB was successful in securing funding from NHS England's Research Engagement Network Team to increase diversity in research locally.

Sharing the Power - One Gloucestershire Research Engagement Network (REN) brings together ICB, local authority, academic research organisations and VCSE colleagues.

This year we have extended the membership of our REN Steering Group adding The Sight Loss Council and Barnwood Trust alongside The Friendship Café, Inclusion Gloucestershire, and The Music Works.

Through promoting joint learning, skill-sharing and capacity building amongst research partners, people and communities across the One Gloucestershire, the REN's aim is to build upon what we have heard is important to people most impacted by health inequalities about their health and wellbeing and seeks to increase their involvement in relevant health and care research.

Acknowledging that communities have previously had mixed experiences of involvement in research, our goal is to work together to build and maintain a sustainable and evolving Research Engagement Network reaching all people and communities in Gloucestershire who want to be involved in health and care research.

Such a network facilitates the codesign of inclusive, creative, research informed, codesigned and delivered within local communities, enabling understanding of how health and care services can become more accessible and responsive to underserved communities across all protected characteristic groups.

REN Cultural Competency Training

This year, REN members and community Research Champions were delighted to visit both Inclusion Gloucestershire and The Music Works to learn about their approaches to working with disabled people and young people in Gloucestershire. These two events form parts of a series of cultural competency training events hosted by REN members.

The aim of the training is to upskill the Sharing the Power Steering Group and other participants to increase the opportunities for impact and working more effectively with different communities internally and externally, thus creating capacity through shared learning and promoting codesigned research opportunities.

Our cultural competency training approach was highlighted at a well-attended workshop at this year's national (REN) Sharing and Learning event.

ICB colleagues and a REN member from Inclusion Gloucestershire, presented information about our training work and shared our definition of cultural competency: ***Cultural competence describes the values, attitudes and principles that drive what you do and how you do it. It acknowledges, respects, and works towards understanding the experiences that people and communities bring with them and how these shape them. When these are considered, individual needs can be addressed more effectively, and health needs can be personalised and tailored appropriately. We aim to put these values into practice.***

Sharing Information

https://getinvolved.glos.nhs.uk/communicating-with-you

The ICB has been encouraging inclusive involvement of people and communities who face health inequalities by going to new places where communities naturally gather, tailoring the approach for each community accordingly and sharing opportunities with community leaders.

As part of this work we have recognised that it is crucial that we provide information and support in a way that is understood by, and accessible to, diverse communities.

Accessible Information Standard

The ICB has been encouraging inclusive involvement of people and communities who face health inequalities by going to new places where communities naturally gather, tailoring the approach for each community accordingly and sharing opportunities with community leaders. As part of this work we have recognised that it is crucial that we provide information and support in a way that is understood by, and accessible to, diverse communities.

Accountability

Involving people and communities (governance)

The ICB believes that working with people and communities is everyone's business not just a handful of people with "involvement, engagement, experience or communications" in their job title. This ethos supports people across the ICS whose role it is to ensure local people can get involved and that we learn from Insight.

The ICB has a dedicated Engagement and Experience Team. The Team is led by an Associate Director for Engagement and Experience **https://www.nhsglos.nhs.uk/have-your-say/working-with-you/our-team/**

The Engagement and Experience Team is fortunate to have access to a number of tools to support its work, these include survey software (SMART Surveys) **https://www.smartsurvey.co.uk/**, an online participation space: *Get Involved in Gloucestershire* **https://getinvolved.glos.nhs.uk/** and, for reaching all parts of the county for face-to-face activities, we have the NHS Information Bus **https://www.nhsglos.nhs.uk/have-your-say/working-with-you/information-bus/**

Working with Elected representatives

We are committed to making sure that we inform, involve, engage, and consult the County Council's Health and Wellbeing Board/Partnership, Health Overview and Scrutiny Committee, Adult Social Care Overview and Scrutiny Committee and Children's Overview and Scrutiny Committee. We hold regular briefings with Members of Parliament.

We have good working relationships with the local HOSC, providing regular updates both in written format and by attending meetings. We take their role of critical friend very seriously. They are an important part of the way we work. When proposed service changes might affect constituents outside of Gloucestershire contact is made with representatives from other areas, information provided and appropriate opportunities to get involved discussed.

Insight developments planned in 2025/26

Sharing good practice and evaluating what we do

In the coming year we will be promoting JIG and encouraging more partners to add their reports to enhance this 'insight' collection.

We plan to run a REN summer school, with Barnwood Trust sharing insights from research they have undertaken. REN members and Research Champions will also be undertaking training provided by the National Development Team for Inclusion (NDTI).

We will continue to use traditional Plan, Do, Study, Act (PDSA) cycles to evaluate the effectiveness of Communications and Engagement/Consultation Plans, building in mid-point reviews to our planned activities and identify learning for future working.

We will know we have made a difference if:

- We hear from people that they feel involved, valued and 'what matters' to them is acknowledged, respected, and acted upon.
- We see behaviours in all ICS colleagues (staff) that mean working together is part of our culture.

As started above, during 24/25 we tested the Health Inequalities Engagement Framework. Part of our testing involved reviewing the framework methodology in the context of the local Working Together Maturity Matrix coproduced with experts by experience by Gloucestershire Health and Care Foundation Trust. In the next twelve months we plan to apply the Framework to a selection of live projects to stimulate honest reflection, shared learning and practical action planning.

Equality, Diversity and Inclusion

Saluting our sisters - some of the inspirational women nominated as part of our Black History Month 2024 celebrations.

NHS Gloucestershire ICB is committed to upholding the Rights set out in the NHS Constitution, specifically in relation to equality, diversity and human rights, and the principle which requires us to provide:

"a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status."

We recognise that Gloucestershire has a diverse population and that individuals may have multiple identities that can cut across more than one protected characteristic e.g. we all have an age and a racial identity. Some of our characteristics may change over the course of our lives e.g. we may acquire a disability, and some of us may change our religion.

Engaging our communities

We want to understand the needs of our diverse community and strive to treat everyone as an individual, with dignity and respect, in accordance with their human rights.

To help us understand "what matters to you," we undertake significant amounts of local engagement across the county. Working in partnership with voluntary sector and community groups and organisations across One Gloucestershire (our Integrated Care System) we co-develop, appropriate and sensitive methods to facilitate the involvement of people from diverse communities.

This year we have continued to work with the LGBT+ Partnership to support the Pride in Gloucestershire events. Our One Gloucestershire Information Bus provides a visible presence and safe space for people to find information, seek support and make a connection with others.

Gloucestershire Pride 2024

To celebrate Black History Month, we hosted a Saluting our Sisters exhibition to acknowledge the remarkable contributions of Black and minority ethnic women across Gloucestershire who have shaped history, inspired change and created impact in their communities. The on-line exhibition **https://hundredheroines.org/nhs-saluting-our-sisters-gallery/** and local event provided an opportunity to celebrate their contributions, in the hope it would inspire and empower future generations.

Further examples of engagement activities, which demonstrate our commitment to working with our diverse communities across the county, can be found above in the main **Working with People and Communities** report.

Accountability

In line with the Public Sector Equality Duty requirements, we are required to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. During 2024/25, we revised our Equality objectives to the following:

- To develop an Equality Statement and robust action plan for promoting equality, diversity, and inclusion, which sets out clear objectives which ensure good practice across our organisation and link to wider health inequalities work that is being undertaken in our Integrated Care System.
- Build a detailed understanding of our population and their health needs, through published data sets, improvements in the quality of our data recording and robust use of Equality and Engagement Impact Assessments.
- To reduce the percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months by at least 2% per annum over the next 3 years.

Equality Statement

Promoting equality, valuing diversity (**https://www.nhsglos.nhs.uk/wp-content/uploads/2024/10/NHS-Gloucestershire-ICB-Promoting-equality-and-valuing-diversity-Draft.pdf**) sets out our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire.

We are keen to build upon the work that is already underway across our Integrated Care System and in recognition of this, our Equality Statement links to other strategies and plans which, when combined, fully document how we will work in partnership to achieve our vision for Gloucestershire.

Our Equality Action Plan (**https://www.nhsglos.nhs.uk/wp-content/uploads/2024/10/Appendix-1-Draft-Action-Plan.docx**) sets out how the ICB will work towards achieving our organisational equality objectives.

Equality and Engagement Impact Assessment

We routinely undertake an Equality and Engagement Impact Assessment (EEIA) to assess the potential impact of any service review, design or changes in service delivery and ensure our services are accessible and non-discriminatory. We then undertake targeted engagement with those who may be disadvantaged by any proposals for change. Some examples of completed EEIAs are available on our website: **https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/equality-impact-assessment/**

Equality Delivery System (EDS)

The NHS Equality Delivery System (EDS) is an accountable improvement tool for NHS organisations in England. It comprises eleven outcomes spread across three Domains:

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

Outcomes are evaluated, scored, and rated using available evidence and are designed to provide assurance or point to the need for improvement. Completion of the EDS, and the creation of interventions and action plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach, the five Health Inequalities Priorities set out in Operational Planning Guidance.

Following our review in 2024/25 we are committed to further improvements over the next 12 months:

- In line with our new ICS Data Strategy we will continue to build a detailed understanding of our population and their health needs, through improvements in the quality of our data recording.
- During 2025-26 the ICB will concentrate on supporting the health and wellbeing of staff during a time of change and transition. We will improve our staff offer around psychological support, resilience training and improve our policies and procedures with regard to wellbeing.
- We will develop system-wide action planning, utilising our Workforce Race Equality System (WRES) and Workforce Disability Equality System (WDES) results, with a continued focus on recruitment and anti-discrimination.
- A health inequalities dashboard is in development and will be available by May 2025.

Accessibility

We are committed to ensuring that our services respond to people's communication and accessibility needs.

Accessible Information Standard

The Accessible Information Standard (AIS) sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

All organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard see: **https://extranet.nhsglos.nhs.uk/accessible-information-standard/**

Reducing health inequalities

Tackling inequalities in outcomes, experience, and access and working towards health equity is a statutory duty of Integrated Care Systems.

Despite being an affluent county and having outcomes that are better than the national average in some areas, such as life expectancy at birth, there is a health inequalities gap in Gloucestershire with people living in the most deprived communities and those from diverse ethnic backgrounds experiencing poorer access, experience, and outcomes with respect to our healthcare services.

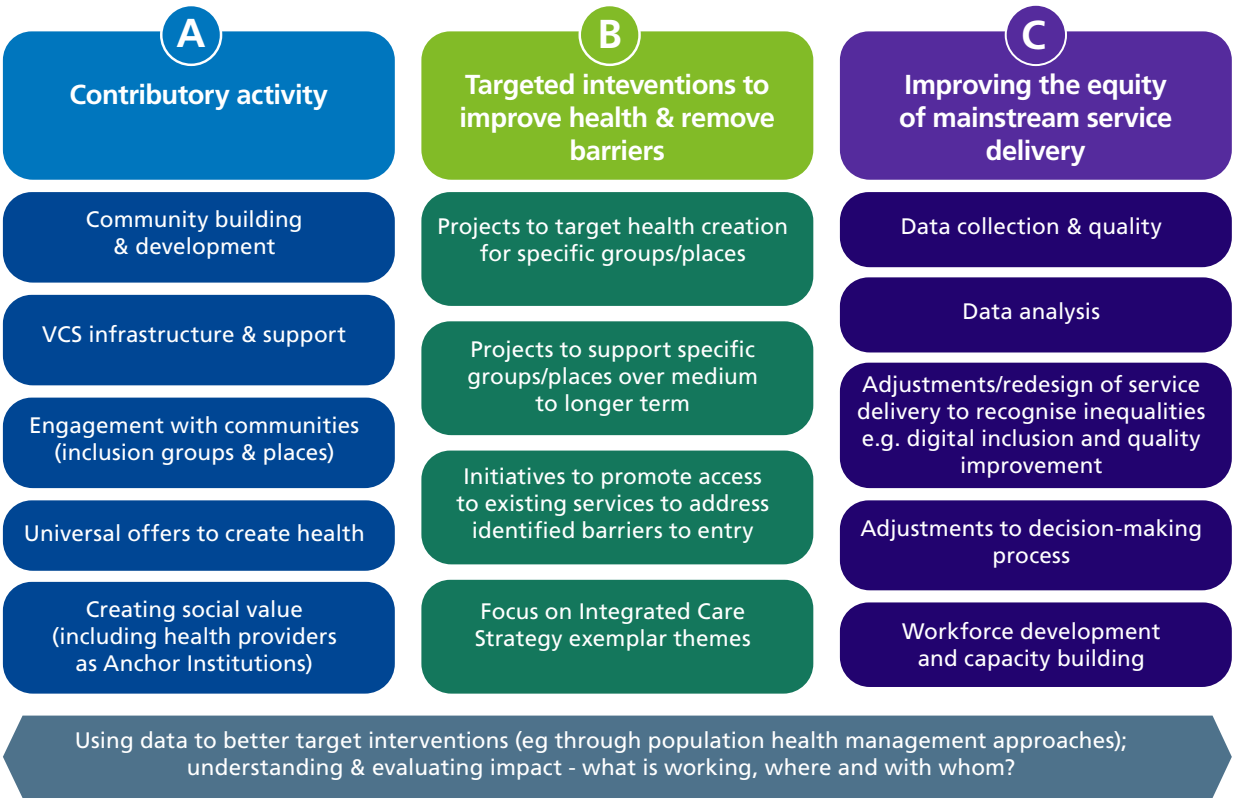
Health inequalities are everyone's business, and it is our ambition that work to achieve health equity is embedded across all programmes and areas. It is a guiding principle of the One Gloucestershire Integrated Care Strategy and system organisational plans and policies.

Our approach to moving towards health equity

We have developed a Gloucestershire Health Inequalities Framework which supports us in taking a more strategic, evidence-based, and systematic approach to tackling health inequalities.

Alongside the framework, our health inequalities planning, and self-assessment process asks Gloucestershire organisations and partnerships in the ICS to set high-level objectives that will enable them to make the biggest impact on reducing health inequalities. We will review these through a health inequality planning process and iteratively develop our priorities.

This will allow the whole system to see where progress against health inequalities is being made, where there are gaps or duplication in our collective response to health inequalities and where we can stretch to go further in the work that we are doing.



A. Contributory activity

Health and wellbeing are impacted by various factors including living environments, employment status, finances, and educational attainment. We aim to influence these factors to improve people's wellbeing and reduce health inequalities by:

- Co-developing a VCSE partnership model to build community capacity and improve support for individuals through organisations with local knowledge and expertise.
- Improving collaboration across health and social care services and community activities, fostering a shift from hospital to community and sickness to prevention.
- Engaging with diverse communities. This helps us understand and overcome barriers to accessing health and care services.
- Contributing to research and pilots around Health Inequality improvement, for example the Health Inequalities Engagement Framework - aiming to ensure ICSs are proactively involving, listening to, and acting on, the experiences of marginalised and underserved communities.

B. Targeted interventions to improve health and remove barriers

We have continued to work to the national **Core20PLUS5** framework with the aim of improving access to, experience of, and outcomes from, health and care for those who experience health inequalities. This includes prioritising:

- People living in the 20% most deprived areas in Gloucestershire (Core20): Of the 373 Lower Super Output Areas (LSOAs) in Gloucestershire, 31 are amongst the most deprived 20% in England, which accounts for 8.2% of our county's population.
- A range of locally identified inclusion health groups (PLUS) who are more likely to experience poorer than average health access, experience and/or outcomes.
- The 5 clinical priority areas for adults, and children and young people.

We are collaborating to identify improvements aligned with the Core20PLUS5 programme and our strategic priorities.

For example, we have launched Targeted Lung Health Checks (TLHCs)/Lung cancer screening in Gloucestershire's most deprived area, Inner City Gloucester. Our data indicated that patients in deprived populations face more barriers to accessing healthcare and are diagnosed later, resulting in poorer outcomes.

The programme aims to improve early lung cancer diagnosis, particularly focusing on current and former smokers who are more likely to be diagnosed with cancer. The checks will also identify other conditions for early intervention such as coronary artery calcification and emphysema, providing an opportunity for early intervention and potentially reducing health inequalities in these areas.

C. Improving the equity of mainstream service delivery

We are leading efforts to make mainstream services more accessible for those experiencing health inequalities and providing additional support as needed. We embed health equity into our strategies, plans, and policies, using Equality Impact Assessments to consider the impact on protected characteristic or inclusion groups as well as those experiencing socioeconomic and geographical inequalities.

To improve our understanding of health inequality and identify priorities for improvement, we are working to improve data quality and completeness, allowing analysis by ethnicity and deprivation, and considering other vulnerable groups. Our second annual review of healthcare inequalities monitors progress against a range of indicators that align to the Core20PLUS5 programme. We are working with partners to develop long-term health inequalities outcomes and measures for system-wide delivery.

We are promoting the Prevention and Health Inequalities Hub, an online compendium of information, resources, and practical tools to help the workforce across the system better understand and take action to reduce health inequalities in their areas of work. We are developing a One Gloucestershire Health Inequalities Community of Practice, which will aim to build confidence, capability, and awareness of system activities and opportunities with regards to reducing health inequalities, identify common solutions to shared problems, and share good practice and learning.

Health & wellbeing Strategy

The Gloucestershire Joint Local Health and Wellbeing Strategy

The Gloucestershire Health and Wellbeing Board ('the Board') brings together partners from across the health and care system to set the strategic direction for local work to improve health and wellbeing.

NHS Gloucestershire Integrated Care Board (ICB) is an active member of the Health and Wellbeing Board, working alongside wider partners from across the local NHS, local government and the statutory and voluntary and community sector.

The Gloucestershire Health and Wellbeing Board is responsible for overseeing the development and delivery of the county's Joint Local Health and Wellbeing Strategy (2020 - 2030) which sets out how will we deliver the Board's shared vision for Gloucestershire to be a place where everyone can live well, be healthy and thrive.

This year we reached the five-year point of the strategy, and the Board has overseen a mid-point review to report on our progress to date in delivering our seven strategic priorities and look forward to the next 5 years.

You can read more about the Joint Local Health and Wellbeing Strategy and the mid-point review here: **https://www.gloucestershire.gov.uk/council-and-democracy/gloucestershire-health-and-wellbeing-board/our-focus/**

The seven strategic priorities in the Gloucestershire Joint Local Health and Wellbeing Strategy:

- Physical activity
- Adverse Childhood Experiences (ACEs)
- Mental wellbeing
- Social isolation and loneliness
- Healthy lifestyles
- Early years and best start in life
- Health and housing.

Members of the Health and Wellbeing Board have worked together to implement the county's Health and Wellbeing strategy focused on those areas where a collective, system wide approach can help to improve health and wellbeing. Reducing health inequalities is a cross-cutting theme of the strategy, alongside work to address the wider determinants or 'building blocks' of health, which include our living conditions, housing, financial circumstances, and our access to employment.

In the last five years, we have made great progress in delivering our priorities, and the work highlighted in this report shows how important partnership working is to achieve our vision. The issues we want to address are often complex. No single organisation can improve health alone, and the delivery of our priorities relies on contributions from a range of individuals and organisations, from across health, social care, local government, our wider statutory partners, and the voluntary and community sector.

In producing the mid-point review of the Joint Local Health and Wellbeing strategy, the Board has recognised an opportunity to develop our approach to measuring progress and showing impact across the seven priorities. It is important that we look at outcomes from the perspective of individuals and communities, as well as the wider system. We will also look at how we can use qualitative data alongside quantitative data to help measure impact and distance travelled. To support this work and the governance of the strategy, each of the strategic priorities will be allocated sponsors from the membership of the Board.

Developing Our Partnership Approach

The introduction of Integrated Care Partnerships (ICPs) in the Health and Social Care Act 2022 ('the Act') has provided a further opportunity to bring those involved in health and social care together from across all sectors. In Gloucestershire we have named this forum the Health and Wellbeing Partnership. We have aligned the work of the county's Health and Wellbeing Board and the Health and Wellbeing Partnership to make the most of our shared priorities to improve health outcomes. This has included aligning the

Integrated Care Strategy, which is a statutory responsibility of the Health and Wellbeing Partnership, with the Health and Wellbeing Strategy.

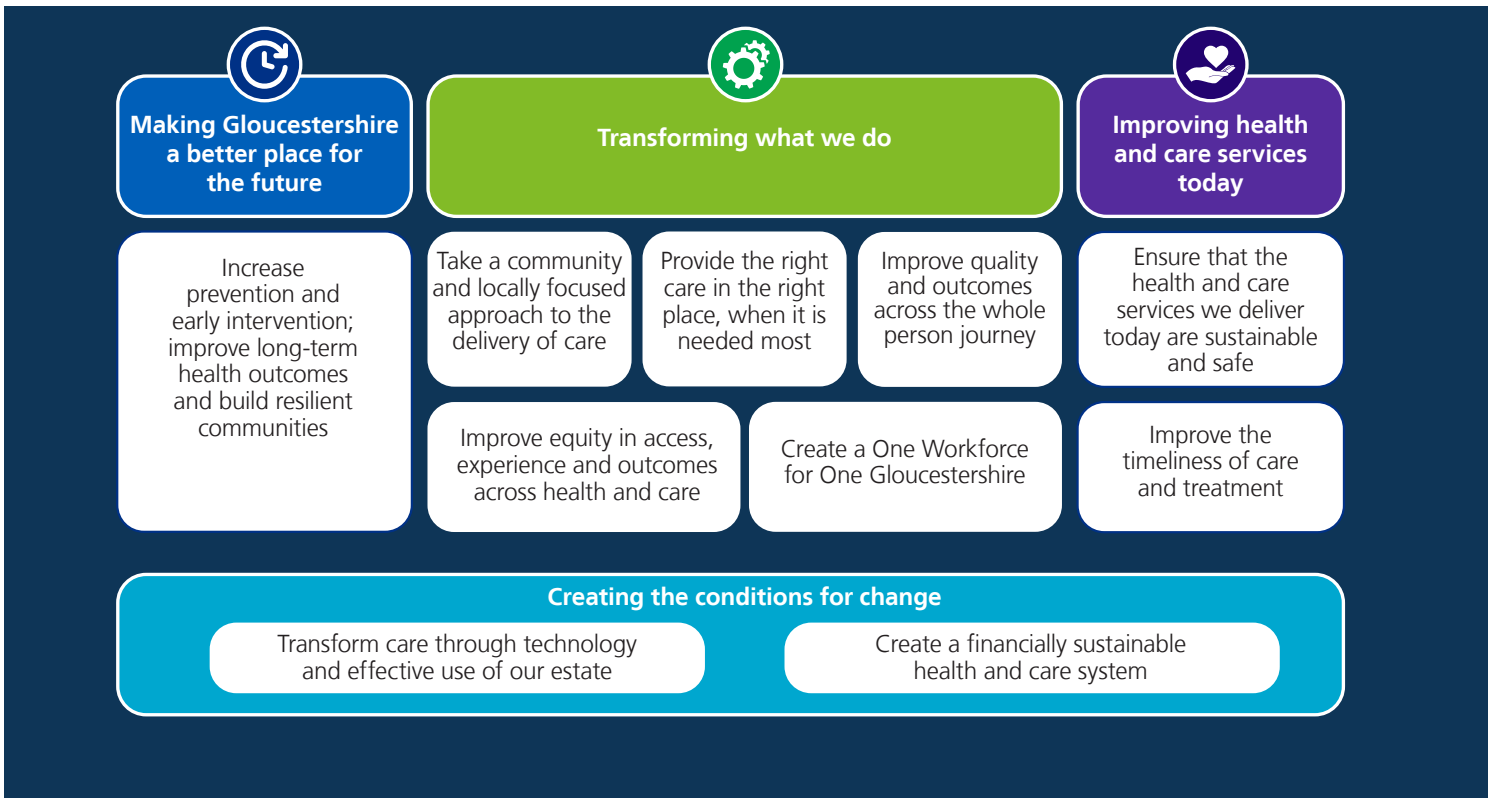
Members have worked together to develop our approach as a partnership, recognising the strengths which come from the range of organisations and sectors represented, and the opportunity to work collectively to address challenges, and look at how we measure the impact and outcomes of our work.

The One Gloucestershire Integrated Care Strategy

A comprehensive Interim Integrated Care Strategy, that encompassed the work we do across our system was developed in 2022. This work was led by the Chair of both the One Gloucestershire Health and Wellbeing Board and Partnership, Councillor Carole Allaway-Martin, and all partner members were involved in its development.

The strategy sets the blueprint for how our health and care organisations, staff, voluntary and community sector, and our people and communities, can work together to achieve the common goal of making Gloucestershire the healthiest place to live and work, championing equity in life chances and the best health and care outcomes for all.

See diagram below:



To help structure the priorities going forward, the Integrated Care Strategy has three overarching pillars which include:

- Making Gloucestershire a better place for the future - focused on prevention and early intervention, this pillar focuses on the seven priorities in the Joint Gloucestershire Health and Wellbeing strategy that can impact health and wellbeing, including physical activity, healthy lifestyle, adverse childhood experiences and housing.
- Transforming what we do - supporting prevention at a local level, joining up services close to home, reducing differences in people's experience, access to care and health outcomes and a One Gloucestershire approach to developing our workforce - ensuring services can access the skills and people they need.
- Improving health and care services today - improving access to care and reducing waiting times for appointments, treatment and operations, improvements in urgent and emergency care and supporting people's mental health.

Making Gloucestershire a better place for the future

Our mid-point review of the Gloucestershire Health and Wellbeing Strategy contains examples of a range of programmes and initiatives being led or supported by organisations represented on the Gloucestershire Health and Wellbeing Board, often working in partnership with each other, and through other multi-agency groups. These include, but are not limited to:

- **The development of an online Prevention and Health Inequalities Hub** (**https://www.gloucestershire.gov.uk/phi-hub**) which provides a toolkit for anyone who has an interest in understanding health inequalities in Gloucestershire, and the steps we can take to reduce them. We have also developed a new Prevention and Health Inequalities Framework to help partners consider inequalities when planning and implementing new programmes or initiatives.
- Support for the countywide **'We can Move' movement** which takes an evidence-based approach to encouraging physical activity and addressing inequalities in access to, and participation in, sport and physical activity.
- Raising awareness of the impact of **Adverse Childhood Experiences** (ACEs) into adulthood, with a focus on how we support organisations to become trauma informed.
- Launching a **healthier lifestyle programme for children and families** to offer free support to families with children who are above an ideal healthy weight; and developing approaches to reach adults who might not usually access healthy weight support.
- Developing our support offers for people experiencing issues with their **mental health and wellbeing** from early intervention support through to programmes to transform care for adults with serious mental illnesses. This includes new services for children and young people.
- Launching the **One Plan for All Children and Young People in Gloucestershire** (**https://www.gloucestershire.gov.uk/health-and-social-care/children-young-people-and-families/one-plan-for-children-and-young-people-in-gloucestershire-2024-2030/**). The plan includes three pillars from Starting Well, to Growing Well into Being Well, and is led by the county's Children's Wellbeing Coalition.
- Supporting the **health and housing** agenda, through the work of the Gloucestershire Housing Partnership (GHP) to ensure that everyone living in Gloucestershire has a home that meets their needs and enables them to live healthy and happy lives.
- Supporting initiatives in conjunction with the Voluntary and Community Sector to enable local people to build strong social networks and vibrant communities to help **reduce social isolation** and create a 'Connected Gloucestershire'.

Transforming what we do

A recent update to Gloucestershire's Health Overview & Scrutiny Committee (**https://glostext.gloucestershire.gov.uk/ieListDocuments.aspx?CId=772&MId=11805&Ver=4**) outlined our progress in transforming the way we deliver health and care in Gloucestershire. This paper highlighted how we are working in partnership to make changes that will be significant for our population, examples include but are not limited to:

- We are continuing to **prioritise our work with 6 Integrated Locality Partnerships**, who bring partners together to take action that improves health and wellbeing and addresses the root causes of health inequalities. We are facilitating conditions for change by growing strong and mature partnerships whilst taking action to improve population health outcomes in priority areas (such as children and young people and pre and mild frailty).
- We have been progressing with our commitment to co-design and develop Integrated Neighbourhood Teams in local areas. We are focusing our work on **supporting people with moderate to severe frailty and dementia** using a new 'Personalised Proactive Care Whiteboard' to identify people who would benefit from proactive care interventions and case manage their support. We have expanded the tool into 14 of 16 Primary Care Networks.
- **Developed and implemented the Health Inequalities Strategic Planning and Review** process to support implementation of the Health Inequalities Framework and prioritisation of activities to improve health equity by asking system organisations and partnerships who have a statutory duty around health inequalities to set high-level objectives that they will focus on each year, that will enable them to make the biggest impact on reducing health inequalities.

- Published our **first annual review of healthcare inequalities** to monitor progress against a range of indicators that align to the Core20PLUS5 programme by deprivation and ethnicity, in line with the NHS England Statement on Health Inequalities.
- Implemented a pilot programme to **raise awareness of health and care careers & pathways** has been delivered by the ICS Careers Engagement & Outreach team across 19 secondary schools. The pilot was extremely successful - engaging with 8,000 young people aged 12 to 15 through in-person sessions including workshops, theatre performances assemblies, mock interviews, talks, attendance at careers fairs and one to one coaching sessions. On the back of this success, the programme has been extended for a further two years to include all secondary schools in the county, with offers tailored to the school.
- **Early diagnosis of conditions remains a priority**. We delivered on our commitment to expand the use of the Community Diagnostic Centre and are introducing a new breathlessness pathway this year to support diagnosis and treatment for people with respiratory related conditions. Within our cancer programme, specific work has been undertaken in Lower GI and Urology to deliver faster diagnosis for suspected cancer. Changes have also been piloted to teledermatology - providing medical photography staff to assess all urgent suspected referral primary care images which are improving triage and supporting patients to reach the correct clinic, diagnostic and treatment faster.
- We delivered on our commitment to **improve rehabilitation for people living with a neurological condition**. A new multi-agency team is showing an impact on supporting people in a timelier way, reducing length of stay and seeing improved experience in the service provided.
- Where people have long-term conditions, we are supporting them in the community. **We are delivering against our commitment to create a network of Asthma Friendly Schools**.

Members of the Health and Wellbeing Partnership also had the chance to contribute to the engagement process for the new national 10-year Health Plan at a workshop focused on the three proposed 'shifts': preventing sickness, not just treating it; moving more care from hospitals to communities; and making better use of technology. This gave a further opportunity to reflect on our local priorities to transform health and care.

Working Locally

When people have good social support networks, are involved, and included in their communities and are valued for their contribution, they experience better health. Across the Integrated Care System, we are investing in local communities, and ensuring local people are involved in the decisions about what matters to them.

In 2024/25, we have completed a grants award process which is building capacity in local communities and continuing our focus on primary prevention through work with the voluntary and community sector. Grants were awarded through a specific grants process to the voluntary and community sector. Over 177 applications were received with investment into 32 organisations both across localities in Gloucestershire as well as county-wide activity.

Funded projects include:

- **Grow with Wiggly** who will be using community land to grow food with people that Wiggly will then use in their programmes to help people learn to cook healthy meals.
- **Gloucester City Mission** who are offering employment, training, and volunteering for people with lived experience of homelessness or addiction via their coffee shop 'Revive' in Gloucester.

We are continuing to prioritise support for people in areas such as tobacco dependence - expanding support in acute settings and establishing new approaches in mental health inpatient and continued work in maternity settings. This is supporting one of the three unifying themes of the Integrated Care Strategy.

We are also on track to deliver our Social Value Policy to support evaluation work on long-term outcomes. This will be finalised by the end of 2025.

Financial Review

NHS Gloucestershire Integrated Care Board (ICB) set a balanced budget for the 2024/25 financial year, in the context of an overall system financial plan of breakeven. The budget was set within the 2024/25 NHS England financial framework.

Key elements of this included:

- A system allocation based on the financial envelope for the Gloucestershire System, plus growth and an efficiency adjustment as part of ensuring value for money.
- Aligned payment incentive contractual arrangements with NHS providers for elective care (e.g. planned care) and with fixed contractual amounts for non-elective care (e.g. emergency care).
- The provision of additional funding for a smaller number of programmes outside main funding.
- Additional funding to take forward the recovery of elective, or planned care, services.

The ICB financial position for the year was a small surplus of £0.187m.

The ICB's cumulative surplus at 31 March 2025 is £21.17m. The cumulative surplus is available to the ICB in future years to use non-recurrently as part of the development of the five-year long-term plan. Use of this funding is subject to business cases and overall affordability for the NHS.

The ICB made a surplus in 2023/24, in the nine-month accounting period 1 Jul 2022 - 31 March 2023 and the predecessor CCG also delivered a surplus in the previous five years.

In addition, the ICB:

- Remained within its maximum cash drawdown (the limit allocated to the ICB) as agreed with NHS England
- Complied with the Better Payments Practice Code (details provided within note 7.1 of the annual accounts).

Table 1 - ICB's financial performance covering 1 April 2024 - 31 March 2025

ICB Financial Summary	Programme Costs including primary care £m	Running Costs £m	Total £m
Revenue resource limit	1,463.514	12.328	1,475.842
Total net operating cost for the financial year	1,463.497	12.158	1,475,655
Surplus/(deficit) in year	(0.017)	0.170	0.187
Brought forward surplus			20.983
Cumulative surplus			21.170

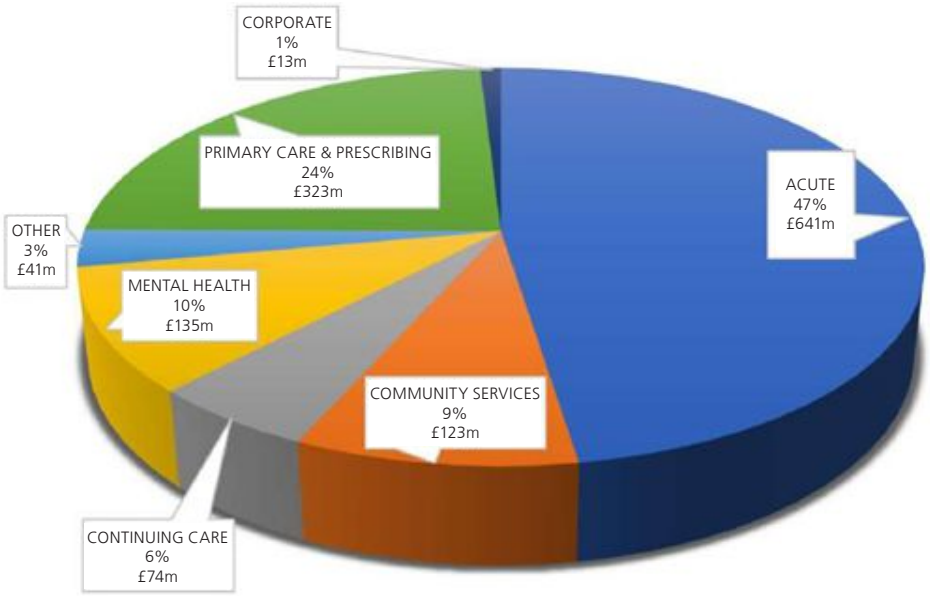
The previous accounting period for the ICB was the 2023/24 period.

System Financial Position

The NHS system in Gloucestershire is comprised of Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHT) and NHS Gloucestershire Integrated Care Board (ICB). The system 2024/25 financial plan was breakeven, and the year-end performance is set out below:

	ICB £m	GHC £m	GHFT £m	Total £m
System position Surplus/(deficit)	0.187	0.312	0.067	0.566
System target				0.000
Variance to target Surplus/(deficit)				0.566

The main areas of ICB expenditure (this includes expenditure by NHS organisations funded by the ICB) fell into the following areas:



The accounts as presented have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Services Act 2006 (as amended).

Mental Health Investment Expenditure

The 2024/25 plan included additional investment in mental health to ensure that the mental health investment standard was met; this standard requires an increase in spending on mental health services equal to or above the increase in the programme allocation increase for the year.

The target investment in year was £114.327m.

	2023/24 £m	2024/25 £m
Mental Health expenditure in year	106.578	114.430
ICB Programme Allocation	1,334.973	1,475.842
Mental Health Spend as a proportion of ICB Programme Allocation	7.99%	7.75%

Programme Allocation excludes any additional allocations for specific purposes such as Service Delivery Funding, Elective Recovery Funding and Discharge Grants.

For 2024/25 the increase in spending was £7.852m. Investments were made in children's services, perinatal mental health, IAPT (Improving Access to Psychological Therapies), and eating disorders, in addition to increases in existing services.

Future Financial Outlook

The NHS system in Gloucestershire, including the ICB, has finalised the majority of the operational and financial plans for 2025/26 with a focus on:

- progressing the recovery of all services, including elective (planned care), and reducing waiting times.
- continued attention to ensuring that we have the right workforce within Gloucestershire as this is fundamental to enabling the system to work effectively.
- transforming the urgent care system to improve the flow across the system and provide a better quality and experience for individuals.
- developing communities jointly with our partners through Integrated Locality Partnership working, plus looking at how we can enable further work on prevention for our communities.
- reducing inequalities within services.
- improving the overall value and productivity of the system.

The 2025/26 system plans build on each organisation's work on underlying recurrent costs and system-wide work on developing a longer-term financial position for Gloucestershire. This is feeding into the medium-term plan, including a financial plan, which is being developed by the system.

The financial situation remains very constrained and the focus on initiatives that deliver value continues. This programme of work includes:

- Service Design/Redesign, informed by intelligence on spend and patient outcomes to focus at how we deliver value to make improvements, including:
  - Urgent care pathway redesign (the service users' journey through care)
  - New pathways and services for areas such as respiratory and circulatory disease
  - Ongoing programmes of work within digital supporting the development of clinical pathways in particular virtual wards.
- Transactional Savings:
  - The agreement of evidence-based activity and activity management actions with providers including appropriate controls (e.g. policies on referrals, our formulary) on the access to and type of treatment
  - Engagement and influence on medicines management
  - Procurement savings on contracts.

Capital

Parliament and Treasury set the Department of Health and Social Care (DHSC) a limit for how much capital it can spend. Capital spending covers long-term spend such as new buildings, equipment, and technology.

This budget limit, called the capital departmental expenditure limit (CDEL), covers all capital spending by the DHSC and the NHS, and they are legally obliged not to spend above this limit. A major part of NHS capital is allocated to Integrated Care Systems who prioritise this capital to develop a system plan with the majority going towards NHS Foundation Trusts and an amount for General Practice requirements (covering information technology and minor improvement grants).

Planning considers the need to upgrade estates, replace medical equipment and information technology equipment, plus the strategic objectives for the system.

The Gloucestershire system has received capital funding relating to its core functions plus some additional targeted funding for areas such as digitisation and new theatres.

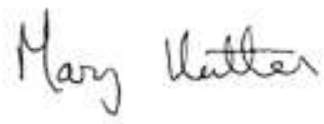
The core capital funding for Gloucestershire was determined through a process of organisational prioritisation and a system review of the proposed programme to assess against priorities and known risks.

		Actual Expenditure			
	2024/25 Plan £'000	Primary Care & the ICB £'000	GHC £'000	GHT £'000	Total £'000
Total Operational Capital	44,793	1,218	7,897	36,014	45,129
IFRS 16 (leases)	8,627		728	4,773	5,501
National Programmes (diagnostics, Front line digitisation, Mental Health, elective services capacity)	2,508		227	2,640	2,867
Total system CDEL	**55,928**	**1,218**	**8,852**	**43,427**	**53,479**

(Primary Care: GP practices within Gloucestershire, GHC: Gloucestershire Health & Care NHS Foundation Trust, GHT: Gloucestershire Hospitals NHS Foundation Trust)

Gloucestershire Health and Care NHS Foundation Trust: Work on the new community hospital in the Forest of Dean completed and the hospital opened in April 2024; this replaced Dilke Memorial Hospital and Lydney Community Hospital. This is a 24 single bedroom hospital, a purpose-built therapy gym for rehabilitation, plus a minor injury and illness unit. In addition, the Trust started the implementation of the transforming care digitally programme. The remainder of the programme was focused on the ongoing maintenance, including backlog, and replacement programme for estates, IT and equipment, plus the continuation of the net zero programme of work.

Gloucestershire Hospitals NHS Foundation Trust: a significant part of the capital programme within GHT has been focussed on backlog maintenance across both the Gloucester and Cheltenham sites plus a focus on areas of fire, electrical and water safety, and resilience. In addition, the work on replacement programme for equipment, including major items and IT has continued throughout the year.



Mary Hutton

Chief Executive Officer

June 2025

Corporate Governance report

Accountability Report - Corporate Governance Report

1 March 2024 – 31 March 2025

The Corporate Governance report (1st April 2024 - 31st March 2025) outlines the composition and organisation of the Integrated Care Board (ICB) governance structures and how they support the achievement of the ICB objectives.

It comprises the:

- Members' Report
- Statement of the Accountable Officer's responsibilities
- Governance Statement.

Members' report

NHS Gloucestershire ICB (The ICB) is responsible for planning and commissioning health services for a registered population of 682,262 and expected to rise to 715,000 by 2038.

The ICB was authorised on 1 July 2022 in accordance with the Health Act 2006 (as amended see s.1I) and operates in line with its Constitution (**https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/icb-constitution/**). The ICB has a Board that comprises 17 members including Executive Directors, Non-executive Directors, and Partner members. The Board is chaired by Dame Gill Morgan.

Member profiles

For a list of ICB members and their records of attendance at ICB meetings see page 7 of this Governance Statement. Member's Profiles can be viewed on the ICB's website **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles/**

Composition of Board

The Chair of the ICB is Dame Gill Morgan and Chief Executive is Mary Hutton. The Board comprises 17 members including Non-Executive Directors, Executive Directors, and Partner members.

Member's Profiles can be viewed on the ICB's website **www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles**

For a list of ICB members and their records of attendance at ICB meetings see **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/**

Committee(s), including Audit Committee

For a list of Audit Committee members and a record of their attendance at meetings see website: **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/** which also includes details of sub-committees of the ICB and members record of attendance at meetings.

Register of Interests

The ICB maintains a Register of Interests in line with its Standards of Business Conduct Policy and details set out within its Constitution.

The Register of Interests (**https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/**) is updated quarterly and posted on the ICB's website on a quarterly basis. The Registers of Interests related to ICB members is included in the papers of the ICB Board meeting which is held on a bi-monthly basis. At each sub-committee of the Board a register of interests pertaining to committee members is included in the papers. There are registers of interest for Board members, ICB staff (those in AFC Band 8A and above), along with registers detailing any gifts and hospitality received, and are available on the ICB's website Gifts and Hospitality Register (**https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/**).

In addition, at the start of each meeting of the ICB Board and sub-committee meetings, members are required to declare any conflicts of interests in relation to the items on the agenda and discussion is held around about how any conflicts should be handled and this is formally recorded in the minutes. The procedures for declaring conflicts of interests are detailed in the ICB's Standards of Business Conduct Policy (**https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook-2/**)

Personal data related incidents

There were no personal data related incidents that took place during the financial year 2024-25 that were reported to the Information Commissioner's Office (ICO).

Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking and meets the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Section 54 of the UK Modern Slavery Act (2015) requires commercial organisations that operate in the UK and have an annual turnover above £36m to produce a Slavery and Human Trafficking statement each year. The statement sets out how a business is taking steps to address and prevent the risk of modern slavery in operations and supply chains. The ICB's Modern Slavery Act (2015) statement can be read on our website **https://www.nhsglos.nhs.uk/about-us/how-we-work/safeguarding/modern-slavery/**

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England. NHS England has appointed Mary Hutton as the ICB Chief Executive to be the Accountable Officer of NHS Gloucestershire ICB.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable.
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- For safeguarding the Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money.
- Ensuring the ICB exercises its functions effectively, efficiently, and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended).
- Ensuring that the ICB complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

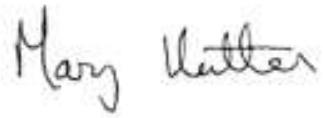
Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Integrated Commissioning Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.

- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts.
- Prepare the accounts on a going concern basis.
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Gloucestershire's ICB auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.



Mary Hutton

Chief Executive Officer

June 2025

Governance Statement

Introduction and context

NHS Gloucestershire Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Gloucestershire ICB's (GICB) statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

The ICB was established on 1 July 2022 and held its inaugural meeting on that day approving:

- The appointment of the Chief Executive, Executive Directors, Non-executive directors, and partner members of the ICB Board.
- The ICB governance and committee structure.
- The core governance documentation to enable the ICB to operate efficiently and effectively within the scope of its legal responsibilities including the Scheme of Reservation and Delegation (SoRD). This is described in the Governance Handbook (**https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook**).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Integrated Care Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB's Constitution which incorporates the Standing Orders establishes the core purposes (strategic aims) and values of the ICB. The ICB and ICS core purposes are:

- 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.

The functions of the ICB and purpose of the One Gloucestershire ICS are defined in the ICS Design Framework as detailed in s.1.1.5ii of the Constitution. In addition to the four key strategic aims, the 168 statutory functions, duties and powers of CCG's were conferred to ICBs as per the Health Act 2006 (as amended).

The Constitution outlines the governance structure of the organisation and details the role and responsibilities of the Board of the ICB, its members and sub-committees.

The ICB operates in line with the good governance standards including the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles, Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review), and the seven key principles of the NHS Constitution. This includes the highest standards of propriety involving impartiality, integrity, and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The ICB's overarching governance arrangements are set out in its Constitution and the ICB's Governance Handbook (**https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/governance-handbook-2/**) which explains the powers reserved to the Board of the ICB and those powers that have been delegated to the board sub-committees, executive directors, chief executive and chief financial officer.

Governance Review Advisory Report

The ICB uses its Internal Audit function to independently audit its governance arrangements and check compliance with legislative requirements and public sector good practice. In June 2023 Internal Audit reported on its findings of the Governance Review (advisory report) that was undertaken of the ICB after 9 months of operation.

The purpose of the advisory work was to review the ICB's governance infrastructure, including the Integrated Care Partnership and the Board effectiveness to ensure there are robust processes for identifying and monitoring finance, operational and governance matters within the existing committee structures. The report and recommendations along with key actions were considered by the Audit Committee and the ICB Board and were implemented during the financial year 2023-2024.

More recently a Board Development session has been organised to review the ICB governance, processes, and performance reporting, within the context of the Insightful Board Guidance for ICBs, scheduled for June 2025. The guidance has been reviewed by governance, BI and performance colleagues identifying the key messages from the guidance and ensuring that the ICB reinforces good practice as follows.

- Effective governance with clear decision-making processes needs to be in place.
- The role of board level sub-committees is crucial to support board governance.
- Boards need to obtain assurance rather than reassurance.
- Well-led, successful boards scrutinise information and data presented to them; making best use of SPC charts, triangulating the information; have an open and curious mindset, to uncover issues and find solutions.
- Clear and explicit governance arrangements and effective decision-making structures between partner organisations for whole-system delivery and performance is required.
- Stakeholder, patient, and public views are important sources of information essential to system wide triangulation of data.
- Boards should make a clear distinction between strategic and operational matters, focusing their attention on a limited number of priority areas for each.
- Boards should not review too many metrics or other sources of intelligence at any one time, they need focus and insightful information / data to allow them to identify trends, risks and areas of concern and where improvements can be made. A curious and open mind-set will drive improvement.

Areas for improvements have been identified and are currently being worked on:

- Triangulation of data qualitative and quantitative to identify issues and areas of concern also where improvements need to be made to services including ***better use of SPC charts to illustrate trends***. This work is undertaken by the performance team and will be highlighted in board papers.
- Baseline and benchmark performance across the ICB and compared to 'statistical neighbours' - other ICBs or places with similar characteristics - peer groups and national trends. This work is undertaken by the performance team and will be highlighted in the Integrated Performance Report that is reported to the Board.

- Systematic 360-degree surveys with stakeholders/committee/board members about the Board, committees and decision-making arrangements could be undertaken to obtain a holistic view of how the Board and its committees are functioning.

This work will be presented to the Board in June 2025. Individual committee surveys are undertaken on an annual basis and reported to those committees and improvement actions undertaken in year.

ICB Board - Meetings

The Board is chaired by Dame Gill Morgan. The Board met on 7 occasions from 1 April 2024 to 31 March 2025, there was an additional meeting in June 2024 to sign off the ICB Annual Report and Annual Accounts. All the Board meetings were quorate.

During the year, the Board received the following reports:

- Patient Story at each meeting
- Chief Executive report with a roundup of contemporary initiatives and schemes
- Urgent and Emergency Care reports including the Public facing Winter Plan in November 2024
- Board Assurance Framework at each meeting
- Integrated Performance Report covering performance standards, quality, workforce, and finance at each meeting
- Clinical Programmes Group overview and update
- The Joint Forward Plan updates given throughout the year; and Operational Planning updates provided during Q4 2024-25
- Annual Assurance report for Emergency Preparedness Resilience and Response (EPRR) 2023-24
- Delivery Plan for Recovering Access to Primary Care – update
- Minutes of the board sub-committees.

From 1 April 2024 to 31 March 2025 the Board approved the following:

- ICB Annual Accounts 2023-24 and Annual Report 2023-24
- Urgent care services for the Forest of Dean
- Upper Gastrointestinal Reconfiguration at Gloucestershire Hospitals NHS Foundation Trust
- Equality Delivery System and Public Sector Equality Duty report and plan
- Joint Forward Plan and Operational Plan 2024-2025
- Renewal by means of legal variation of the Section 75 Agreement
- The ICB Budgets for 2024-25
- Changes to Board sub-committee Terms of Reference
- Provided its support to the One Plan for all Children & Young People in Gloucestershire 2024 to 2030.

ICB Board papers are published on the ICB's website and can be found on our website: **https://www.nhsglos.nhs.uk/news/icb-board-meeting-in-public-2pm-25th-january-2023**

Audit Committee

The Audit Committee is responsible for the oversight of financial assurance covering the system of internal controls, counter fraud arrangements and review of all internal and external audit reports.

The committee has no executive members and entirely comprises non-executive members from both the ICB and Integrated Care System (ICS). The committee is also responsible for assuring the organisation's risk management arrangements, providing assurance to the Board that risk structures, processes and practices are robust and embedded throughout the organisation. The committee receives regular reports on risk management, including copies of the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

The committee met 5 times from 1 April 2024 - 31 March 2025. The committee was quorate on each occasion. The committee is chaired by Julie Soutter, Non-Executive Director. The membership of the committee and attendance at each meeting can be found here **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/**

During the period 1 April 2024 - 31 March 2025, the committee reviewed a number of internal audit reports undertaken by BDO including action plans, relating to the following service areas:

- Primary Care Commissioning – POD – Dental Arrangements
- Primary Care Commissioning report
- Key Financial System report
- Cyber Security report
- Data Security and Protection Toolkit report
- Population Health Inequalities report
- Conflicts of Interests report
- Equality, Diversity, and Inclusion - Advisory report.

In addition, the committee has oversight and receives regular reports on the following areas:

- Counter Fraud reports
- Declarations of Interests including the gifts and hospitality registers
- ICS Savings / Solutions report
- Risk Management reports including (Corporate Risk Register and Board Assurance Framework)
- Procurement Decisions
- Waivers of Standing Orders report
- Service Auditors reports
- Aged Debtor report.

The System Quality Committee

The System Resources Committee is chaired by Professor Joanna Coast, Non-executive Director of System Resources; and is responsible for contributing 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 financial performance.

The committee is responsible for helping improve population heath and healthcare, oversee the collective management of resources and performance at system, place-based and organisational levels, contributing to the System Oversight Framework. The membership of the committee and attendance at each meeting can be found here **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/**

During the period 1 April 2024 to 31 March 2025 the committee met 6 times and was quorate on each occasion. The Committee received the following reports:

- Integrated Performance Report at each meeting
- IPR Metrics Report at each meeting
- ICS Finance Report at each meeting
- Financial Risk Shared Proposals paper
- Shared Outcomes Framework: A Discussion Paper
- Joint Forward Plan – Medium Term Financial Plan
- Population Health Inequalities Audit Report

- Specialised Commissioning update
- Productivity (Creating the Capacity to Care) Programme 2024/25
- Investment Reviews and Next Steps.

Remuneration Committee

The Remuneration Committee determines and approves the remuneration, fees, and other allowances for ICB employees (specifically, very senior managers, non-executive directors). The membership of the committee and attendance at each meeting can be found here **https://www.nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/**

The Remuneration Committee is chaired by Karen Clements. The committee met on 2 occasions from 1 April 2024 to 31 March 2025 and was quorate at each meeting.

The full Remuneration Report can be found within the ICB Annual Report and Accounts..

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance.

The guidance contained within the UK Corporate Governance Code (Sept 2012) and the NHS CCG Code of Governance (Nov 2013) has been followed. I consider that the organisation complies with the principles and standards of best practices.

The arrangements in place for the discharge of statutory functions have been reviewed for any irregularities as part of the internal and external audit work and are considered to be legally compliant. Further assurance has been obtained through the work of the Accountable Officer, Chief Finance Officer, the ICB Board and the Audit Committee.

The ICB has followed guidance issued by NHS England on the role and powers of integrated care boards and employs experienced and well qualified staff. Legal advice and the views of NHS England South West have been sought to obtain clarification and interpretation of laws, regulations, and guidance, where appropriate.

Discharge of Statutory Functions

NHS Gloucestershire ICB has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the ICB's statutory duties.

Risk management arrangements and effectiveness

During the financial year 2024/25 work was undertaken to improve the format and reporting of risk to the ICB's committees and Board. The Board Assurance Framework (BAF) was refreshed in 2024/25 to include the three core pillars in the ICS Strategy, the key strategic objectives, and priorities for 2024/2025.

The strategic objectives and priorities for the ICB/ICS had been agreed earlier in the year by ICS partners. The new format for the BAF which included a clearer layout and summary overview of the risks was presented to the April 2024 ICB Board.

Additionally, the Corporate Risk Register's format and reporting has been further improved with visual highlight reports made available to the Audit Committee and sub-committees of the Board.

The ICB has a Risk Management Framework and Strategy inclusive of the ICB's Risk Appetite which provides a systematic approach to:

- Risk identification, their cause and effect
- How risks are managed
- Creating and developing risk mitigation plans

- The likelihood of occurrence and impact
- Risk rating - escalation and de-escalation process.

The ICB's Risk Management Strategy outlines the vision and objectives of the organisation's risk management system; the strategy embodies 8 key principles to achieve effective risk management: (Integrated, Structured and Comprehensive, Customised, Inclusive, Dynamic, Informed, Audience-appropriate and Always improving).

The Framework incorporates the organisation's approach to working collaboratively with system partners to develop system wide strategic risks incorporated into the Board Assurance Framework, and an agreed statement on the ICB's Risk Appetite.

As part of the annual assurance process on risk management a Board Development session was held in October 2024 on strategic risks and the risk appetite. The Board agreed the approach to the risk appetite but requested that once Gloucestershire Hospitals NHS Foundation Trust had refreshed its Corporate Strategy and hence Risk Management Strategy, the ICB risk appetite statement should be reviewed by the Audit Committee to ensure alignment.

Work has taken place on embedding this risk management approach in all business activities and processes of the ICB, ensuring that a risk aware culture is embraced throughout the organisation.

There is an inclusive approach to risk management involving ICS partners contributing to the development of the ICB BAF through the identification of strategic risks and the involvement of the Strategic Executive, Operational Executive and directorate teams and risk leads.

The Risk Management training and support, is provided by the Governance Team on a monthly basis to risk leads and directorates and reinforces this systematic approach to identifying, managing, and reporting risks as well as assessing the impact and occurrence of risk. Training has more recently focused on understanding the Audit Committee feedback on strategic risks.

Reporting & Assurance

The reporting schedule for the BAF and corporate risk register is as follows:

- **The Board** receives the Assurance Framework comprising system wide risks at every other formal meeting of the Board. The BAF includes high rated risks which should be rated 15 and above.
- **The Audit Committee** receives a report on the medium, high, and significant risks at every meeting i.e. the Corporate Risk Register (12+ rating) and the BAF (15+rating).
- **The Quality Committee** receives a report showing all risks relating to Quality including safeguarding and patient safety as well as Emergency Planning Resilience and Response (EPRR) at each meeting. The BAF strategic risks on quality and EPRR are also included.
- **The System Resources Committee** receives a risk report showing risks relating to performance and finance at each meeting. The BAF strategic risks on health inequalities, recovery, financial sustainability, and capital are also reported.
- **The Primary Care and Direct Commissioning committee** receives a risk report showing all risks relating to primary care at each meeting. The BAF strategic risk on primary care sustainability and resilience is also reported.
- **The People Committee** receives a risk report showing all risks relating to HR/OD and workforce at each meeting. This also includes the strategic BAF risks on workforce and Equality, Diversity, and Inclusion.
- **The Operational Executive** receives bi-monthly CRR and BAF reports. The scheduling of the reports is aligned with the Board and other committee meetings.
- **Strategic Executive** receives the Board Assurance Framework on a bi-monthly basis. The Strategic Executive comprises ICS partners and is the monthly forum for partners to discuss and agree key operational and strategic issues including agreeing strategic risks affecting the system.
- **Operational Groups** (for example Primary Care Operational Group) receive reports for risks relating to their respective areas.

The Board has a duty to assure itself that the organisation has properly identified the risks it faces,

and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The Board receives assurance reports from its sub-committees on the controls and mitigation plans in place to manage significant and high rated risks, reported through the minutes of meetings with a specific Assurance Report provided by the Chair of the Audit Committee following each meeting. Overall assurance reports from committees are included in the Integrated Performance Report which is submitted to the Board on a bi-monthly basis.

Capacity to Handle Risk

The Governance Team meets with risk leads on a monthly basis to discuss their directorate risk register and provide timely support and advice. Risks are transferred to a Corporate Risk Register and high rated risks of 12 or more are reported to the Audit Committee and Operational Executive.

The Governance Team ensures that risk reports are made available to the Strategic Executive, all board sub-committees and the ICB Board in a cyclical manner. All of these forums include ICS partners who are involved in risk discussions.

Key risks identified in 2023/24

There were a number of high-level strategic risks reported in 2024/25 to the ICB Board via the Board Assurance Framework.

The strategic risks identified were aligned to the ICS three pillars, strategic objectives, and key priorities for 2024/25 which had been agreed with system partners and focused on key priority areas such as urgent care, workforce, the recovery of services, cyber security and financial balance, amongst others. It should be noted that the ICB/ICS BAF is correlated with our ICS partners BAFs, and relevant risks included.

As of the 31 March 2025 there were 114 risks in total on the ICB Corporate Risk Register, with 33 red rated risks at 15 and above.

As of the 31 March 2025, there were 13 risks on the BAF, i.e. Approximately 9 were red rated risks at 15 and above and 4 were amber rated risks at 12. The following risks were rated as RED high risks:

BAF 3a. People & Culture: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans. Current risk rating 16 (Red).

BAF 3b. Equality, Diversity, and Inclusion: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse, and engaging culture for staff we employ. Current risk rating 15 (Red).

BAF 4 Quality: 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. Current risk rating 16 (Red).

BAF 6. Primary Care: 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. Current risk rating 20 (Red).

BAF 7. Recovery and Productivity: Failing to deliver increased productivity requirements to meet both backlogs and growing demand. Current risk rating 16 (Red).

BAF 9. Financial Sustainability: Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity. Current risk rated as 16 (red).

BAF 10. Estates: 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. Current risk rating 16 (Red).

BAF 11. EPRR: Failure to meet the minimum occupational standards for EPRR and Business Continuity. Current risk rating 16 (Red).

BAF 12. Cyber Security: Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS. Current risk rating 15 (Red).

The outstanding risks in place on 31 March 2025 are carried over into the new financial year and will continue to be managed within the Risk Management Framework described within this statement.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness see the Risk Management Strategy and Framework **https://www.nhsglos.nhs.uk/wp-content/uploads/2024/04/Risk-Framework-Strategy-and-Policy_Jan23_v1.docx**

Conflicts of interest management

The ICB complies with the guidance on 'Managing Conflicts of Interest in the NHS' that was published by NHS England on 17 September 2024.

The guiding principle for conflicts of interests that decisions are made in the public interest by avoiding any undue influence is incorporated into the ICB's policy on Standards of Business Conduct that also covers the principles of collaboration, transparency and subsidiarity which are at the centre of any decision-making.

The ICB has assurances mechanisms in place reporting to the Audit Committee on the CoI policy. This includes how guidance on CoI is being compiled with, regular reports on compliance with the policy through Declarations of Interest registers published on the ICB website **(https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/using-your-information/register-of-interests/**) and training and the management of potential conflicts in procurement and other ICB business.

The ICB has a CoI training programme, which starts with induction, team meetings and all staff meetings. There are dedicated intranet pages explaining CoI and providing guidance to all staff, including bank, agency workers and contractors.

Conflicts of interest process

The ICB follows a robust process for managing conflicts of interests ensuring that staff are made aware from initial appointment, and throughout their employment they are required to register their interests on an annual basis.

All staff and members of the Board are required to undertake this annual process irrespective if there have been any changes to their interests.

The electronic CoI system, Civica Declare emails staff as soon as they are appointed and repeatedly emails them requiring their interests to be declared until this has been completed; line managers are also emailed to notify them that they have interests to review and either accept/decline. The electronic email notification system provides regular reminders to staff and managers that interests must be declared annually.

Conflicts of Interests Internal Audit (IA) Report 2024/25

A detailed review of conflicts of interest was undertaken by internal auditors during Q4 2024/25 covering a broader remit than previous audits. The audit covered Integrated Locality Partnerships and operational meetings as well as the Board, committees, and a review of the system and processes for managing conflicts of Interests. The assessment provided by the auditors was 'substantial assurance' for design and 'substantial assurance' for operational effectiveness.

There were no 'key' findings from the audit. However, there were two low priority findings, one in relation to the Integrated Locality Partnerships requiring a clearer indication of dates on the register. The

second finding was around the Operational Executive meeting minutes. Both of these recommendations for improvements were implemented.

There were a number of good practice areas identified as follows:

- The Register of Interests for Managers and Board/Committee members were up to date and declarations were made in accordance with CoI Guidance.
- Gifts and hospitality were declared within 28 days of the person becoming aware of the interest, gift or hospitality and reporting was in line with NHSE Guidance. The Gifts and Hospitality register is reported to the Audit Committee every quarter.
- For single tender waivers, appropriate Declaration of Interest's had been collected for the contract from the signatories on the Single Tender Waiver form.
- Appropriate Declaration of Interest's were collected for the contract from both bidders and the evaluation panel for the Integrated Urgent Care Service procurement.
- Training compliance levels for Conflict of Interest training reported to the Audit Committee were over the required 95% compliance standard.
- The ICB monitors declarations and any activity associated with the Association of British Pharmaceutical Industry (ABPI) conflict, or potential of interest.

Data Quality

Board members of the ICB consider data quality to be an integral part of its system of internal controls in order that it can assess both the effectiveness and performance of the organisation and its contracted services. There have been no significant concerns about data quality reported in 2024/25.

Information Governance

The NHS Data Security Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information; this is supported by the Data Security and Protection Toolkit, and the annual submission process by the ICB provides assurances to the Integrated Care Board, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

As part of the annual Data Security and Protection Toolkit submission a comprehensive assessment of information security was undertaken; further assurance has been provided by the ICB's internal auditors who reviewed the submission. The effectiveness of these measures is reported to, and monitored by, the Data Security and Awareness Working Group and the Audit Committee. This includes details of any personal data related serious incidents, the ICB's annual data security toolkit assessment and reports of other data security incidents and audit reviews.

In 2024/2025 the ICB made a toolkit submission that met the Data Security and Protection standards.

In compliance with NHS Digital Information Governance Toolkit, the ICB ensured that all key information security risks are monitored and controlled, this is via its informatics providers: South, Central and West Commissioning Support Unit (CSU) and Countywide IT Services who ensure that the ICB operates secure information networks and systems.

New systems and processes are assessed by governance and information security staff at the point of design or procurement, and appropriate safeguards to minimise risk are put in place. The ICB has a robust process for recording and managing incidents which are monitored by the CSU's governance team with input from Data and Information Security experts as required.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed data security and protection processes and procedures in line with the Data Security and Protection toolkit.

We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. For those members of staff in specialist information governance roles within the ICB,

there is bespoke training provided on an annual basis i.e. for the Caldicott Guardian, Senior Information Risk Owner (SIRO) and the Data Protection Officer (DPO).

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information.

The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

There are processes in place for incident reporting and investigation of serious incidents which are reported via to the Data Security and Protection Group that meets on a monthly basis. Information risk assessment and management procedures are in place and a programme to ensure that a fully embedded information risk culture throughout the organisation against identified risks.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

The ICB works in close partnership with Gloucestershire County Council to manage both the Better Care Fund and other partnership budgets.

The arrangement is governed by a Section 75 agreement. On 27 November 2024, the Board of the ICB gave approval for the renewal of the term of the Section 75 Agreement (by way of a Deed of Variation between the ICB and GCC) for a further 3-year period (1/4/2025 to 31/3/2028).

Control Issues

The ICB can state that there were no significant control issues to report.

Commissioning of delegated specialised services

Gloucestershire ICB signed a delegation agreement (DA) with NHS England - South West which put in place the joint NHSE and ICB systems statutory joint committee for commissioning arrangements for delegated services during the 2024/25 reporting period. Following the ICB Board meeting held on 26th March 2025, approval was given for the full delegation of responsibility for Specialised Commissioning services to Gloucestershire ICB from NHS England under the Principal Commissioner operating model from 2025/26 (with NHS Somerset ICB assuming the role of principal commissioner).
To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the delegation agreement are being met.

Where there are known compliance issues, the ICB leadership will work collectively with other ICBs (e.g. through multi-ICB working arrangements with Somerset ICB as the principal commissioner) and engage with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership can provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of functions

The ICB has a defined Scheme of Reservation and Delegation (SoRD) as well as a Detailed Financial Delegation document which is a supplement to the Standing Financial Instructions.

These documents were approved by the ICB Board on 1 July 2022. Further updates to the detailed scheme of delegation have been made and reported to the Audit Committee in November 2022.

The SoRD identifies which functions are reserved for the Board and which are delegated for discharge across the ICB in line with effective use of resources and risk management processes. In support of this the ICB has a Detailed Scheme of Delegation which identifies what financial responsibilities the following levels of authority have:

- Level 1 - Board of the ICB
- Level 2 - Chief Executive Officer (Accountable Officer)
- Level 3 - Chief Finance Officer
- Level 4 - Other Directors
- Level 5 - Budget holders, in accordance with specific levels of authority granted to individuals
- Level 6 - all other office holders.

The Board receives regular reports from all its committees to provide assurance regarding the arrangements for the discharge of delegated functions, including those relating to quality, finance, risk, and performance, particularly relating to constitution targets.

The Board receives minutes from the Primary Care & Direct Commissioning Committee ensuring they are meeting their delegated duties for Primary Care and Pharmacy, Optometry and Dental (POD) services and that conflicts of interests are being effectively managed.

Internal Audit provides independent assurance on the processes in place as part of the annual internal audit plan which is supplemented by the oversight of the assurance of the ICB's value for money, economy, efficiency, and effectiveness by the External Auditors.

Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption

The Chief Finance Officer is the lead for counter fraud within the ICB and works with the nominated Local Counter Fraud Specialist to develop the annual work-plan which is approved by the Audit Committee.

The ICB's Counter Fraud Service is provided by the Gloucestershire Shared Service for NHS (GSS). GSS employs a team of three accredited Local Counter Fraud Specialists who provide the full range of Counter Fraud functions.

The Head of Counter Fraud meets regularly with the Chief Finance Officer to discuss progress against the Action Plan and areas of potential risk. During the period 1 April 2024 to 31 March 2025 regular reports and updates were given to the Audit Committee on:

- Counter Fraud, Bribery and Corruption Annual report.
- Counter Fraud, Bribery and Corruption work-plan.
- Counter Fraud Progress reports.
- Counter Fraud Staff Survey.
- Counter Fraud Functional Standard Return 2023/24.
- Counter Fraud, Bribery and Corruption Policy updated.
- National counter fraud initiative.
- Counter Fraud training (face to face and e-learning).
- Current Cases and Proactive Counter Fraud Work.

Counter Fraud deliver face to face training to all staff as a part of the ICB's Statutory and Mandatory Training Policy. This training is delivered via the Corporate Induction Day and team and directorate meetings.

The Counter Fraud Service provide a monthly face to face drop-in service for ICB staff which is advertised in the electronic Staff Bulletin. All staff are required to complete their annual e-learning module on counter fraud in addition to face-to-face counter fraud training, which is now available via their Electronic Staff Record (ESR). Managers have access to ESR manager self-service to review individual and team compliance.

The Deputy Head of Counter Fraud attends all Audit Committee meetings to provide both a written and verbal update on progress against the Counter Fraud Annual Plan and counter fraud initiatives.

Service Auditor Reports

The ICB relies on a number of third parties to provide services, these include human resources and payroll services, payments to GPs, dentist, optometrists and pharmacists.

Suppliers of services have engaged with auditors to carry out ISAE3402 Service Audit Type II reports to review and provide assurance on the controls within the third party organisations, these reports have/are in the process been received by the organisation for 2024/25.

Qualified opinions were given on the GP Data extraction service, Capita primary care support services and SBS finance and accounting services.

Unqualified opinions were given on the BSA – dental and prescription payments, SBS employment services, SCW CSU – CQRS services and ESR.

The ICB has compensating controls in place to mitigate any increased areas of risk.

Review of economy, efficiency & effectiveness of the use of resources

The Board has overarching responsibility for ensuring the ICB carries out its activities effectively, efficiently, and economically. To ensure this:

- There are procurement processes to which the ICB adheres. There is a scheme of delegation which ensures that financial controls are in place across the organisation. The roles of the accountable and delegated committees and groups are shown within this report.
- The ICB Board receives a report from the Chief Finance Officer at each of its Public Board meetings through the Integrated Finance and Performance report on a bi-monthly basis and an update on finance at the Board Development sessions where required.
- The Audit Committee receives regular reports on financial governance, monitors the Internal Audit programme and reviews the draft and final annual accounts.
- The ICB has a programme of Internal Audits that provides assurance to the Board and Executive Team of the effectiveness of its internal controls and processes.
- The ICB 's annual accounts are reviewed by the Audit Committee and audited by our external auditors.

Following completion of the planned audit work our external auditors will issue an Independent and objective opinion on the ICB's arrangements for securing economy, efficiency, and effectiveness in the use of resources.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board, which is assured of a sound system of internal control by reports by its committees, executives and the Audit Committee which oversees the reporting and monitoring of the ICB's internal controls systems, processes and reporting.

- The audit committee (see section on the Audit Committee which has had good oversight and robust processes to assure the Board and ICB that is has a sound system of internal controls.
- If relevant, the risk / clinical governance / quality committee (see BAF report with regard to quality risks, which are scrutinised and monitored by the System Quality Committee, providing assurance to the Board that clinical / quality risks are being effectively managed and reported.)
- Internal audit (see HoIA opinion see below).

Conclusion

Based on the assurances provided to me (see above) for the year 2025-26 I (as the Accountable Officer) can state that there were no significant control issues to report.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Board Assurance Framework and supporting processes
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year; this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
- Any reliance that is being place upon third party assurance.

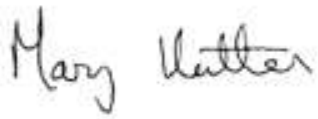
The Head of Internal Audit concluded that:

Overall, we provide **Moderate** Assurance that there is a sound system of internal controls, designed to meet the ICB's objectives, that controls are being applied consistently across various services.

In forming our view, we have taken into account that:

- So far, we have completed a total of five assurance reviews and one advisory review, the remaining three audits are work in progress.
- The advisory review related to the Data Security Protection Toolkit and did not carry an opinion.
- For the five assurance audits, three were rated substantial, one moderate and one limited in the design of the controls. This is similar to the prior year. (Further comparison will be provided in the final version of the Internal Audit Annual Report). The limited opinion related to cyber security of GP IT assets as the ICB has limited visibility of GP IT hardware. The location of a number of assets that were deployed during the pandemic have yet to be established. Applications may be in use, particularly by non-CITS technical teams (e.g. external contractors), that have not validated/approved by CITS and therefore may not be appropriately supported.
- Three were rated substantial and three were rated moderate in their operational effectiveness. This is similar to the prior year. (Further comparison will be provided in the final version of the Internal Audit Annual Report).
- Our six reports for the year resulted in a total of 20 recommendations (High: 2, Medium: 5 and Low: 13), compared to 30 recommendations the year before (High: 2, Medium: 19 and Low: 9). (Further comparison will be provided in the final version of the Internal Audit Annual Report).
- The ICB has displayed strong controls in relation to its Financial and Conflicts of Interest processes. In addition, strong controls for the oversight of the Primary Care Access Recovery plans were evidenced.
- The ICB has performed satisfactorily in implementing our audit recommendations within the specified timeframes. As at the end of February 2025, there is one medium recommendation in progress and two medium recommendations that are overdue.

- As is the case across the NHS, the ICB has faced financial challenges during the year. However, the ICB plans to deliver (subject to external audit) a break-even income and expenditure financial position for the year April 2024 to March 2025.
- We have considered the results of the service auditor reports that had been provided in May 2024. There were no matters which required us to undertake additional testing or change the scope of our work.



Mary Hutton

Chief Executive Officer

June 2025

Remuneration and staff report

Remuneration and staff report

Remuneration report

The Remuneration Committee makes decisions about the remuneration, fees and allowances for board members of the ICB, and other senior staff employed outside agenda for change terms and conditions, who are appointed by or who provide services to the ICB. Details on the Remuneration Committee are shown within the Governance report including membership and number of meetings. Full details of the remuneration paid to the ICB board members and senior employees are provided within the Remuneration Report included herein, together with their pension entitlements.

Senior Managers Remuneration Report

For the purpose of this report, senior managers are defined as being 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Integrated Care Board (ICB). This means those who influence the decisions of the organisation rather than the decisions of individual directorates or departments. Such persons will include non-executive directors and partner members of the ICB board. It is the Remuneration Committee that decides the reward packages of Executive Directors of the ICB. Information on the Remuneration Committee can be found in the Governance Statement.

Policy on the remuneration of senior managers

The policy on remuneration of senior managers has been set using national guidance issued by NHS England, ICB Executive Pay Ranges and Guidance version 1.0 (17 March 2022); guidance for Non-executive Directors (NEDs) pay was also made available in 2021 and updated in 2022 to assist ICBs determine remuneration for NEDs. The ICB does not have a policy for performance related pay for its senior managers.

Senior Manager Contracts

Senior officer appointments to the ICB are consistent with the employment policies of the ICB. Where appropriate, duration of contracts is determined by the needs of the business. Notice periods take account of statutory requirements and terms previously established by the NHS very senior managers' pay framework. Liability in the event of early termination is in accordance with the NHS Agenda for Change terms and conditions handbook. Further guidance is also provided by NHS England on the termination and reengagement of senior managers. They also include any additional pension benefit accrued to the members as a result of their purchasing additional years of pension service in the scheme at their own cost. Cash Equivalent Transfer Values (CETVs) are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Fair pay disclosure (Subject to Audit)

The annualised range of remuneration for 2024/25 is £20.7k to £198.7k (2023/24 is £25.15k to £189.26k).

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid member of the Governing Body in the ICB in the financial year was £195k - £200k (£185k - £190k in 2023/24).

The relationship of the highest paid director to the remuneration of the organisation's workforce is disclosed in the below table.

The median pay ratio has reduced slightly as a result of departmental changes in staffing.

Pay Ratio information

2024-25	25th Percentile	Median	75th Percentile
Total remuneration (£)	£37,338	£48,526	£66,246
Pay ratio information	5.32:1	4.1:1	3:1

2023-24	25th Percentile	Median	75th Percentile
Total remuneration (£)	£35,392	£45,996	£58,972
Pay ratio information	5.35:1	4.11:1	3.21:1

* All Remuneration relates to Salary only. There have been no performance related pay or bonuses

The average percentage change for the ICB as a whole has seen a 8.27%/£4,438 increase in 24/25. (4.6%/£2,357 increase in 23/24). The majority of this relates to nationally agreed pay awards. There has been an increase in the highest paid directors remuneration in 24/25 of 5% £9,463 (No change in 23/24).

In 2024/25 no employee received remuneration in excess of the governing body. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer of pensions.

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2025, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2023	5
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	5

All existing off-payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2023	6
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	5

All existing off-payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

Remuneration Report for NHS Gloucestershire ICB 2024-25 (audited)

	2024/25						
Name & Title	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500) *	Total (bands of £5,000)
Dame Gill Morgan, Chair	65-70	0	0	0	65-70	0	65-70
Mary Hutton, Chief Executive	195-200	0	0	0	195-200	0	195-200
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	165-170	0	0	0	165-170	62.5-65	230-235
Cath Leech, Chief Finance Officer	155-160	0	0	0	155-160	0	155-160
Mark Walkingshaw, Director of Operational Planning & Performance	145-150	0	0	0	145-150	17.5-20	165-170
Helen Goodey, Director of Primary Care & Place [1]	135-140	0	0	0	135-140	22.5-25	160-165
Marie Crofts (Yvonne), Chief Nursing Officer	155-160	0	0	0	155-160	260-262.5	415-420
Tracey Cox, Director of People, Culture and Engagement	155-160	0	0	0	155-160	20-22.5	175-180
Dr Paul Atkinson, Chief Clinical Information Officer	140-145	0	0	0	140-145	30-32.5	170-175
Dr Ananthakrishnan Raghuram, Chief Medical Officer	125-130	0	0	0	125-130	55-57.5	180-185
Benedict Leigh, Director of Integrated Commissioning [2]	90-95	0	0	0	90-95	0	90-95
Professor Joanna Coast, Non Executive Director System Resources	10-15	0	0	0	10-15	0	10-15
Professor Jane Cummings CBE RN, Non Executive Director System Quality	20-25	0	0	0	20-25	0	20-25
Julie Soutter, Non Executive Director Audit	15-20	0	0	0	15-20	0	15-20
Karen Clements, Non Executive Director, People and Remuneration	15-15	0	0	0	15-15	0	15-15
Ayesha Janjua, Non Executive Director, Primary Care and Direct Commissioning	15-15	0	0	0	15-15	0	15-15
Dr Jo Bayley, Primary Medical Services (Primary Care Network perspective) [3]	15-20	0	0	0	15-20	0	15-20
Dr Emma Crutchlow Primary Care Network perspective (Board participant) G Doc Ltd[3]	5-10	0	0	0	5-10	0	5-10
Dr Olesya Atkinson, Primary Medical Services (Primary Care Network perspective)	0-5	0	0	0	0-5	0	0-5

*These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme. A zero balance either means that the member has chose not to be covered by the NHS pension arrangements during the reporting year or where the figures supplied by NHS Pensions have produced a negative value.

These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act

2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

*Due to changes in the NHS pension scheme and, in particular, where individuals are new in post or may have changed schemes in previous years this distorts the calculations.

1. Remuneration relates to Work for Gloucestershre ICB. Non disclosed remuneration for role at Gloucestershire Care and Health NHSFT until August 24. Total remuneration received is within band (145-150)

2. Remuneration relates to Work for Gloucestershre ICB. Employed by Gloucestershire County Council and recharged to Gloucestershire ICB

3. Employed By G Doc Ltd and recharged to Gloucestershire ICB.

The Board includes representatives of system partners within Gloucestershire Integrated Care System where there is no remuneration received. This includes representatives from Gloucestershire County Council as well as the Chief Executive of Gloucestershire Hospital NHS Foundation Trust and the Chief Executive of Gloucestershire Health and Care NHS Foundation Trust who are funded by their respective organisations.

Remuneration Report for NHS Gloucestershire ICB 2023-24 (audited)

	2023/24						
Name & Title	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500) *	Total (bands of £5,000)
Dame Gill Morgan, Chair	65-70	0	0	0	65-70	0	65-70
Mary Hutton, Chief Executive	190-195	0	0	0	190-195	0	190-195
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	155-160	0	0	0	155-160	0	155-160
Cath Leech, Chief Finance Officer	145-150	0	0	0	145-150	22.5-25	170-175
Mark Walkingshaw, Director of Operational Planning & Performance	140-145	0	0	0	140-145	0	140-145
Helen Goodey, Director of Primary Care & Place [1]	110-115	0	0	0	110-115	0	110-115
Dr Marion Andrews-Evans, Chief Nursing Officer (to 31st December 2023)	110-115	0	0	0	110-115	0	110-115
Marie Crofts (Yvonne), Chief Nursing Officer (from 1st January 2024)	35-40	0	0	0	35-40	280-282.5	315-320
Benedict Leigh, Director of Integrated Commissioning [2]	45-50	0	0	0	45-50	0	45-50
Tracey Cox, Director of People, Culture and Engagement	145-150	0	0	0	145-150	0	145-150
Dr Paul Atkinson, Chief Clinical Information Officer	135-140	0	0	0	135-140	0	135-140
Dr Andy Seymour, Chief Medical Officer (to 15th December 2023)	85-90	0	0	0	85-90	0	85-90
Dr Ananthakrishnan Raghuram, Chief Medical Officer (From 18th December 2023)	35-40	0	0	0	35-40	0	35-40
Professor Joanna Coast, Non Executive Director System Resources	10-15	0	0	0	10-15	0	10-15
Professor Jane Cummings CBE RN, Non Executive Director System Quality	15-20	0	0	0	15-20	0	15-20
Julie Soutter, Non Executive Director Audit	15-20	0	0	0	15-20	0	15-20
Dr Olesya Atkinson, Primary Medical Services (Primary Care Network perspective)	15-20	0	0	0	15-20	0	15-20
Dr Jo Bayley, Primary Medical Services (Primary Care Network perspective) [4]	15-20	0	0	0	15-20	0	15-20
Clive Lewis OBE DL, Non Executive Director People and Remuneration (to 22nd May 2024)	0-5	0	0	0	0-5	0	0-5
Karen Clements, Non Executive Director, People and Remuneration (From 1st January 2024)	0-5	0	0	0	0-5	0	0-5
Colin Greaves, Non Executive Director, Primary Care and Direct Commissioning (To 31st October 2023)	5-10	0	0	0	5-10	0	5-10
Ayesha Janjua, Non Executive Director, Primary Care and Direct Commissioning (From 1st December 2023)	5-10	0	0	0	5-10	0	5-10

*These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme.

These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

*Due to changes in the NHS pension scheme and, in particular, where individuals are new in post or may have changed schemes in previous years this distorts the calculations.

1.Remuneration relates to Work for Gloucestershre ICB. Non disclosed remuneration for role at Gloucestershire Care and Health NHSFT. Total remuneration received is within band (140-145)

2.Remuneration relates to Work for Gloucestershre ICB. Employed by Gloucestershire County Council and recharged to Gloucestershire ICB

3.Employed By G Doc Ltd and recharged to Gloucestershire ICB.

The Board includes representatives of system partners within Gloucestershire Integrated Care System. This includes the Chief Executive of Gloucestershire Hospital NHS Foundation Trust and the Chief Executive of Gloucestershire Health and Care NHS Foundation Trust who are funded by their respective organisations.

Pensions Report 2024-25 (subject to audit)

Name & Title	2024/25							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employers contribution to stakeholder pension
Tracey Cox, Director of People, Culture and Engagement	0-2.5	0-0	70-75	185-190	1,505	32	1,658	0
Dr Paul Atkinson, Chief Clinical Information Officer	0-2.5	0-0	25-30	45-50	400	18	462	0
Marie Crofts (Yvonne), Chief Nursing Officer	12.5-15	27.5-30	85-90	250-255	1,783	310	2,232	0
Cath Leech, Chief Finance Officer	0-0	0-0	60-65	165-170	1,404	1	1,505	0
Dr Ananthakrishnan Raghuram, Chief Medical Officer	2.5-5	2.5-5	75-80	205-210	1,745	75	1,965	0
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	2.5-5	5-7.5	30-35	85-90	584	63	697	0
Mark Walkingshaw, Director of Operational Planning & Performance	0-2.5	0-0	55-60	150-155	1,235	26	1,362	0
Helen Goodey, Director of Primary Care & Place	0-2.5	0-0	40-45	100-105	892	28	999	0
Mary Hutton, Chief Executive	Mary Hutton has received her NHS pension benefits							

Pensions Report 2023-24 (audited)

Name & Title	2023/24							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employers contribution to stakeholder pension
Tracey Cox, Director of People, Culture and Engagement	0-0	27.5-30	60-65	175-180	1,236	125	508	22
Dr Paul Atkinson, Chief Clinical Information Officer	0-0	20-22.5	20-25	45-50	273	81	1,047	20
Marie Crofts (Yvonne), Chief Nursing Officer (from 1st January 2024)	2.5-5	15-17.5	65-70	205-210	1,251	400	920	5
Cath Leech, Chief Finance Officer	0-0	40-42.5	55-60	160-165	1,047	234	466	19
Dr Ananthakrishnan Raghuram, Chief Medical Officer (From 18th December 2023)	0-0	0-0	70-75	190-195	1,687	0	1,013	5
Ellen Rule, Deputy CEO/Director of Strategy and Transformation	0-0	15-17.5	25-30	75-80	433	28	101	8
Mark Walkingshaw, Director of Operational Planning & Performance	0-0	20-22.5	50-55	140-145	1,013	33	101	20
Helen Goodey, Director of Primary Care & Place	0-0	0-2.5	35-40	95-100	920	33	0	20

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Staff Report

NHS Gloucestershire ICB employed a headcount staff of 465 equating to 395.84 WTEs as at the 31 March 2025. These figures include all permanent staff, those on short-term contracts but is exclusive of staff employed on bank contracts. The annual staff turnover rate is 11.9% (staff headcount). The ICB has a well-structured HR service with the Commissioning Support Unit's People Resource function providing transactional and employee relations HR services. The ICB has an internal HR team with a Director of People, Culture and Engagement leading the service with responsibility for HR strategy and organisational development, and the Associate Director of Corporate Affairs providing operational support working closely with the CSU People Resource Team and ICS HR/OD partners.

Governance arrangements for HR

The reporting structure for HR and workforce reports is through the People Committee which was established on 1 July 2022. The Chair of the committee is Karen Clements, Non-executive Director and the executive lead is Tracey Cox, Director of People, Culture and Engagement.

The People Committee has responsibility for the oversight and scrutiny of the effectiveness of the ICS People Function including the governance structure and the development of an ICS People strategy and plan.

The Committee routinely receives reports on the ICS workforce profile covering Gloucestershire demographics, numbers of staff employed in health and care roles, key workforce demographics (age, ethnicity, gender, disability etc) as well as workforce vacancies and sickness rates.

The People Committee has received reports on the One Gloucestershire Workforce Delivery Plan; System wide reports on key performance indicators within the Integrated People Report, Training and Development reports, Staff Retention report, the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and staff survey reports as well as many other HR/OD topics. The People Committee also approves all ICB HR policies (see Governance Statement for more detail).

The Staff Side Partnership (SPF) has an important role providing staff feedback and input to the development of ICB HR plans, policies, staff events and the staff survey. Health and wellbeing is included on every agenda as well as Equality, Diversity and Inclusion. The committee meets on approximately 10 occasions during the year and is co-chaired by the Staff Side Representative for the ICB and the Director of People, Culture and Engagement. Each directorate has one or more SPF representatives who attend the meeting along with HR / OD colleagues and the Health and Wellbeing lead and the Health and Safety Representative for the ICB. These arrangements are set out in the Trade Union Recognition Agreement which the ICB has agreed with SPF.

From 1 July 2022 through to 31 March 2025 there has been good representation from staff at the SPF meetings noting that staff reps have found the forum important to staff engagement and in understanding the forthcoming changes resulting from the reduction in ICB running costs. The main focus of the SPF meetings during the financial year (April 2024 to March 2025) was the development of new policies such as Flexible Retirement, Carers Policy, and the Freedom to Speak Up (FTSU) policy in addition to updating current policies, as well as wellbeing initiatives and Equality, Diversity and Inclusion work particularly around creating an inclusive culture. Other key topics that the SPF has been engaged with raising awareness of the FTSU Guardian roles across the ICB, equality and diversity reports particularly the Public Sector Equality Duty / Equality Delivery System 2, staff survey reports and actions, as well as initiatives around supporting staff with bereavement and caring responsibilities.

Staff survey results 2024

The ICB partook in the national staff survey in 2024 and received early in 2025 a suite of reports including a full and detailed report of the findings which were benchmarked against other ICBs which participated in the Picker Staff Survey. This included a summary report of the seven People Promises along with the additional two themes on staff engagement and morale.

In addition, detailed directorate reports providing a breakdown of the results were provided. This was the sixth year that the ICB partook in the national survey with benchmark data available from 2019 on key themes. A total of 346 questionnaires were completed by ICB staff, representing 77% of the

workforce; this compared well with other ICBs with a 74% median response rate. There was an increase in participation rates compared to 2022 where 74% workforce responded to the survey. Much of this can be attributable to early communications out to staff before the staff survey was launched, as well as timely messaging throughout the survey period.

The national reports provide an overview of the seven people promises and two additional themes detailing where NHS Gloucestershire ICB scored in terms of the best, worst and average compared to other ICBs.

In the seven people promise elements NHS Gloucestershire ICB scored at the Picker average for ICBs and close to the best in several elements. The ICB also scored above average on the two additional themes (staff engagement and morale) which compared well to other ICBs and close to the 'best' ICBs. See graphic below:

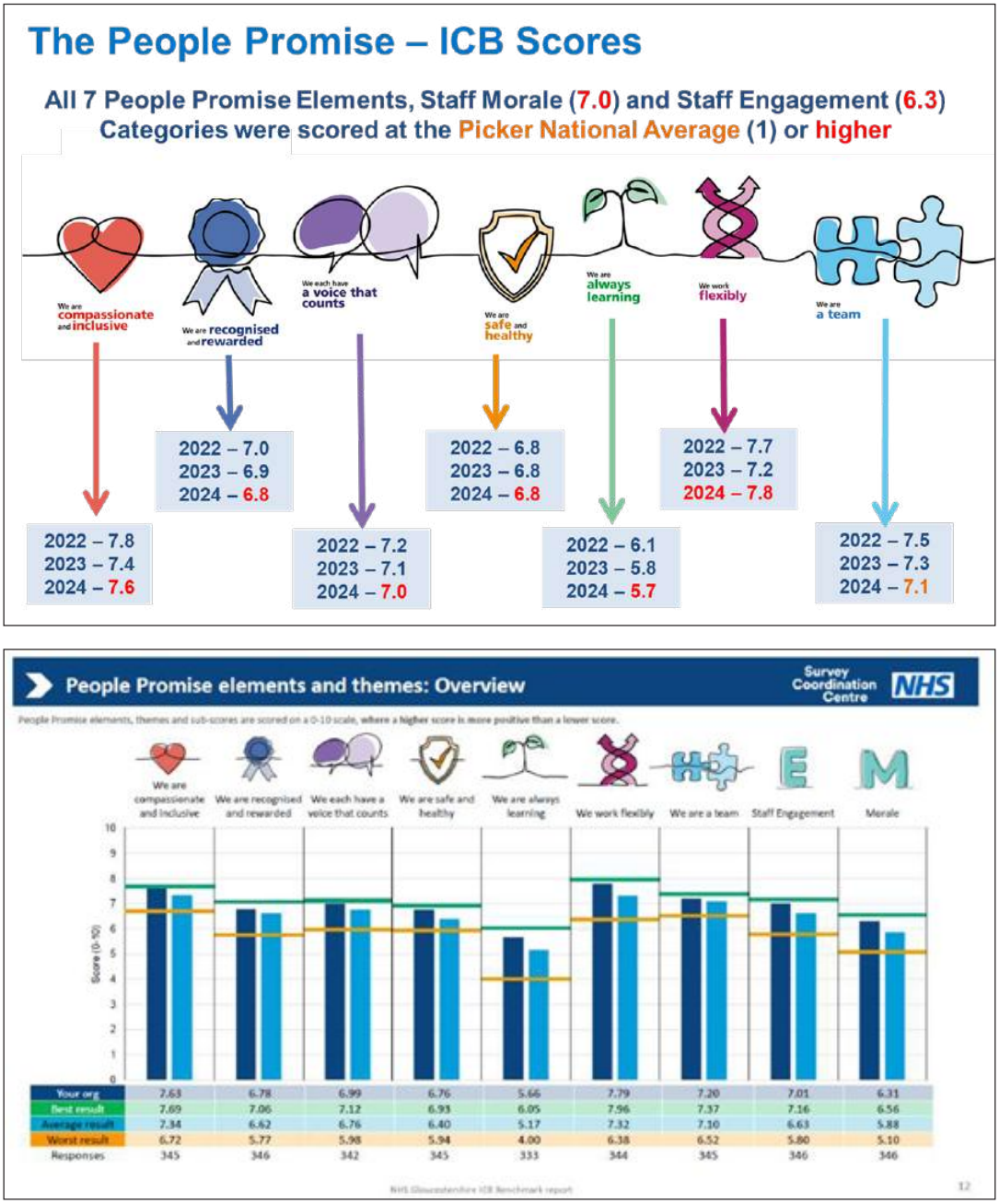


Diagram 2 People Promise elements and themes in comparison to other ICBs who participated in the Picker National Staff Survey

It should be noted that that trend data shows that while the ICB did score at the average of above in comparison with other ICBs, there was a dip in scores compared to previous years, this was also evident in other ICBs.

Overall, the ICB performed well compared to other ICBs and improved its score from 2023 in a number of key areas. For the third year running NHS Gloucestershire ICB was the top rated ICB for recommending the organisation as a place to work with 73.41% of our staff responding positively to this question.

A summary of some of the key highlights are given below.

Above average or above scores in relation to other ICBs include:

- Care of patients and service users is my organisation's top priority – 74.28%
- My immediate manager cares about my concerns – 81.45%
- My organisation respects individual differences (e.g. cultures, working style, background, and ideas) – 79.36%
- I feel valued by my team – 79.31%
- The people I work with are understanding and kind to one another – 83.77% close to the 'best'
- My immediate manager values my work – 82.9%
- My immediate manager is interested in listening to me when I describe challenges I face – 80.6%
- I am trusted to do my job – 86.9%
- There are frequent opportunities to show initiative in my role – 76.88%
- There are frequent opportunities for me to show initiative in my role – 76.88%
- I always know what my work responsibilities are – 78%
- feel safe to speak up about anything that concerns me in this organisation – 66.50% close to the 'best'
- I have adequate materials, supplies and equipment to do my work – 78%
- Organisation takes positive action on health and well-being – 77.5%
- In the last 12-months, have not experienced MSK problems as a result of work activities – 79.2%
- In the last 12-months, have not felt unwell due to work related stress – 66.5%
- Not felt pressure from manager to come to work when not feeling well enough – 86.9%.

Top 5 scores vs Organisation Average	Org	Picker Avg
q25c. Would recommend organisation as place to work	73.41%	54%
q11a. Organisation takes positive action on health and well-being	77%	61%
q24e. Able to access the right learning and development opportunities when I need to	63%	51%
q6b. Organisation is committed to helping balance work and home life	77%	65%
q12g. Never/rarely lack energy for family and friends	55%	44%

Most improved scores	Org 2024	Org 2023
q12g. Never/rarely lack energy for family and friends	55%	47%
q6c. Achieve a good balance between work and home life	75%	69%
q23a. Received appraisal in the past 12 months	85%	79%
q22. I can eat nutritious and affordable food at work	77%	72%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	37%	32%

There were a number of areas where the ICB needs to improve including:

- Satisfied with level of pay: 54.3% compared to 57.8 % nationally but improved from 51.9% in 2023
- Not experienced harassment, bullying or abuse from patients/service users, their relatives, or members of the public: 89.8% compared to national average 92.8%
- Appraisal helped me agree clear objectives for my work: 30.7% compared to 35.2% nationally. A deterioration from 2023 when the ICB scored 32.8%.

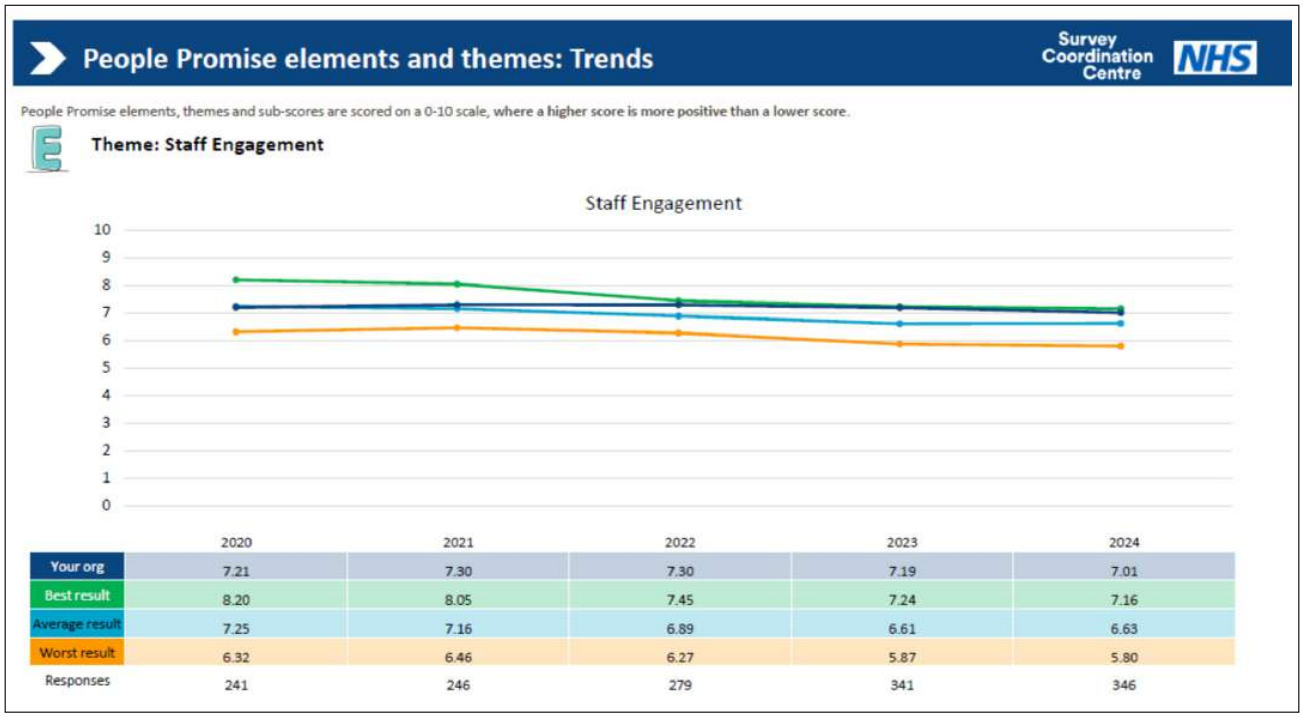
These over-arching results are underpinned by a range of detailed findings. More information can be found on the National Staff Survey Coordination Centre website **https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/**

The ICB has developed a Staff Survey Action Plan focusing on the key improvement themes from the 2024 survey including addressing stress and burnout through enhanced wellbeing support provided to staff. There will be a focus on ensuring that staff have the support they need during this period of change and transition with a focus on health and wellbeing – tackling stress and anxiety, managing change with resilience, and promoting bone health through diet and exercise as a means of addressing Musculo Skeletal health. There are plans in the spring and summer for wellbeing seminars and events which will focus on Dementia Awareness (Dementia Awareness Week19th – 25th May), Carers Support and further training opportunities to prepare staff for transition and change. Other areas of focus will be on appraisals and continuing with the work around developing an inclusive culture and addressing bullying and harassment.

The Staff Survey results and action plan are reported to the People Committee, which monitor the implementation of the actions.

Staff Engagement - Staff Survey benchmark data

The ICB scored above average in relation to questions about staff engagement in the 2024 Staff Survey. Benchmark data show the ICB was close to the 'best' performing ICBs scoring 7.01 compared to the best at 7.16 and average at 6.63, but there has been a dip in results from 2022 and may be reflected in the increased pressures experienced by staff working in the NHS.



	2020	2021	2022	2023	2024
Your org	7.21	7.30	7.30	7.19	7.01
Best result	8.20	8.05	7.45	7.24	7.16
Average result	7.25	7.16	6.89	6.61	6.63
Worst result	6.32	6.46	6.27	5.87	5.80
Responses	241	246	279	341	346

It is evident that as we continue to work in a hybrid manner combining on site and home working staff engagement has been made more challenging. However, we have used technology to reach many more staff in more flexible ways such as, organising hybrid staff meetings using MS Teams and recording those meetings and uploading them to the intranet to be viewed at a time convenient to staff. A summary of staff engagement activities is given below:

- Monthly hybrid Staff Meetings hosted by the Chair and Chief Executive, which is supported by a written Team Brief e-bulletin which is then distributed after the meeting.
- Weekly staff communications sent out each Friday providing the latest updates to staff.
- Monthly Team Directorate meetings.
- The Staff Award scheme to recognise staff who go the extra mile.
- Senior Managers development session which has to date focussed on Civility and Respect and the ICB values and behaviour framework.
- Lunch and learn sessions run by staff and the HR team to share their work and learning with other staff members including ESR self-service – managing sickness absence, booking annual leave on ESR, safeguarding training, training on bullying and harassment as well as managing grievances amongst other topics.
- The ICB intranet holds information on all team briefs, policies, procedures, and other information.
- The ICB Executive Team meets with senior managers on a monthly basis.
- Managers hold regular one-to-one meetings with staff and a robust appraisal system ensures that staff work towards clearly defined personal objectives which are supported with learning, training, and development opportunities.

Staff Wellbeing

The ICB has a dedicated Health and Wellbeing lead employed for 1 day a week from 1 April 2024 – 31 March 2025, who provided practical resources and events to support staff wellbeing including meeting regularly with the ICB Wellbeing Champions. There are 15 Wellbeing Champions who represent the 9 directorates within the ICB.

Health Champions support colleague's mental health and wellbeing through:

- Organising social events and activities (both in-person and virtual).
- Setting up a safe space for people to voice mental health concerns.
- Directing colleagues to resources to help them work from home safely and healthily.
- Introducing initiatives for keeping colleagues engaged and healthy, including setting up work sports teams or crafting sessions.
- Keeping teams informed of upcoming events and sending links to Wellbeing sessions.

The wellbeing programme for 2024-25 included a continuation of the focus on reducing stress, improving health and mental health, as well as dedicated sessions on Menopause, Cervical Screening and Oral Health. There was the continuation of health checks for new recruits as well as a spot light on Men's Health in the autumn of 2024. The Employee Assistance Programme ran a number of webinars on women's health, mental health, and financial health.

The ICB provides an Occupational Health Service and Employee Assistance Programme and funds the Gloucestershire Wellbeing Line which provides staff with counselling and support. The ICB was awarded the Gloucestershire Healthy Workplaces Advanced Award in 2022 building on our accreditation of the Healthy Workplaces Foundation Award in 2021.

Staff Numbers

Average Contracted WTE of Staff Groupings by Occupational Code (excluding Off Payroll engagements only)	24/25			23/24		
	Male	Female	Total	Male	Female	Total
Governing Body members	0	1	1	0	1	1
Executive Directors	3	6	9	3	6	9
Senior Manager G0 (Band 8D and Above)	8	11	19	7	6	13
Manager G1 (Band 8A, 8B, 8C)	25	46	71	24	37	61
Clerical and Admininstrative G2 (Band 7 and Below)	51	126	177	57	163	220
Nursing, midwifery and health visiting staff	1	2	3	3	5	8
Medical and dental staff	1	55	56	5	47	52
Scientific, therapeutic and technical staff	8	23	31	6	22	28
Sub Totals	**97**	**270**	**367**	**105**	**287**	**392**
Grand Total		**367**			**392**	

Staff profile

The profile of staff within the ICB, based on the average number of Whole Time Equivalent contracted in 2024-25, is as presented in the table below. This is referred to in note 4 of the Annual Accounts.

Avg No WTE contracted (including Directors & Off Payroll engagements)	24/25			23/24		
	Director	Other Ee	Total	Director	Other Ee	Total
total Staff	9	365	**374**	9	391	**400**
of which:						
Perm	9	342	**351**	9	334	**343**
Other	0	23	**23**	0	57	**57**
of which:						
Male	3	100	**103**	3	107	**110**
Female	6	265	**271**	6	284	**290**

Total staff costs including employers national insurance and pension

	24/25			23/24		
	Directors £'000	Other Ees £'000	Total £'000	Directors £'000	Other Ees £'000	Total £'000
total Staff Costs	1,733	19,845	**21,578**	1,653	18,640	**20,293**
of which:						
permanent	1,733	19,191	**20,924**	1,653	18,069	**19,722**
other	-	654	654	-	571	**571**

Employee benefits and staff numbers (subject to audit)

	24/25			23/24		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits						
Salaries and Wages	21,578	20,924	654	20,293	19,722	571
Social Security Costs	2,322	2,322	0	2,329	2,325	4
Employer Contributions to NHS Pension scheme	4,638	4,638	0	3,757	3,749	8
Other Pension Costs	5	5	0	6	6	0
Apprenticeship Levy	84	84	0	105	105	0
Termination Benefits	0	0	0	0	0	0
Gross employee benefits expenditure	**28,627**	**27,973**	**654**	**26,490**	**25,907**	**583**
Total – Net admin employee benefits including capitalised costs	**28,627**	**27,973**	**654**	**26,490**	**25,907**	**583**
Net employee benefits excluding capitalised costs	**28,627**	**27,973**	**654**	**26,490**	**25,907**	**583**

There were no significant increases in staff groups in 2024/25
There has been no significant awards made to past senior managers in 2024/25
There has been no compensation on early retirement or for loss of office in 2024/25
There has been no payment to past directors in 2024/25
Nine staff on Very Senior Manager contracts earn in excess of £150,000 pa on a pro rata basis.

Exit Packages (subject to audit)

There were no exit packages in 24/25

Exit Packages 2023/24 (audited)

There were no exit packages in 24/25

Exit Package cost band (inc.any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	**£s**	**Whole numbers only**	**£s**	**Whole numbers only**	**£s**	**Whole numbers only**	**£s**
Less than £10,000	0	£0.00	0	£0.00	0	£0.00	0	£0.00
£10,000 - £25,000	0	£0.00	2	£40,428.18	2	£40,428.18	0	£0.00
£25,001 - £50,000	0	£0.00	0	£0.00	0	£0.00	0	£0.00
£50,001 - £100,000	0	£0.00	0	£0.00	0	£0.00	0	£0.00
£100,001 - £150,000	0	£0.00	0	£0.00	0	£0.00	0	£0.00
£150,001 - £200,000	0	£0.00	0	£0.00	0	£0.00	0	£0.00
> £200,001	0	£0.00	0	£0.00	0	£0.00	0	£0.00
TOTALS	**0**	**£0.00**	**2**	**£40,428.18**	**2**	**£40,428.18**	**0**	**£0.00**

Redundancy and other departure cost have been paid in accordance with the provisions of the terms of the individual contracts of employment. Exit costs in this note are the full costs of departures agreed in the year. Where Gloucestershire ICB has agreed early retirements, the additional costs are met by Gloucestershire ICB and not by the NHS Pensions Scheme. Ill health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Compensation on early retirement or for loss of office

There was 1 ill-health retirement in 2024/25 totalling £310k (none in 23/24).

Sickness absence data

Details of the level of sickness absence are given below. The organisation has an approved policy and associated procedure to help with the management of sickness absence.

Sickness absence is managed in a supportive and effective manner by ICB managers, with professional advice and support from ConsultHR, Occupational Health and Care First (Employee Assistance Programme) and the Gloucestershire Wellbeing Line. The ICB's approach to managing sickness absence is governed by a clear HR policy and this is further reinforced by the provision of HR support and training sessions for all line managers on the effective management of sickness absence. The manager is advised to have a supportive conversation with the staff member.

Monthly Sickness Absence Rates for English NHS bodies – December 2024	5.74%
Monthly Sickness Absence Rate for NHS Gloucestershire Integrated Care Board – December 2024	3.00%
Monthly Sickness Absence Rate for NHS Gloucestershire Integrated Care Board - Average for 2024-25	2.83%

The figures above are provided by NHS Digital and can be found on the following website: **www.digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates**

Staff policies

The ICB like other NHS employers has a host of HR policies, user guides, forms, and resources. Policies are formally reviewed both by the Executive Management Team and the Staff Partnership Forum (SPF) before being approved by the relevant ICB Committee. Over the past 12 months a number of HR policies have been reviewed and updated. Please see the Governance Statement for full details of policies that have been approved.

Trade Union Facility Time Reporting Requirements

The ICB confirms that for the financial year 2024-25 there were no relevant union officials who are staff members of the ICB for the entire period, as the Joint Chair of SPF who was the recognised trade union official left the ICB in May 2024. This will be remedied in May 2025 with the appointment of the new Joint Chair of the SPF who is a trade union official.

In 2023 after discussion with staff side colleagues a decision was made to change the name of the Joint Staff -Side Consultative Committee (JSCC) to the Staff Partnership Forum (SPF) in line with convention and our system partners. A SPF Agreement was developed and agreed, which set out how the forum would operate and the joint chairing of the SPF by the Chair of Staff Side (TU Rep) and the Director of People, Culture and Engagement. The ICB provides dedicated TU facilities and time for the Joint Chair of Staff Side to fulfil their role, which has equated to one and half days per month, based on previous years' records.

Equality, Diversity, and Inclusion

The ICB is committed to creating an open and welcoming organisational culture for all staff, ensuring that we recruit from as wide a pool of talent as possible, create opportunities for all staff to advance their careers, in a supportive and compassionate organisation that proactively tackles discrimination, bullying and intimidation of any kind.

The ICB has an Equality, Diversity, and Inclusion statement.

NHS Gloucestershire is committed to upholding the NHS Constitution and, specifically in relation to equality, diversity and human rights, the principle which requires us to provide "a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership status".

Promoting equality, valuing diversity (**https://www.nhsglos.nhs.uk/wp-content/uploads/2024/10/NHS-Gloucestershire-ICB-Promoting-equality-and-valuing-diversity-Draft.pdf**) sets out our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire.

We are keen to build upon the work that is already underway across our Integrated Care System and in recognition of this, our Equality Statement links to other strategies and plans which, when combined, fully document how we will work in partnership to achieve our vision for Gloucestershire.

Our Equality Action Plan (**https://www.nhsglos.nhs.uk/wp-content/uploads/2024/10/Appendix-1-Draft-Action-Plan.docx**) sets out how the ICB will work towards achieving our organisational equality objectives.

Equality Objectives

In line with the Public Sector Equality Duty requirements we are required to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. During 2024-25 we revised our Equality objectives to the following:

- To develop an Equality Statement and robust action plan for promoting equality, diversity, and inclusion, which sets out clear objectives which ensure good practice across our organisation and link to wider health inequalities work that is being undertaken in our Integrated Care System.
- Build a detailed understanding of our population and their health needs, through published data sets, improvements in the quality of our data recording and robust use of Equality and Engagement Impact Assessments.
- To reduce the percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months by at least 2% per annum over the next 3 years.

Following on from the annual WRES, WDES and Gender Pay reports, an integrated action plan covering the full range of actions was produced to monitor the implementation of the many ED&I initiatives and schemes. The ICB has worked with system partners on a range of ED&I programmes which ICB staff have participated in including:

- Flourish scheme based on the national 'stepping up' programme available to ethnic minority staff, disabled staff, and LGBTQ+.
- The Reciprocal Mentoring programme.
- Allyship Programme.

In addition, the ICB has undertaken some bespoke schemes for ICB staff including:

- ED&I training commissioned for all managers and staff.
- Commissioned a programme of Train the Trainer in Building a Culture of Conscious Inclusion that system partners have participated in.
- Supported the BAME Staff Network within the ICB and support offered to staff to develop other staff networks.
- Participated in the 10,000 Black Interns scheme in 2024-25 placing 3 interns within the ICB for 3-month placements.

During the year 2024-25 some of key ED&I headlines are as follows:

- The mean gender pay gap was 12% as of 31 March 2024. In 2023 it was 18% and that was the same gap reported in 2022. So there has been a significant reduction in one year. The next reporting period is in May 2025 which covers 1 April 2024 – 31st March 2025.
- The ICB increased its percentage of BME staff in 2024 to 9% compared to 8.3% on average during the previous 2 years.
- While BME staff continued to be less likely to be found in higher grade non-clinical jobs in the ICB they were more likely to be found in clinical medical and dental roles where there has been an increase
- ICB employs 3% (16) disabled staff which is a slight reduction from the last two years average of 3.35% of disabled staff. 11% (52) staff did not disclose
- 18% (2) of board members have a disability, an increase from 0 from the previous two years
- BME and disabled people are 2.3 and 2.4 times (respectively) less likely to be appointed to a role from shortlisting, which is an area of focus for our ED&I work during 2025-26.

The ICB's progress on advancing our work within ED&I is explained in detail within the report made to the ICB Board at its meeting on 26th March 2025, the Public Sector Equality Duty and Equality Delivery System 2 can be found on the ICB website see **https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/**.

Disability

Disability Flag	Headcount	%	FTE
No	396	85.16	341.82
Not Declared	44	9.46	34.44
Prefer Not to Answer	2	0.43	1.60
Yes	23	4.95	17.98
Grand Total	**465**	**100.00**	**395.84**

Gender

Gender	Headcount	%	FTE
Female	346	74.4	287.57
Male	119	25.6	108.27
Total	**465**	**100.0**	**395.84**

Ethnicity as at 31 March 2024

Ethnic Group	Headcount	%	FTE
A White - British	365	78.49%	313.41
B White - Irish	5	1.08%	4.80
C White - Any other White background	5	1.08%	4.00
C3 White Unspecified	1	0.22%	1.00
CA White English	13	2.80%	11.38
CC White Welsh	2	0.43%	1.48
CP White Polish	1	0.22%	0.60
CY White Other European	3	0.65%	3.00
D Mixed - White & Black Caribbean	3	0.65%	3.00
F Mixed - White & Asian	1	0.22%	0.80
G Mixed - Any other mixed background	1	0.22%	1.00
GC Mixed - Black & White	1	0.22%	1.00
H Asian or Asian British - Indian	17	3.66%	14.57
J Asian or Asian British - Pakistani	2	0.43%	1.18
K Asian or Asian British - Bangladeshi	3	0.65%	2.40
L Asian or Asian British - Any other Asian background	3	0.65%	1.83
M Black or Black British - Caribbean	2	0.43%	1.20
N Black or Black British - African	5	1.08%	5.00
R Chinese	3	0.65%	2.24
S Any Other Ethnic Group	1	0.22%	0.80
SC Filipino	1	0.22%	1.00
SE Other Specified	1	0.22%	0.32
Z Not Stated	26	5.59%	19.82
Grand Total	**465**	**100.00%**	**395.84**

Age Band

Age Band	Headcount	%	FTE
21-25	12	2.58	11.60
26-30	36	7.74	34.78
31-35	38	8.17	34.08
36-40	60	12.90	50.00
41-45	74	15.91	62.48
46-50	53	11.40	44.87
51-55	68	14.62	57.94
56-60	70	15.05	61.68
61-65	40	8.60	30.34
66-70	11	2.37	6.28
>=71 Years	3	0.65	1.80
Grand Total	**465**	**100.00**	**395.84**

Other employee matters

Health and Safety at work

We are committed to ensuring the health and safety of all our employees.

It is important to us as an organisation that we provide a safe working environment for people, where their health and safety is valued, and in doing this we continue to work closely with our landlord and security management teams at Shire Hall.

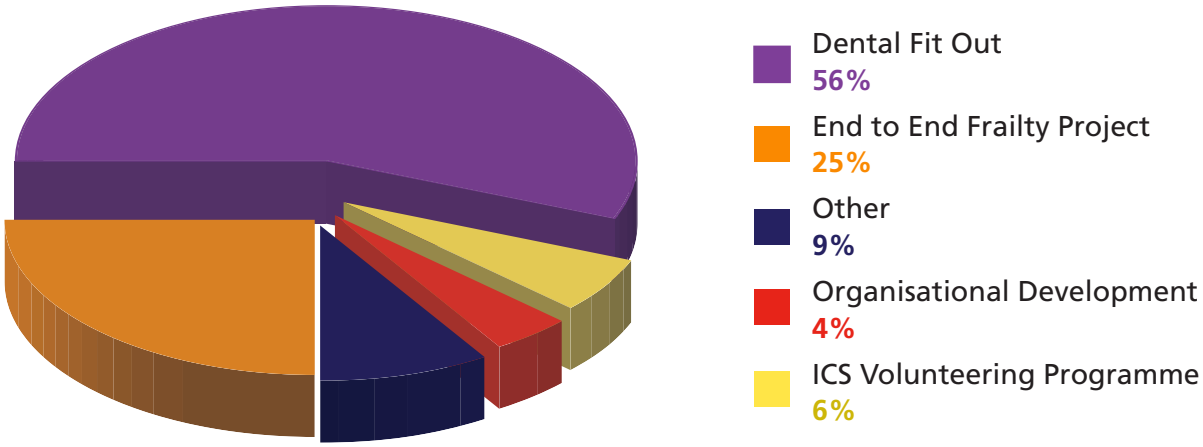
Our security management and facilities management services are provided by Gloucestershire County Council (GCC) as part of our lease agreement and FM Service Level Agreement.

The Director of People, Culture and Engagement is the Health and Safety Lead for the organisation. The Associate Director of Corporate Affairs along with the ICB Reception Team meet with the GCC FM team on a quarterly basis to discuss health and safety related to the occupancy of offices in Shire Hall.

The ICB follows GCC's policies and procedures on fire safety and evacuations, first aid, waste disposal, water and PAT testing along with all other health and safety matters. These procedures are set out in the Shire Hall Handbook which accompanies the ICB Staff Handbook. Both documents are made available to all our staff via the intranet.

Consultancy

Consultancy costs of £125k in 2024-25 were spent in the following areas:



External Audit

The ICB's external aud ry audit for the period 1st April 2024 t so provided for an additional audit ser ard (MHIS) audit totalling £42k..

TO BE UPDATED

Parliamentary Accountability and Audit Report

NHS Gloucestershire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on losses and special payments, gifts and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Mary Hutton

Chief Executive Officer

June 2025

The financial statements

Independent auditor's report to the members of the Governing Body of NHS Gloucestershire CCG

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Gloucestershire CCG (the 'CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 and Health and Social Care Act 2012.

AUDITORS REPORT TO BE UPDATED WHEN AVAILABLE

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accountable Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the CCG's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the CCG's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going

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Gloucestershire, GL1 2TG

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Agenda Item 5

NHS Gloucestershire ICB Extraordinary Public Board Meeting

Wednesday 18th June 2025

Report Title	**NHS Gloucestershire ICB Annual Report 2024/25**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			✓				
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
	Health Inequalities SRO and SRC Chair review	June 2025					
	Audit Committee	June 2025					
Executive Summary	This paper presents the Gloucestershire Health Inequalities Information Review 2024/25 for approval by the ICB Board. This was presented to the Audit Committee prior being presented to the ICB Board. The Review has been developed in line with the NHS England Statement on Health Inequalities, which describes the powers available to relevant NHS bodies to collect, analyse, and publish certain information related to health inequalities. It includes: 1. Reporting on a number of healthcare indicators across several domains that align to the national Core20PLUS5 framework. 2. Analysis of the data by age, sex, deprivation, and ethnicity (where possible) and explain the inequalities that it reveals. 3. Information about our work programmes and priorities in relation to each indicator. The Review focuses on trends in the data overtime, and variations between population groups. Where possible, it includes age-standardised data and confidence intervals to enable the identification of statistically significant differences between demographic groups. It also includes a more detailed analysis of our blood pressure data. We will feed this data into our programme areas and work with them to identify disparities within our population and to inform the design, delivery and improvement of services aimed at narrowing the health inequalities gap in Gloucestershire.						

Key Issues to note	The Review highlights ongoing health inequalities in Gloucestershire, with people in the most deprived communities and those from diverse ethnic communities experiencing poorer healthcare access, experience and outcomes. The analysis in the Review will allow us to identify whether the gap between population groups is reducing with respect to access, experience and outcomes of our healthcare services. The Review also highlights issues in the quality and completeness of some of the demographic data in our datasets, particularly in terms of ethnicity recording. The Review has identified some areas that were unexpected or harder to explain, which be taken forward for further analysis.		
Key Risks:	Linked to BAF 1		
Management of Conflicts of Interest	N/A		
Resource Impact (X)	N/A		
Financial Impact	N/A		
Regulatory and Legal Issues (including NHS Constitution)	The ICB has produced its Review in line with NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006).		
Impact on Health Inequalities	The Review will assist the ICB in identifying areas of focus with respect to responding to health inequalities in the population.		
Impact on Equality and Diversity	The Review will assist the ICB in identifying areas of focus with respect to responding to health inequalities in the population.		
Impact on Sustainable Development	N/A		
Patient and Public Involvement	N/A		
Recommendation	The Board is requested to approve the Gloucestershire Health Inequalities Information Review 2024/25.		
Author	**Katharine Doherty** **Sarah MacDonald**	**Role Title**	**Senior Performance Management Lead** **Health Inequalities Improvement Manager**
Sponsoring Director (if not author)	**Mark Walkingshaw, Director of Operational Planning and Performance**		

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

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Gloucestershire Health Inequalities Information Review

2024-25

One Gloucestershire Health Inequalities Information Review, 2025/26

Contents

1.0 Introduction

This is our second annual review of healthcare inequalities in Gloucestershire, which has been refreshed and updated since our first Gloucestershire Health Inequalities Information Review 2023/24.

Last year, we comprehensively reviewed snapshots of the indicators listed in the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006), which enabled us to understand our performance against each indicator and variations in performance between different population groups based on their level of deprivation and their ethnicity. This showed that in Gloucestershire there is a health inequalities gap, with people living in the most deprived communities and those from diverse ethnic communities experiencing poorer access, experience, and outcomes with respect to our healthcare services. While this is what we expected to see, the data showed that the disparities between groups was wider than we would like, despite at least a decade of effort.

This year's review focuses on trends in the data and a more detailed analysis of significant variations between population groups, with the aim of expanding our in-depth knowledge of key areas where health inequalities are seen. This includes a deep dive into our hypertension identification, diagnosis, and treatment data.

During 2024/25 we have also developed our Health Inequalities Framework to ensure that as a system we are taking an evidence based and strategic approach to tackling health inequalities. This includes shared strategic priorities such as improving data quality in the system and increasing visibility of health inequality analysis. It is hoped that the publication of our review supports this approach, and we will continue to build on this in the future. Further information can be found in the full annual report (link to be added).

This report should be read in conjunction with our local joint strategic needs assessment (JSNA) to join the data presented here with information on our population and the geographical distribution of our more disadvantaged groups.

2.0 Reporting by Programme Area

2.1 Elective recovery

2.1.1 Elective waiting list – data and analysis

Figure 1: Elective waiting list as of April 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: National Waiting List Data.

The overall rate of the waiting list in Gloucestershire has remained generally constant over the last 2 years. Individuals residing in Gloucester and the Forest of Dean are significantly more likely to be on the waiting list compared to those living in other districts, which may suggest higher care needs in these areas driving higher referral volumes, or overall longer waits leading to disproportionately larger numbers from Gloucester and the Forest of Dean waiting. This trend also corresponds to the distribution of the waiting list population by deprivation decile, with individuals living in the most deprived areas being significantly more likely to be on the waiting list compared to those in the least deprived areas. This aligns with broader trends in health inequalities, where deprivation amplifies delays in accessing treatment. The King's Fund have identified a number of explanations as to why people experiencing deprivation are more likely to wait longer for elective care, including a higher likelihood of multiple health conditions among individuals from more deprived areas, leading to increased demand, difficulty attending appointments due to work commitments and access issues, and difficulties navigating the NHS[1]. Currently, the waiting list rate is higher for residents of the Forest of Dean than for those living in Gloucester, whereas in 2023, the rate was higher for Gloucester residents.

[1] Tackling health inequalities on NHS waiting lists

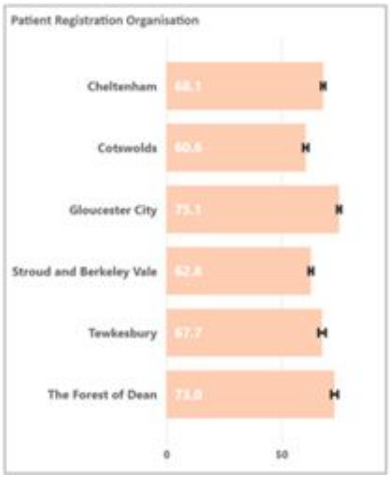


Figure 2: Elective waiting list as of April 2023, age standardised. Broken down by district. Source: National Waiting List Data.

Figure 3: Elective waiting list as of April 2025, age standardised. Broken down by district. Source: National Waiting List Data.

People from White, Mixed, Black or Black British, and Asian or Asian British backgrounds are significantly more likely to be on the waiting list compared to those from Other Ethnic Groups. This trend has remains unchanged since 2023.

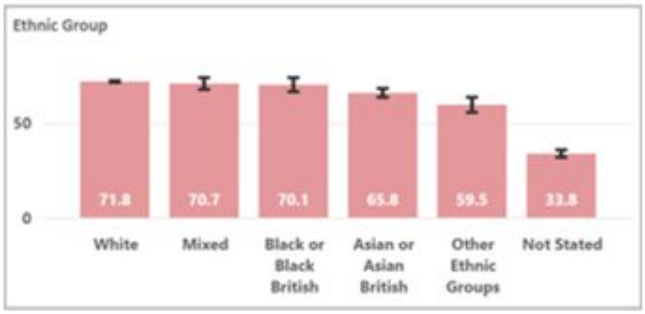


Figure 4: Elective waiting list as of April 2023, age standardised. Broken down by ethnic group. Source: National Waiting List Data.

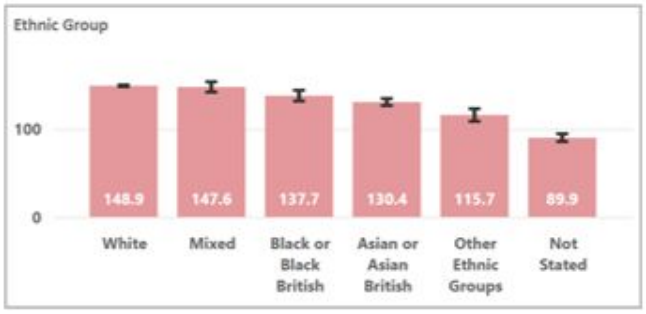


Figure 5: Elective waiting list as of April 2025, age standardised. Broken down by ethnic group. Source: National Waiting List Data.

Females are disproportionately more likely to be on the waiting list compared to males, which corresponds to findings from Healthwatch indicating that women are more likely to wait over 4 months for NHS treatment than men and are also more likely to experience adverse impacts of long waits[2]. While research by the Royal College of Obstetricians and Gynaecologists shows that women are waiting too long for gynaecological care[3], analysis of the Gloucestershire data shows that women wait longer for all specialities, not just gynaecology.

[2] We need to focus on inequalities to address NHS waiting list | Healthwatch
[3] Gynaecology waiting lists leave thousands of women waiting too long for care

Figure 6: Elective waiting list over 52 weeks, as of April 2025, overall total numbers. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: National Waiting List Data.

Figure 7: Elective waiting list over 65 weeks, as of April 2025, overall total numbers. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: National Waiting List Data.

Throughout 2024/25 the system has been focussing on eliminating the longest waits for elective care in line with national targets. Gloucestershire's main provider Gloucestershire Hospitals Foundation Trust (GHFT) has been particularly successful, using additional capacity to reduce long waits in particularly challenged specialties. While a universal approach, it has seen total numbers of people waiting over 52 weeks drop significantly over the year, with 247 waiting over 52 weeks at the start of the year, and 10 waiting over 65 weeks in March 2025 at all providers (116 52 week waits and 4 65 week waits at GHFT)[4]. The chart in figure 7 shows unvalidated weekly waiting list information, and therefore has slightly higher event values.

[4] Referral to Treatment (RTT) Waiting Times

Generally, we see more 52 and 65 week waits for elective care in the more affluent parts of Gloucestershire compared to the more deprived areas, which is due to the structure of the population as when the data is age standardised, the rate of people waiting over 52 weeks and over 65 weeks is higher in the more deprived populations.

2.1.2 Elective activity – data and analysis

Figure 8: Elective admissions as of February 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: SUS Admitted Patient Care Data.

Figure 9: Outpatient attendances as of February 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: SUS Outpatient Care Data. Commissioned by NHS Gloucestershire ICB.

Figure 10: Virtual outpatient attendances as of February 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: SUS Outpatient Care Data.

The rate of elective admissions, outpatient attendances, and virtual outpatient attendances in Gloucestershire have generally increased since 2023/24. Females are significantly more likely than males to have an elective admission, outpatient attendance, and virtual outpatient attendance.

Outpatient attendance rates are significantly higher in Gloucestershire's core20 population (those living in IMDs 1 and 2) compared to those living in all other deprivation deciles. This aligns to findings from a review of hospital episode statistics, population, and IMD data, which showed that outpatient hospital use increases with greater deprivation level[5], reflecting the high burden of ill health amongst patients from lower socioeconomic backgrounds. The same relationship was found between deprivation and inpatient hospital admissions; however there is no clear trend between deprivation and elective admissions in the Gloucestershire data but people in IMD 10 are significantly less likely to have an elective admission compared to people living in all other deciles, with the exception of IMD 7. There is no significant difference in virtual outpatient attendances based on deprivation.

There is no significant difference in the rate of elective admissions between ethnic groups; however, the rate of outpatient attendances and virtual outpatient attendances are significantly higher in people from White backgrounds compared to all other groups. People from Asian or Asian British backgrounds are least likely to have an elective attendance or virtual outpatient attendance. This may be an after-effect from the COVID-19 pandemic which saw people from Asian groups experiencing a larger fall in planned hospital care than people from White, Black or Mixed ethnic groups[6], while an evaluation of virtual wards in South East England found that people from Black, Asian, and minoritised ethnic backgrounds are consistently underrepresented in virtual ward patient cohorts[7].

Figure 11: Elective activity recovery by children and young people aged under 18-years (purple line) compared to the ICB population (green line) as of March 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender. Source: SUS Admitted Patient Care Data and SUS Outpatient Care Data.

[5] The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation

[6] The elective care backlog and ethnicity

[7] Summary of South East region virtual wards evaluation

2.1.3 Elective activity vs pre-pandemic levels – data and analysis

Figure 12: Elective activity recovery by adults aged 18-years and over (purple line and comparison bar) compared to the ICB population (green line) as of March 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender. Source: SUS Admitted Patient Care Data and SUS Outpatient Care Data.

The rate of elective activity dipped in March/April 2020 at the start of lockdown in England, and increased over the following year, returning generally to pre-pandemic levels over 2023/24 and 2024/25, following the trend seen in the rest of the country following the pandemic. The rate of elective activity for people aged under 18 and for people aged 18 and over has followed the same trend as that for the overall ICB population and although the rates of elective activity are significantly lower in the under 18 age group due to small numbers in the cohort. Males aged under 18 have a higher rate of elective activity than females, while females aged 18 and over have a higher rate than males.

The rate of elective activity in people aged 18 and over is significantly higher in the core20 population (IMDs 1 and 2) compared to all other deprivation deciles. People from Black or Black British and White backgrounds have a significantly higher rate of elective activity compared to those from other ethnic groups.

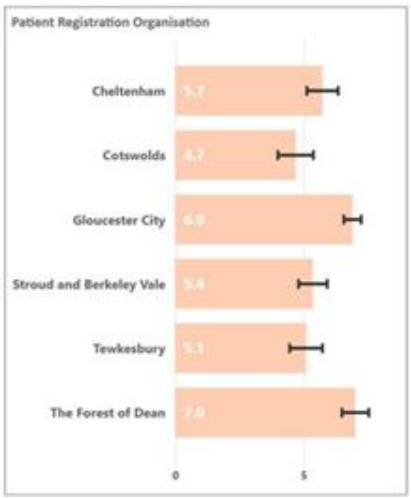


Figure 13: Elective activity recovery by children and young people aged under 18-years as of March 2025, age standardised. Broken down by district. Source: SUS Admitted Patient Care Data and SUS Outpatient Care Data.

For under 18-year-olds living in IMD 5, the gap has narrowed between males and females and there is no statistical significance between the genders.

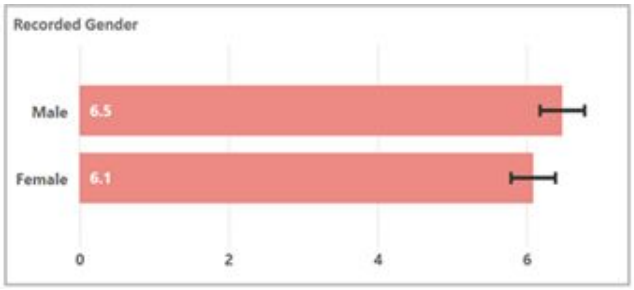


Figure 14: Elective activity recovery by children and young people aged under 18-years living in IMD 5 as of March 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data and SUS Outpatient Care Data.

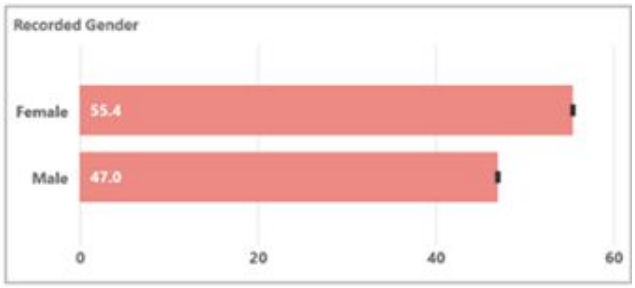


Figure 15: Elective activity recovery by children and young people aged under 18-years as of March 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data and SUS Outpatient Care

2.1.3 Associated programmes of work

Reducing health inequalities is at the centre of all our elective recovery and transformation plans.

- Analysis of the waiting list highlights access to elective care as a key driver of inequality, therefore our work to improve access includes reviewing the demographics of those who DNA to identify systematic contributors to missed appointments and identifying how these can be addressed, proactively working with the Elective Care Hub to support people while they wait, and improving communication and appointment reminders through the Patient Engagement Portal.
- In line with the national focus, recovery for children and young people's services remains a local priority. Our aims for 2025/26 include reviewing paediatric bed allocation, the paediatric pre-op assessment pathway, and implementing high volume theatre lists for children and young people where possible.

2.2 Urgent and emergency care

2.2.1 Emergency activity- Data and analysis

Figure 16: Emergency attendances as of March 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: Emergency Care Dataset.

Figure 17: Emergency admissions as of February 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: SUS Admitted Patient Care Data.

The rate of emergency attendances in Gloucestershire have remained generally constant over the last two years, however it appears that the rate of emergency admissions has gradually increased.

A&E attendances and admissions are significantly higher in the most deprived areas of Gloucestershire. The rate of attendances and admissions decreases with increasing levels of affluence, consistent with the trend observed in the 2021 Census data[8]. This data showed that the odds of A&E attendance increased with the level of deprivation, with individuals living in the most deprived decile being 1.7 times more likely to attend A&E compared to those living in the least deprived decile. A report by the British Red Cross suggested that the more frequent use of A&E by people who experience deprivation may be associated with not only underlying physical and mental health conditions causing symptoms that warrant a visit to A&E but also dealing with sudden life changes such as job loss, relationship breakdown, or grief combined with social and economic challenges[9].

Proximity of an A&E to a person's home is known to impact their likelihood of attending for emergency care[10] and several of the most deprived areas in Gloucestershire are located nearer to acute hospital sites, which may account for some of the higher use of A&E by Gloucestershire's more deprived communities. A&E attendances are significantly higher in Gloucester and Cheltenham, where Gloucestershire's A&E departments are located, which supports this assumption. Further work to determine the true gap between district use of emergency care may be required, as the A&E departments in Gloucester and Cheltenham also act as local Minor Injury and Illness Units for the local population. The activity data for Type 1 A&E departments therefore includes these presentations, whereas the other Gloucestershire districts have their own Minor Injury and Illness Units. A next step would be to understand the total emergency presentation in each district and how this varies.

The rate of emergency admissions is significantly higher in people living in Gloucester, followed by the Forest of Dean compared to other districts, and from Other Ethnic Groups and Mixed Ethnic Groups compared to those from White, and Asian or Asian British groups. Emergency attendances are significantly higher in Black or Black British and Mixed ethnic groups compared to those from Other Ethnic Groups, Asian or Asian British, and White groups. This is likely to be due to higher proportions of people from diverse ethnic groups living in Gloucester.

[8] Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022
[9] Nowhere else to turn: Exploring high intensity use of Accident and Emergency services
[10] What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the north west of England

2.2.2 Emergency admissions for under 18s- Data and analysis

Figure 18: Emergency admissions for under 18-year-olds as of March 2025, age standardised. Broken down by a) district, b) deprivation, c) ethnic group, d) gender. Source: SUS Admitted Patient Care Data.

The rate of emergency admissions for under 18-year-olds is significantly higher in Gloucester compared to all other districts, which is expected due to the close proximity of the acute hospital. Rates are also significantly higher in the most deprived areas of Gloucestershire compared to the most affluent areas, and the majority of these neighbourhoods are in Gloucester City. This is in line with research showing that children and young people from the most deprived areas are consistently more likely both to go to A&E and to need emergency hospital treatment than those from the least deprived areas[11].

While the rate of emergency admissions is significantly higher in males compared to females in the under 18-year-old population, further analysis of emergency admissions in children and young people shows that females in IMD 1 have higher rates of emergency admissions compared to females from all other deciles, and similar rates to males living in IMD 1.

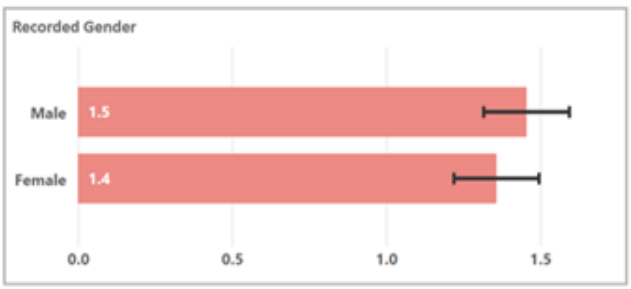


Figure 19: Emergency admissions for under 18-year-olds living in IMD 1 as of March 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

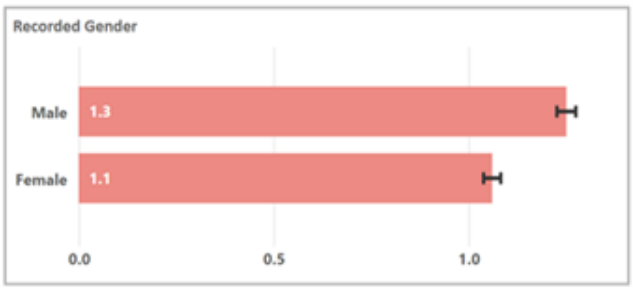


Figure 20: Emergency admissions for under 18-year-olds as of March 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

[11] Admissions of inequality: emergency hospital use for children and young people

Counter to documented trends, the Gloucestershire data shows that children and young people living in IMD 5 have higher rates of emergency admissions compared to those living in some of the more deprived deciles. Figure 21 shows that several Lower Super Output Areas in IMD 5 in Gloucestershire are located close to the acute hospitals in Gloucester and Cheltenham, indicating that the higher rate of admissions in those living in IMD 5 may be associated with proximity to the hospitals.

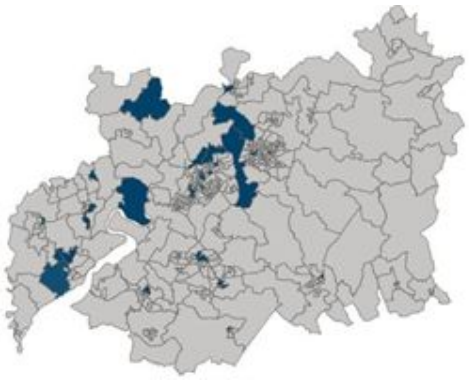


Figure 21: Location of Lower Super Output Areas in IMD 5.
Source: Person Demographic Service (2025)

2.2.3 Associated programmes of work

We are prioritising addressing the needs of individuals who frequently attend A&E departments, recognising that their attendance often significantly impacts these services. Many of these attendances are driven by socioeconomic or mental health issues rather than purely medical factors. Our initiatives include:

- Providing clinics in the community through our High Intensity User service to enhance engagement with individuals likely to frequent A&E.
- Developing a local system strategy for identifying High Intensity Users and offering comprehensive, holistic solutions for these often vulnerable individuals who frequently access urgent care services.
- Delivering non-clinical, one-on-one support, signposting, and guidance to vulnerable patients seeking help in A&E at Gloucester Royal Hospital.

These efforts aim to reduce unnecessary A&E visits while providing targeted support to those in need.

2.3 Respiratory

2.3.1 Influenza Vaccination – Data and analysis

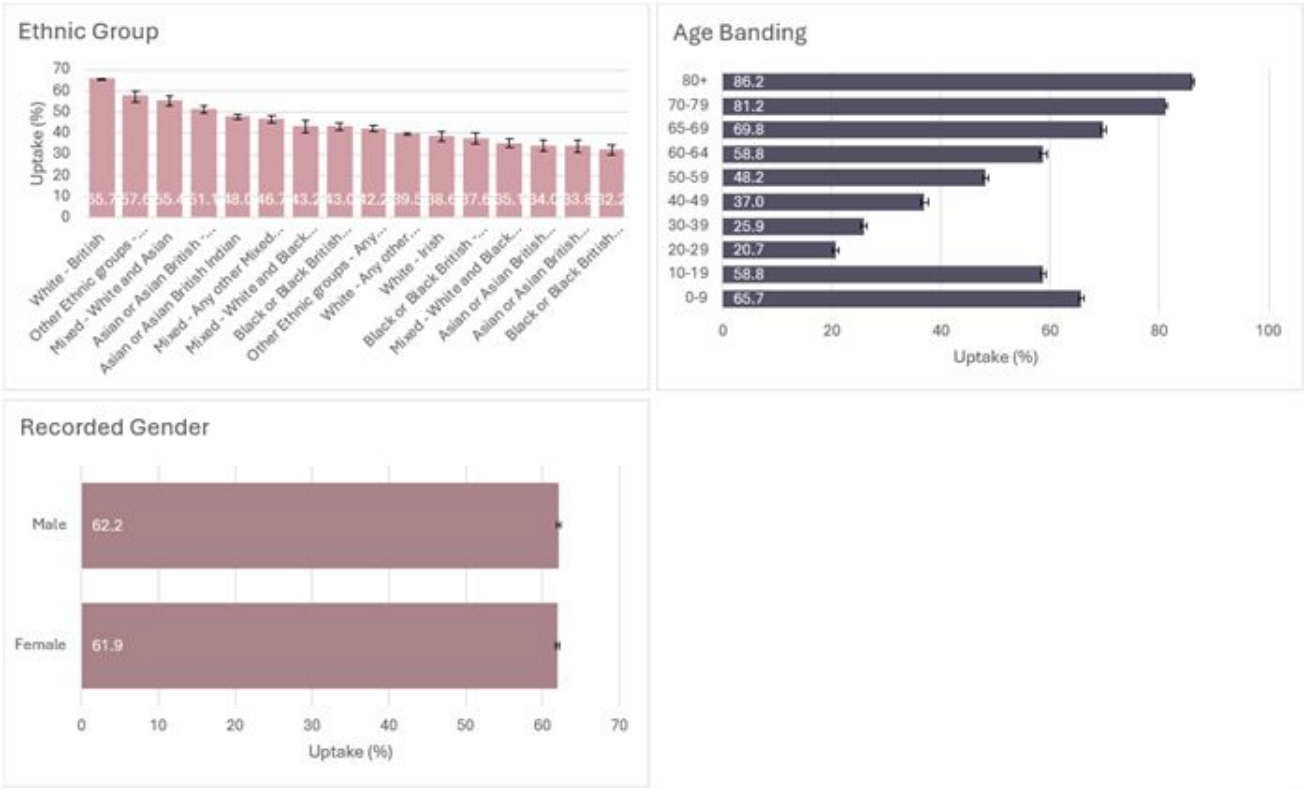


Figure 22: Influenza vaccination uptake. Proportion of eligible people who took up the offer of the influenza vaccination broken down by a) ethnic group, b) age banding, c) gender. Source: Vaccines dashboard. NHS Federated Data Platform (2024/25).

The distribution of influenza vaccination uptake by age group broadly aligns to the main cohorts who are eligible for the free jab: adults aged 65 and over, all children aged two to three years, all primary school children, and some secondary school children. There has generally been no change in the distribution by demographic group from 2023/24, but there is an overall lower uptake in common with other areas[12]. However, Gloucestershire benchmarks well compared to other areas with respect to influenza vaccination uptake, despite seeing this trend.

Uptake of the influenza vaccination is higher in people living in the most affluent areas of Gloucestershire, and uptake decreases as the level of deprivation increases. This follows the same trend that was seen in the 2023/24 data and may be partially attributable to the age profile in the least deprived populations, making them more likely to be eligible for the vaccination programme, which is only free to certain groups of people including those aged 65 and over. However, there are known socioeconomic inequalities in influenza vaccine uptake, with lower uptake in more deprived areas compared to less deprived areas[13][14].

The proportion of people who took up the influenza vaccination from White backgrounds is higher than those from other ethnic groups, and people from Black or Black British backgrounds were least likely to take up the offer.

[12] Seasonal influenza vaccine uptake in frontline healthcare workers in England: winter season 2024 to 2025
[13] Evaluating socioeconomic inequalities in influenza vaccine uptake during the COVID-19 pandemic: A cohort study in Greater Manchester, England
[14] Influenza vaccine uptake in socially deprived areas: A multilevel retrospective population-based cross-sectional study using electronic health records in Liverpool, United Kingdom

2.3.2 COVID-19 Vaccination – Data and analysis

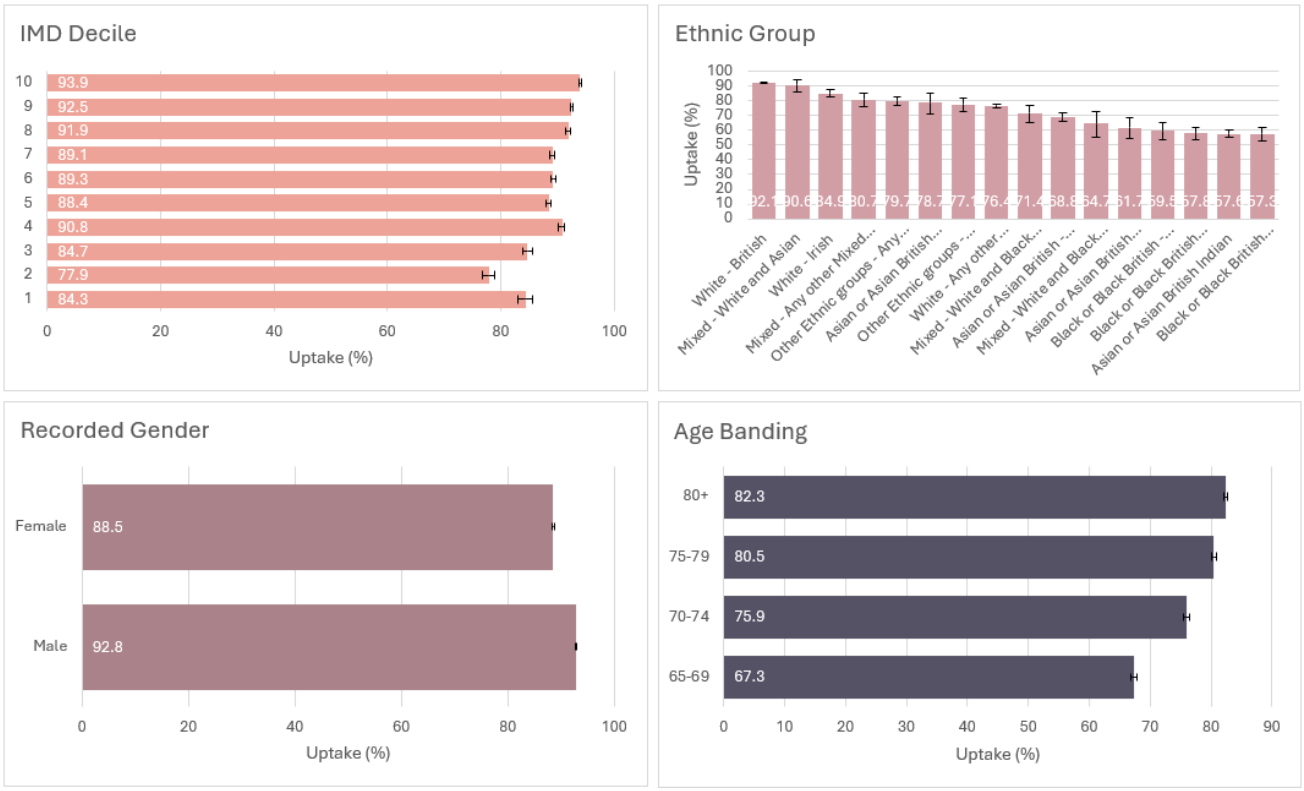


Figure 23: COVID-19 vaccination uptake. Proportion of eligible people who took up the offer of the COVID-19 vaccination by a) deprivation, b) ethnic group, c) gender, d) age banding. Source Vaccines dashboard. NHS Federated Data Platform (2024/25).

The COVID-19 Autumn Winter 2024 booster campaign was only available to adults aged over 65. The proportion of adults who took up the COVID-19 booster vaccination increased in 2024/25 compared to 2023/24.

The uptake of the COVID-19 vaccination was lower in the three most deprived deciles of Gloucestershire compared to the more affluent areas. As with the influenza vaccination, this may be due to the more affluent areas having higher proportions of older people, making them more likely to be eligible for the vaccination programme. The distribution of uptake across the older age groups also aligns to the eligibility criteria.

The proportion of adults who took up the COVID vaccination has increased across every deprivation decile since 2023/24. This could be associated with the tightening of the eligibility criteria for the free vaccination, with health and social care workers, 12 to 64 year olds who are household contacts of people with immunosuppression, and 16 to 64 year old carers being eligible for the vaccination during the winter campaign of 2023/24[15], but not during the 2024/25 campaign[16]. This may make it easier to achieve a higher proportion of eligible people taking up the vaccination offer, but could disadvantage people in areas of higher deprivation, where a younger but potentially more unwell and at risk population may have less immunity in the community and at a personal level as a result.

People from Black or Black British backgrounds were less likely to take up the COVID-19 vaccination offer. It is well documented that ethnic minority communities in the UK were disproportionately affected by the pandemic, and there continue to be disparities in COVID-19 coverage with people from Black ethnic groups being less likely to be vaccinated and more likely to experience vaccine hesitancy compared to those from White groups[17].

[15] Autumn/Winter (AW) 2023-24 Flu and COVID-19 Seasonal Campaign
[16] Flu and COVID-19 Seasonal Vaccination Programme: autum/winter 2024/25
[17] Overcoming COVID-19 vaccine hesitancy among ethnic minorities: A systematic review of UK studies

2.3.3 Associated programmes of work

The COVID-19 Mass Vaccination programme has a dedicated outreach team focussed on improving accessibility to and reducing inequalities in the vaccine provision. This includes delivering vaccines in non-NHS settings close to communities and vulnerable groups that typically have the lowest uptake rates. The activities that the team are carrying out to increase vaccination uptake in underrepresented groups include:

- Working with community champions, faith leaders and partners in the VCSE sectors to identify culturally appropriate approaches to the delivery of pop-up events offering general health information, including information on vaccine hesitancy and when vaccinations are appropriate.
- During 2024/25 the outreach team delivered over 140 community events and vaccinated over 500 of the most vulnerable of the Gloucestershire population.

2.4 Mental health

2.4.1 Severe Mental Illness (SMI) and Physical Health Checks – data and analysis

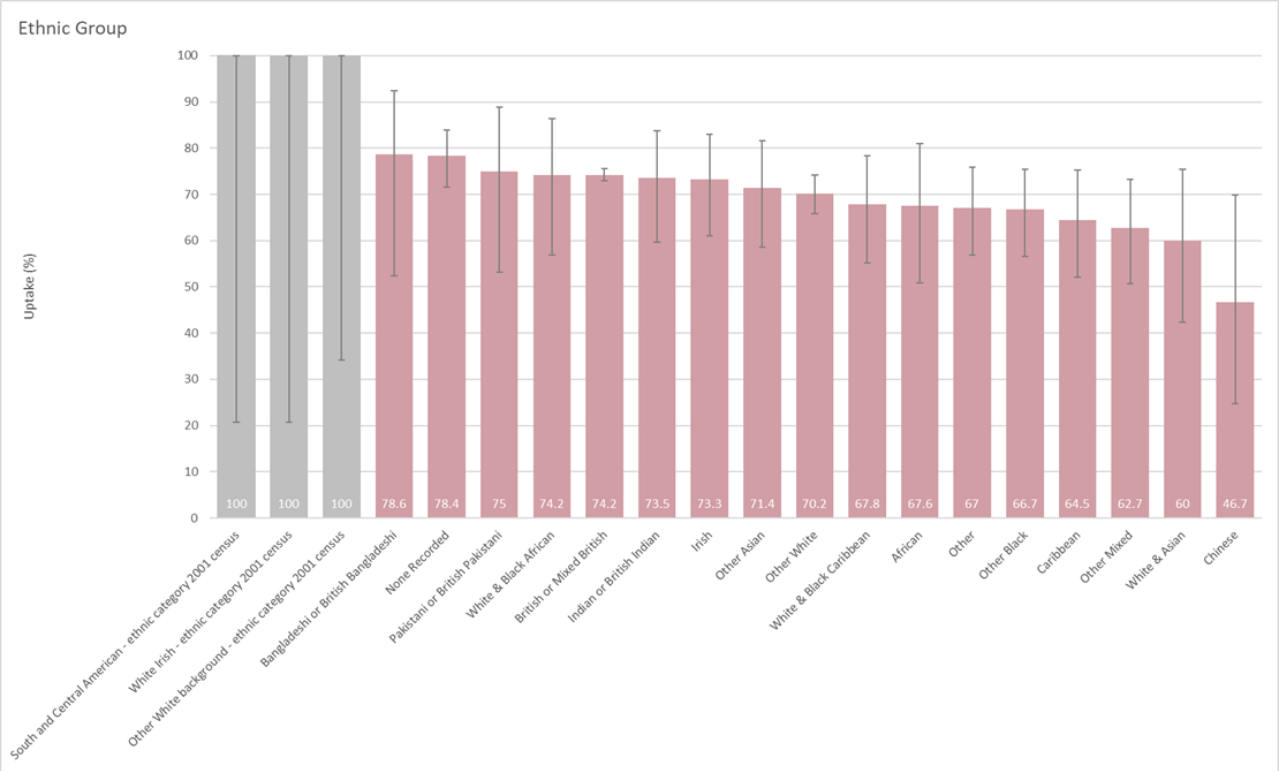


Figure 24: Severe Mental Illness (SMI) physical health checks. Proportion of people on the General Practice SMI register who received a physical health check in the last 12 months to the end of the reporting period in Gloucestershire by ethnic group. Source: Adult Mental Health Dashboard, Future NHS (14 April 2025).

The overall proportion of people with a current SMI diagnosis who have had a Physical Health Check in the last 12 months in Gloucestershire is 73.2%, which is an increase from the 2023/24 figure of 66.4%.

The ethnic categories of South and Central American, White Irish, and Other White background were not disaggregated in the 2024/25 report, so it is not possible to look at changes in uptake of Physical Health Checks for people with SMI in these groups. While 100% of people in these groups have had a Physical Health Check, the numbers are extremely small.

The Bangladeshi or British Bangladeshi group has the highest proportion of people with a current SMI diagnosis who have had a Physical Health Check, whereas last year this group had the second lowest proportion of all ethnic groups. Those from Chinese backgrounds are the least likely to have a current SMI diagnosis and to have had a Physical Health Check, which aligns to the findings from 2023/24.

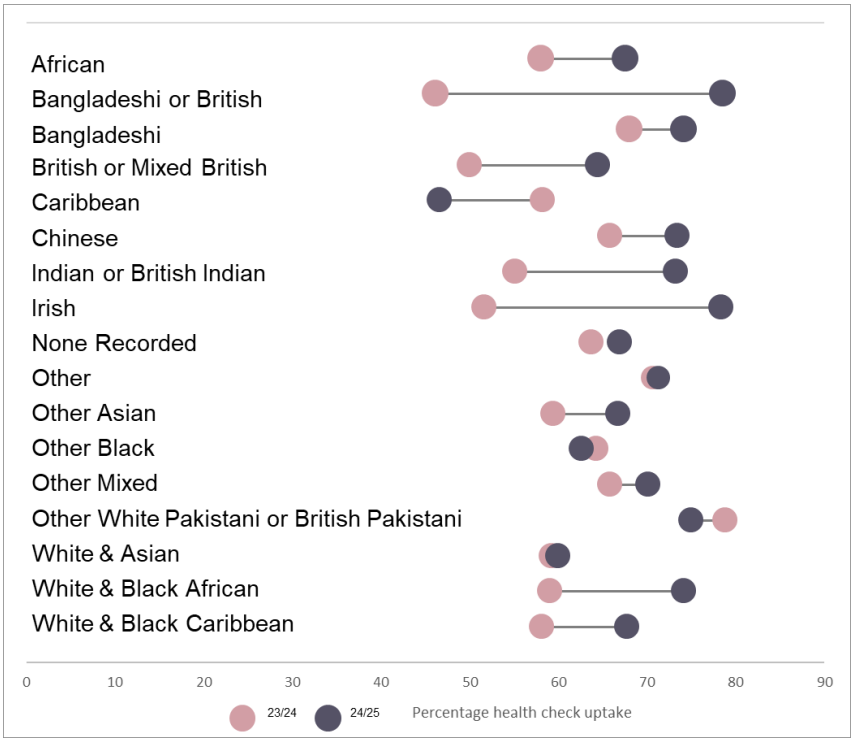


Figure 25: Severe Mental Illness (SMI) physical health checks. Comparison of the proportion of people on the General Practice SMI register who received a physical health check in the last 12 months to the end of the reporting period between 2023/24 and 2024/25 in Gloucestershire by ethnic group. Source: Adult Mental Health Dashboard, Future NHS (1st May 2024 and 14 April 2025).

The proportion of people with a current SMI diagnosis who have had a Physical Health Check in the last 12 months increased significantly in the British or Mixed British ethnic group between 2023/24 and 2024/25, from 68.1% to 74.2%. Other ethnic groups have seen an increase in the proportion of people with a current SMI diagnosis who have had a Physical Health Check in the last 12 months, but these increases are not statistically significant, which is likely to be due to the small numbers involved in the cohorts.

The only ethnic groups that have seen a decrease in the proportion of people with a current SMI diagnosis who have had a Physical Health Check in the last 12 months between 2023/24 and 2024/25 are the Pakistani or British Pakistani, and Chinese groups; however, these differences are not statistically significant.

2.4.2 Mental Health Detention and Restrictive Interventions – data and analysis

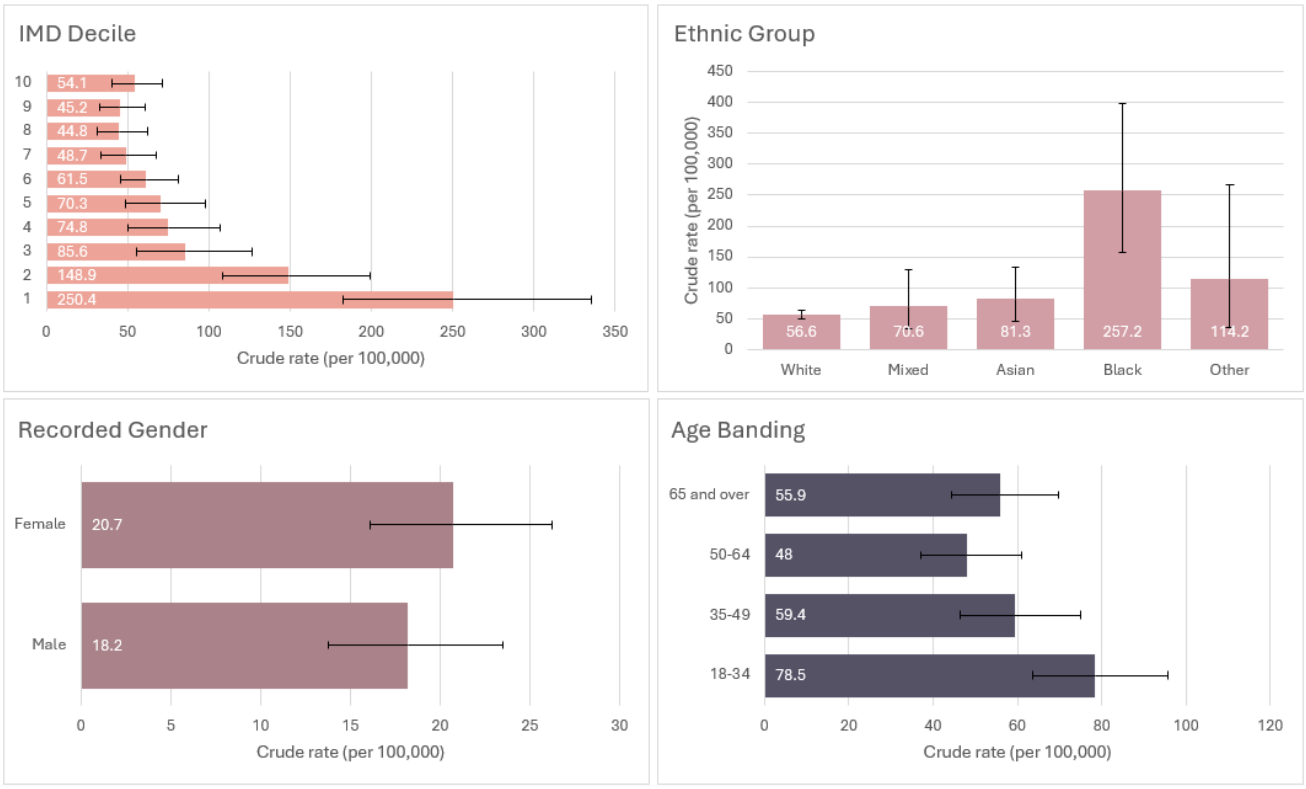


Figure 26: Mental Health Act detentions. Crude rate per 100,000 people subject to a detention under the Mental Health Act 1983 by: a) IMD decile, b) ethnic group, c) gender, c) age banding. Source: Mental Health Act Statistics, Annual Figures, 2023-24, NHS Digital (2023-24).

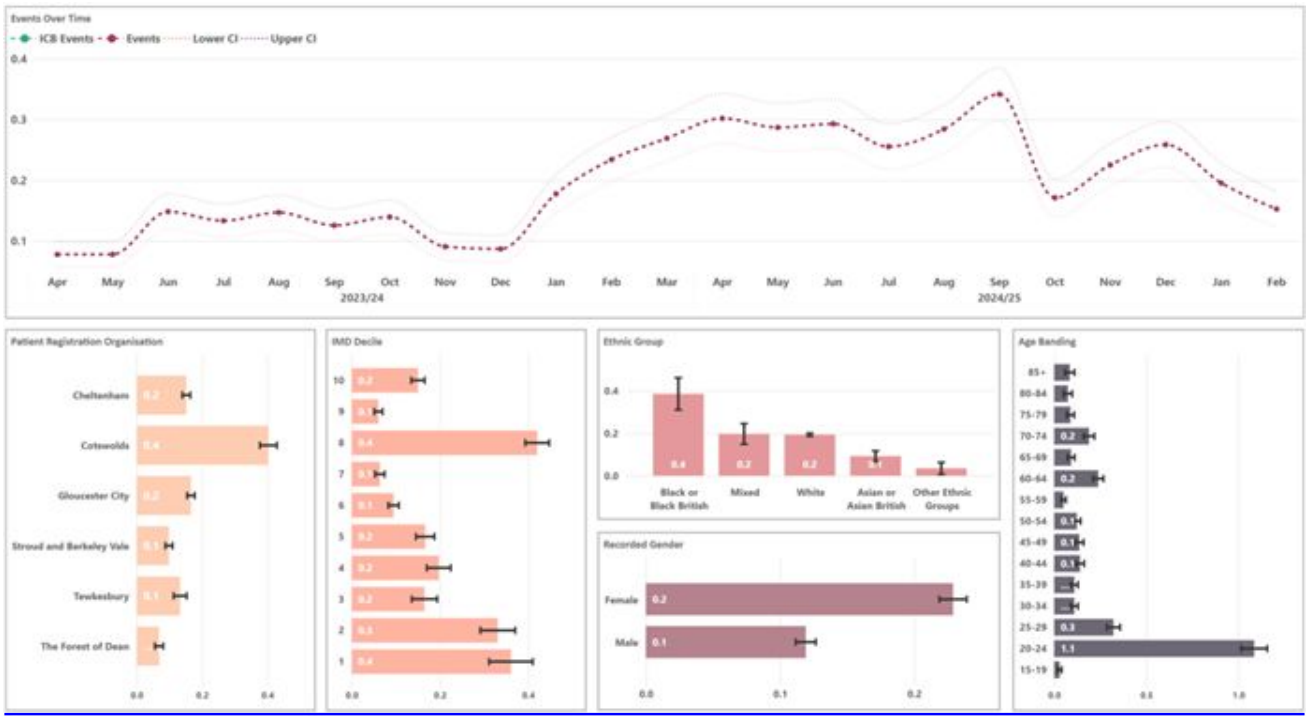


Figure 27: Rates of restrictive interventions as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: Mental Health Service Data Set.

The rate of restrictive interventions in Gloucestershire increased gradually from 0.1 per 1,000 people in December 2023 to 0.3 per 1,000 people in September 2024 before decreasing to 0.2 per 1,000 people.

An analysis of patients detained in low, medium, and high secure services in England and Wales found that women were physically restrained more often than men, and chemical restraint was also used more often in women[18]. However, while the Gloucestershire data suggests higher detention rates for females, this difference is not statistically significant in the Gloucestershire data and could be driven by small numbers in the cohort, as it does not align to national figures from 2023/24 which showed higher detention rates in males[19]. Rates of restrictive interventions and detentions under the Mental Health Act are higher in the younger population compared to other age groups, which is broadly in line with national data[20].

Rates of detentions under the Mental Health Act and restrictive interventions are highest in people living in the most deprived areas in Gloucestershire, which is in line with national data that shows people in deprived areas are at a much greater risk of being detained under the Mental Health Act compared to those in the least deprived areas[21]. They are also higher in females compared to males. The rate of detentions under the Mental Health Act increased in Gloucestershire's least deprived decile from 44 per 100,000 people in 2022/23 to 54.1 per 100,000 people in 2023/24 and in the most deprived decile from 195 per 100,000 people to 250.4 per 100,000 people, but decreased in every other decile during this time. The rate of detentions is still lower in people living in IMD 10 compared to those living in the most deprived deciles, and the gap between the most and least deprived deciles has increased.

While the majority of restrictive interventions are concentrated in the 20 to 24 age group, this is not what we see in IMD 1 where the rate is higher in the older age groups from 30 to 64 years.

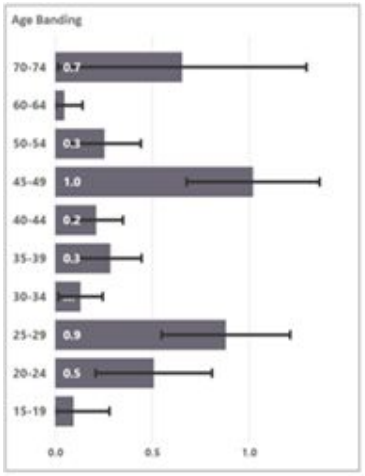


Figure 28: Rates of restrictive interventions for people living in IMD 1 as of February 2025, age standardised. Broken down by age banding. Source: Mental Health Service Data Set.

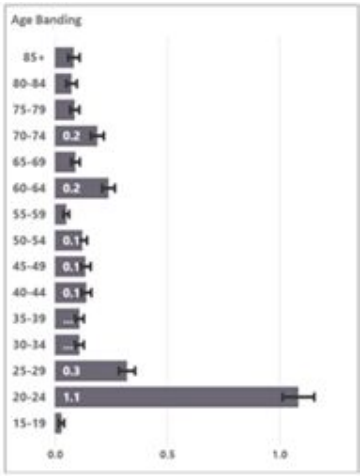


Figure 29: Rates of restrictive interventions as of February 2025, age standardised. Broken down by age banding. Source: Mental Health Service

An unexpected finding from the analysis is that alongside IMDs 1 and 2, people living in IMD 8 also had significantly higher rates of restrictive interventions than people in other deprivation deciles. Between December 2023 and August 2024, the rate of restrictive interventions was between 0.5 per 1,000 people and 0.8 per 1,000 people higher in people living in IMD 8 compared with those living in all deciles. Further work is needed to understand why rates of restrictive intervention are higher in this cohort.

[18] Differences between restrictive practices applied to men and women in UK secure mental health services
[19] Mental Health Act Statistics, Annual Figures, 2023-24
[20] Mental Health Act Statistics, Annual Figures, 2023-24
[21] Monitoring the Mental Health Act in 2021/22

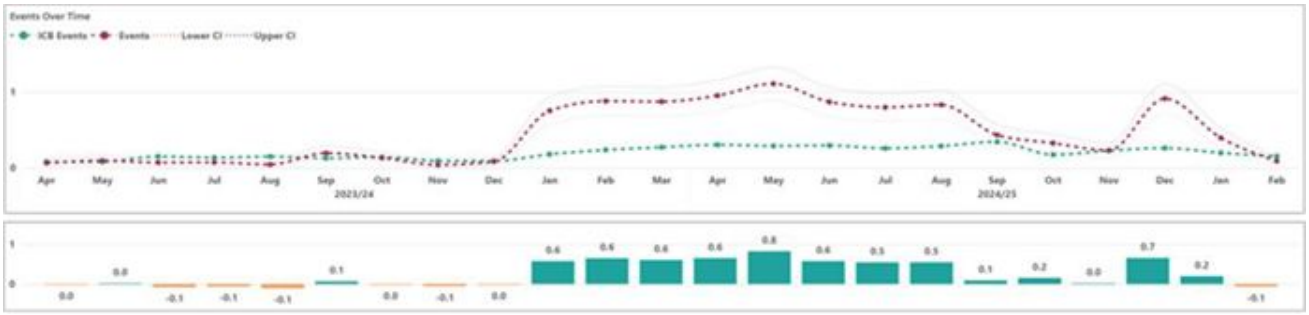


Figure 31: Rates of restrictive interventions for people living in IMD 8 (purple line) compared to people living in all deprivation deciles (green line) as of February 2025, age standardised. Source: Mental Health Service Data Set.

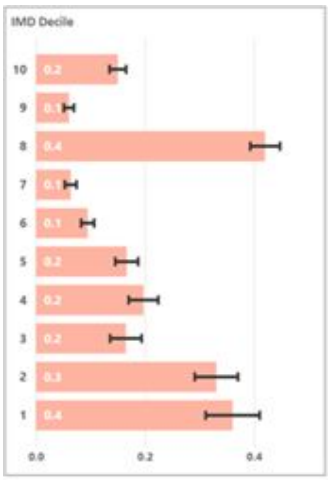


Figure 30: Rates of restrictive interventions as of February 2025, age standardised. Broken down by deprivation. Source: Mental Health Service Data Set.

People from Black or Black British backgrounds are significantly more likely to experience a restrictive intervention compared to those from all other ethnic backgrounds. There is a wider spread in the rate of restrictive interventions for people from the Black and Black British ethnic group with respect to age groups compared to the ICB population, but due to small numbers in the cohort there is no statistically significant difference.

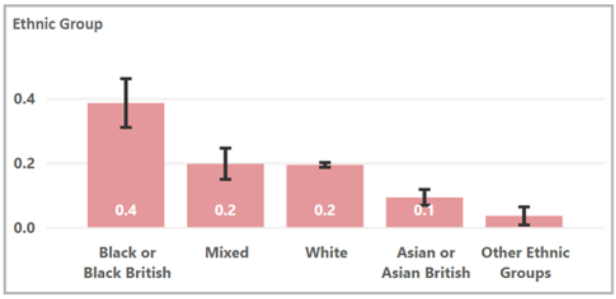


Figure 32: Rates of restrictive interventions as of February 2025, age standardised. Broken down by ethnic group. Source: Mental Health Service Data Set.

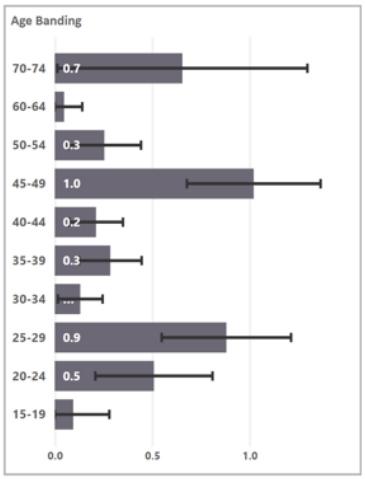


Figure 33: Rates of restrictive interventions for people in the Black or Black British ethnic group as of February 2025, age standardised. Broken down by age group. Source: Mental Health Service Data Set.

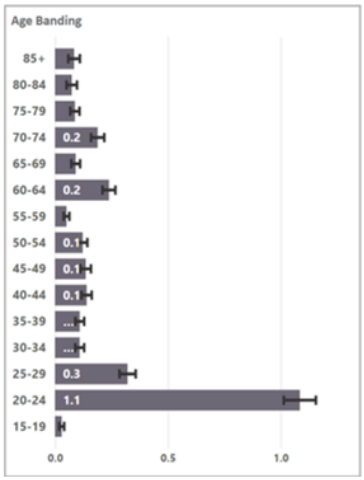


Figure 34: Rates of restrictive interventions as of February 2025, age standardised. Broken down by age group. Source: Mental Health Service Data Set.

Rates of detentions under the Mental Health Act are also higher in the Black or Black British group, but not statistically significantly. National data showed that in 2021/22, Black people are over four times more likely than White people to be detained under the Mental Health Act[22].

2.4.3 Talking Therapies – data and analysis

Figure 35: IAPT (Talking Therapies) Caseness as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: Improving Access to Psychological Therapies (IAPT) Data Set.

[22] Monitoring the Mental Health Act in 2021/22

Figure 36: IAPT (Talking Therapies) Completed Treatment as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: Improving Access to Psychological Therapies (IAPT) Data Set.

Figure 37: IAPT (Talking Therapies) Recovery as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: Improving Access to Psychological Therapies (IAPT) Data Set.

The trends among different demographic groups in the rate of completion of Talking Therapies treatment follow the rate of caseness, which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case.

The rate of completion of Talking Therapies treatment is significantly higher in females compared to males, as is the rate of recovery following Talking Therapies treatment, whereby people scoring above the clinical threshold on a clinical measurement of depression or anxiety before treatment (at assessment), then score below the clinical threshold for both depression and anxiety on clinical measures at the last treatment appointment with the service. The rate of treatment completion is 1.1 per 1,000 people in females and 0.5 per 1,000 people in males but drops to 0.6 per 1,000 people in females and 0.3 per 1,000 people in males when looking at recovery following treatment.

People from White and Mixed ethnic groups are significantly more likely to complete Talking Therapies treatment compared to Asian or Asian British, Black or Black British, and Other ethnic groups, whereas rates of treatment completion are significantly lower in the Asian or Asian British ethnic group, which is in line with findings from a review of national IAPT (Talking Therapies) data collected between 2017 and 2018 showing that people with Asian ethnicity are the least likely to report common mental disorders in the general population and the least likely to access IAPT services[23]. However, the rate of recovery following Talking Therapies treatement remains highest in people from White and Mixed ethnic groups, and lowest in the Asian and Asian British, Black or Black British, and Other ethnic groups.

There is no significant difference between deprivation deciles with regards to completion of Talking Therapies treatment, however the rate of recovery is significantly lower in people living in IMD 1 compared to those living in more affluent areas (IMDs 4 to 10). Evidence from the analysis of healthcare records from 44,805 patients who accessed psychological treatement suggests that living in economically deprived neighbourhoods is linked with more severe symptoms of depression and anxiety post Talking Therapies treatment, with lengthier interventions required to achieve improvements[24].

2.4.4 Associated programmes of work

We are working with community partners to improve uptake of Physical Health Checks in people with SMI, including:

- Providing tailored support to underrepresented communities, informing and encouraging them to attend their appointments, and supporting those who have missed their appointments to reschedule and attend, including providing transportation assistance and flexible appointments to meet their needs.
- Working with Primary Care Networks to identify individuals who need Physical Health Checks, ensuring no one is overlooked.

We know that people from disadvantaged communities and diverse ethnic communities experience challenges to accessing and engaging with mental health services. To address this, we are:

- Focussing on the development of a comprehensive psychosis pathway that is flexible and wraps around the individual, providing support that is responsive to the changing needs of the individual.
- Using data to improve our understanding of the variation in access to, and completion of Talking Therapies treatment by underserved population groups to inform targeted activity that will improve equity for those experiencing barriers in accessing the service.

[23] Socio-demographic differences in access to psychological treatment services: evidence from a national cohort study
[24] Adverse impact of neighbourhood socioeconomic deprivation on psychological treatment outcomes: the role of area-level income and crime

2.4.5 Children's Mental Health Access – data and analysis

Figure 38: Access to NHS funded mental health services as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: Mental Health Services Data Set.

The overall rate of children and young people accessing NHS funded mental health services has increased since April 2024, from 2.4 per 1,000 people to 3.2 per 1,000 people, although there have been fluctuations in the rate of access over this time. Females are significantly more likely to access services compared to males, and the highest rates of access are in the 10 to 14 age group.

Children and young people from White or Mixed backgrounds are more likely to access services than those from other ethnic groups, for example, the rate of access is 2.1 per 1,000 people for White children and young people compared to 0.9 per 1,000 people for those from Black or Black British backgrounds and 0.8 per 1,000 people for those from Asian or Asian British backgrounds. This corresponds to the findings from a review of studies on the experiences of children and young people facing mental health problems and accessing services, which showed that in the UK, children and young people from ethnic minority groups have greater difficulties in accessing mental healthcare and variable levels of engagement with services than White British people, which results from a lack of understanding of mental health problems, lack of information about services, lack of trust in healthcare professionals, social stigma and cultural expectations about mental resilience[25].

The variation in access between females and males is less pronounced in the Asian or Asian British, Black or Black British, and Other ethnic groups compared to the White and Mixed groups.

[25] Experiences of children and young people from ethnic minorities in accessing mental health care and support: rapid scoping review

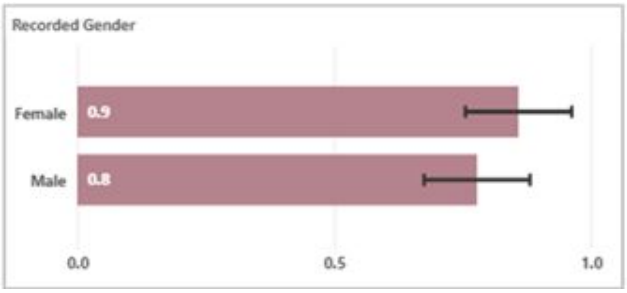


Figure 39: Access to NHS funded mental health services for people from the Asian or Asian British ethnic group as of February 2025, age standardised. Broken down by gender. Source: Mental Health Services Data Set.

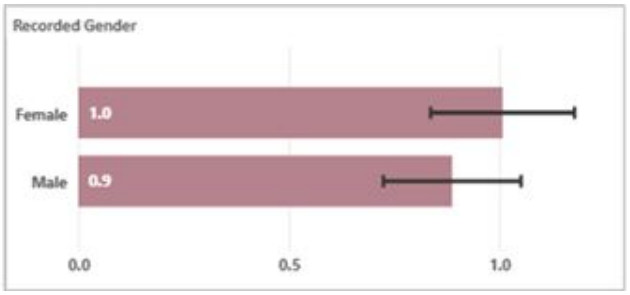


Figure 40: Access to NHS funded mental health services for people from the Black or Black British ethnic group as of February 2025, age standardised. Broken down by gender. Source: Mental Health Services Data Set.

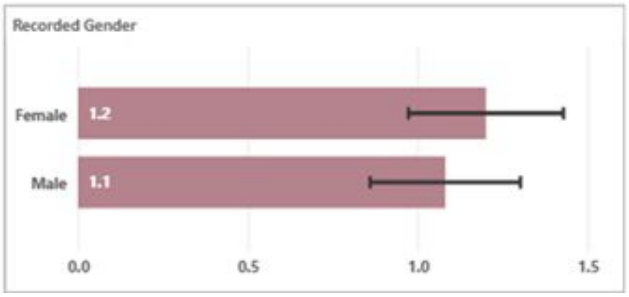


Figure 41: Access to NHS funded mental health services for people from the Other Ethnic Group as of February 2025, age standardised. Broken down by gender. Source: Mental Health Services Data Set.

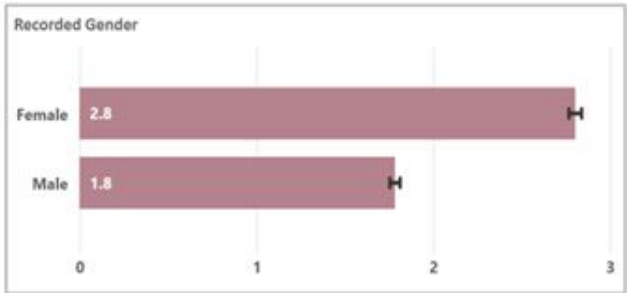


Figure 42: Access to NHS funded mental health services as of February 2025, age standardised. Broken down by gender. Source: Mental Health Services Data Set.

In the Asian or Asian British ethnic group, the rate of access to mental health services is highest in the 10 to 14, and 15 to 19 age groups, whereas for all ethnic groups, the rate is significantly higher in the 10 to 14 age group, showing that children and young people from Asian or Asian British backgrounds are more likely to access services later.

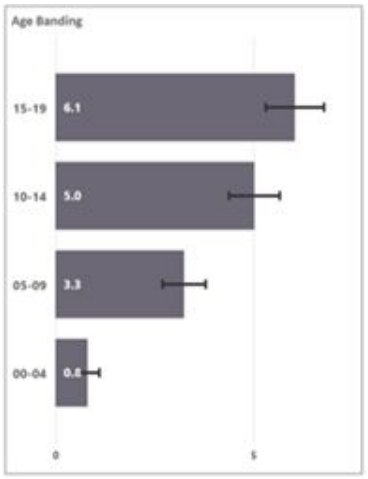


Figure 43: Access to NHS funded mental health services for people from the Asian or Asian British ethnic group as of February 2025, age standardised. Broken down by age group. Source: Mental Health Services Data Set.

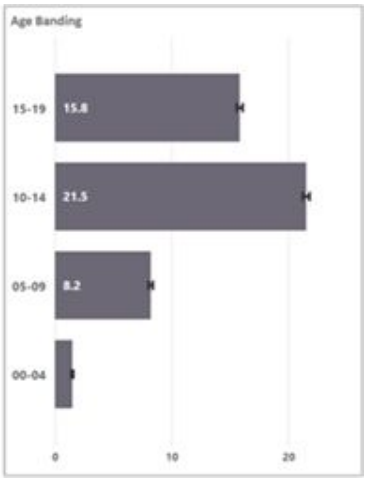


Figure 44: Access to NHS funded mental health services as of February 2025, age standardised. Broken down by age group. Source: Mental Health Services Data Set.

The rate of access to services is significantly lower for children and young people living in the most affluent parts of the county, in IMDs 5 to 10, compared to those living in the most deprived parts of the county, in IMDs 1 to 4. The National Children's Bureau report that mental ill health is disproportionately higher in children living in deprived areas[26], which may explain this trend; alternatively, children in more affluent areas may have lower access to certain services compared to those in deprived areas due to support services being concentrated in areas with higher need, or due to the healthcare-seeking behaviours of families in more affluent areas who may rely more on private healthcare.

Access to mental health services is highest in the Forest of Dean followed by Gloucester and Tewkesbury, and lowest in the Cotswolds, which aligns broadly to the deprivation profile of the county with the Forest of Dean being the second most deprived district in Gloucestershire, and the Cotswolds being the second least deprived district.

2.4.6 Associated programmes of work

A major challenge in children and young people's mental health is long waiting times for services. Those from disadvantaged areas and diverse ethnic communities are more likely to come to the attention of services late, often when they are in crisis, and then face long waiting times for support[27] . To address this, we are focussing on prevention, early access, and community support, including:

- Expanding Mental Health Support Teams in Gloucestershire schools, targeting underserved areas.
- Piloting the Multi-Agency Navigation Hub in Gloucester City, integrating health, education, and voluntary sectors to support those with complex mental health needs.
- Provision of mental health support to you people through Young Gloucestershire youth workers both in the community and within the paediatric ward at Gloucester Royal Hospital.
- Embedding youth-focused mental health support in primary care in underserved areas for timely local access.
- Providing creative mental health support such as art therapy, music therapy, and play therapy in low-income and rural areas.

[26] Mental Health Inequalities and Social Deprivation
[27] Children's mental health services 2023-24

2.5 Cancer

2.5.1 Early cancer diagnosis – data and analysis

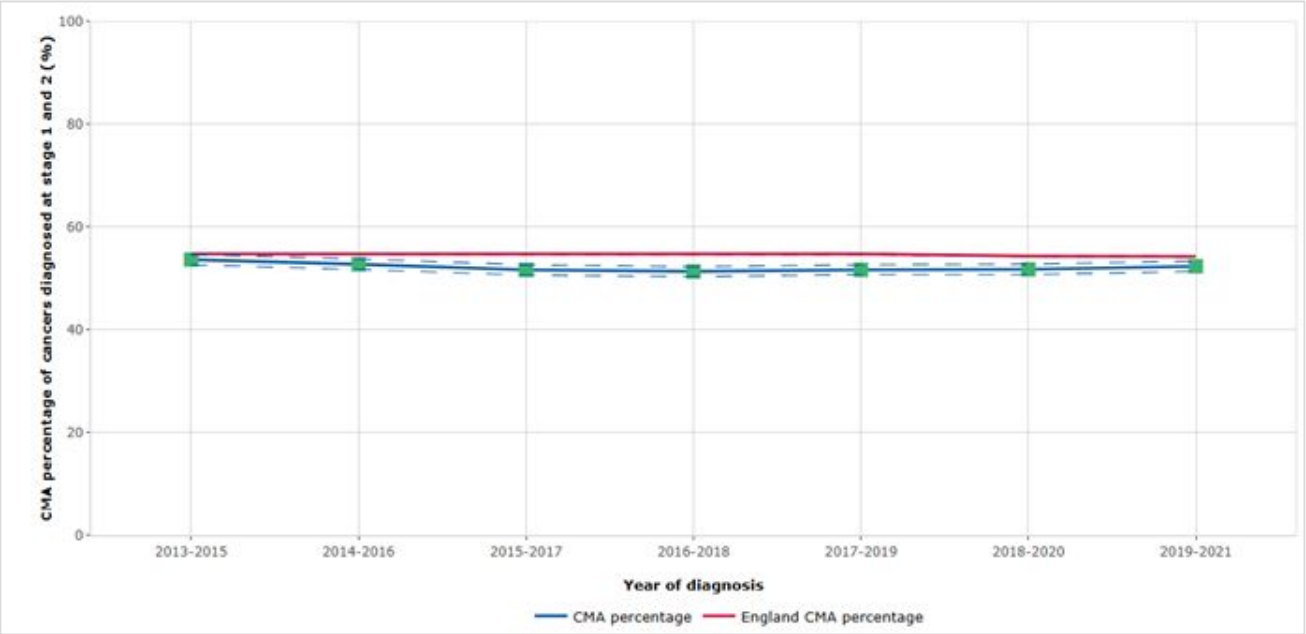


Figure 45: Early cancer diagnosis. Comparison of the percentage of 18 malignant cancers diagnosed at stage 1 and 2, case mix adjusted (CMA) for cancer site, age at diagnosis, sex and deprivation, between England and Gloucestershire. Source: National Cancer Registration Dataset, National Disease Registration Service, NHS Digital, 2013-2021).

The percentage of cancers diagnosed at stage 1 and 2 is significantly lower in Gloucestershire compared to the England average. However, the data shows that performance is improving, with the gap between Gloucestershire's performance and the national performance narrowing. While this is positive, the data indicates that the national target to diagnose 75% of cancers at stage 1 or 2 by 2028 is unlikely to be achieved with the national position static for diagnosis of cancer at an early stage[28].

2.5.2 Associated programmes of work

We recognise the link between deprivation and increased cancer mortality. Therefore, we are focussing our efforts on improving understanding of cancer pathways, timely presentation to cancer services, and timely access to cancer investigation in target cohorts, including:

- Community engagement events in deprived and non-White communities, including a general cancer information session in one of Gloucestershire's areas of highest deprivation, a breast cancer awareness session with Afghani women and a prostate and skin cancer awareness session at Jamaica Day for the Afro Caribbean community.
- The recruitment of a Learning Disabilities Screening Nurse to provide a personalised approach to improve uptake of cancer screening in people with Learning Disabilities and collaborative work with the VCSE Alliance to identify opportunities to reach other target populations.
- The expansion of the Lung Cancer Screening programme to Primary Care Networks covering areas of high deprivation and ethnic diversity.

[28] Cancer in the UK: Overview 2025

2.6 Cardiovascular disease

2.6.1 Stroke admissions and myocardial infarction admissions – data and analysis

Figure 46: Non-elective admissions for stroke as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: SUS Admitted Patient Care Data. Commissioned by NHS Gloucestershire ICB.

Figure 47: Non-elective admissions for myocardial infarction as of February 2025, age standardised. Broken down by a) district, b) deprivation, decile c) ethnic group, d) gender, e) age banding. Source: SUS Admitted Patient Care Data. Commissioned by NHS Gloucestershire ICB.

The rate of non-elective admissions for stroke and myocardial infarction have not varied significantly since April 2023, and the small numbers involved make it difficult to identify trends in admission rates at a local level. The British Heart Foundation reported that in 2022, the premature death rate for CVD had risen year-on-year in England since 2019[29] while data from the Office for Health Improvement and Disparities[30] showed that hospital admission rates for coronary heart disease (CHD) have decreased since 2010. Taken together this indicates a complex relationship: while fewer people may be hospitalised for CHD, premature deaths from CVD are not reducing, suggesting there may be a gap in early intervention or long-term management. It also raises questions about whether broader health factors, such as access to care or lifestyle, are influencing these trends.

Admissions for myocardial infarction are significantly higher in males compared to females, people from Other ethnic groups, and people living in the most deprived areas of Gloucestershire, particularly IMD 1 and IMD 2, compared to those living in more affluent areas in IMD 5 to 10. This is in line with reporting from Public Health England in 2019 that CVD is strongly associated with health inequalities, and amendable CVD deaths are significantly more likely to occur in the 3 most deprived deciles[31].

While CVD is more common in men[32], further analysis of the Gloucestershire data of people living in IMD 1 and IMD 2 shows that the rate of admissions for myocardial infarction is higher in females in this cohort. While this trend is not statistically significant, it indicates that differences in CVD admissions based on gender become less pronounced in more deprived populations. For people living in IMDs 1 and 2, the gap in admissions for stroke also become smaller and lose statistical significance.

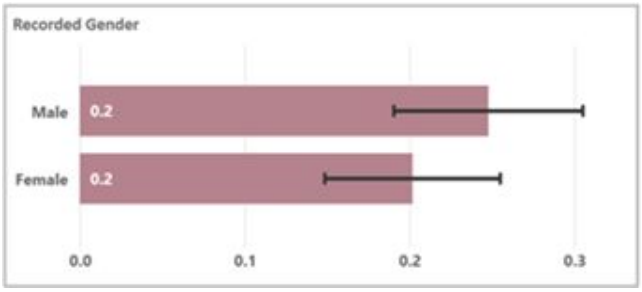


Figure 48: Non-elective admissions for stroke for people living in IMDs 1 and 2 as of February 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

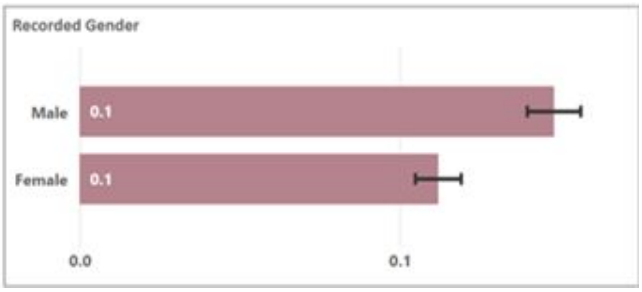


Figure 49: Non-elective admissions for stroke as of February 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

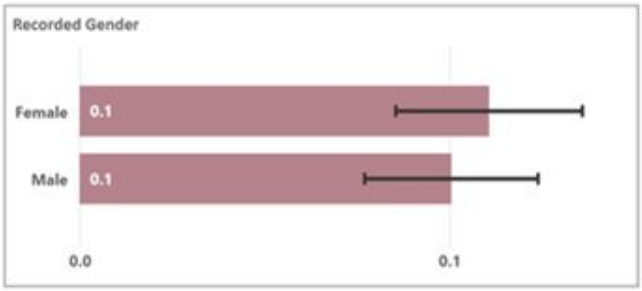


Figure 50: Non-elective admissions for myocardial infarction for people living in IMDs 1 and 2 as of February 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

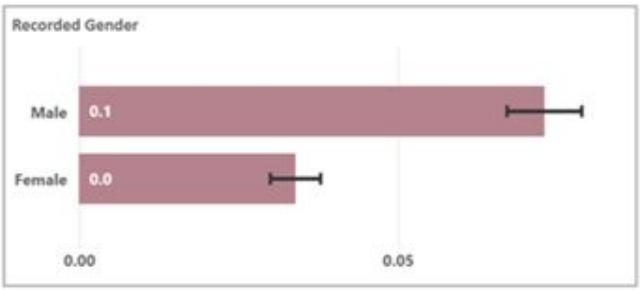


Figure 51: Non-elective admissions for myocardial infarction for people living in IMDs 1 and 2 as of February 2025, age standardised. Broken down by gender. Source: SUS Admitted Patient Care Data.

[29] Early deaths from cardiovascular disease reach 14 year high in England
[30] Cardiovascular disease profiles: short statistical commentary
[31] Health matters: preventing cardiovascular disease
[32] CVD risk assessment and management: what is the impact of CVD?

People living in areas of deprivation are more likely to be admitted for stroke and myocardial infarction at a younger age compared to the general Gloucestershire population. For example, the rate of admissions for stroke for people in IMDs 1 and 2 is 0.3 per 1,000 people compared to 0.2 per 1,000 people for the ICB population and remains higher in all older age groups up to the 81+ age group. The rate of admission for myocardial infarction is 0.4 per 1,000 people in the 65-70 age group compared to 0.1 per 1,000 people in the ICB population and remains higher in all older age groups.

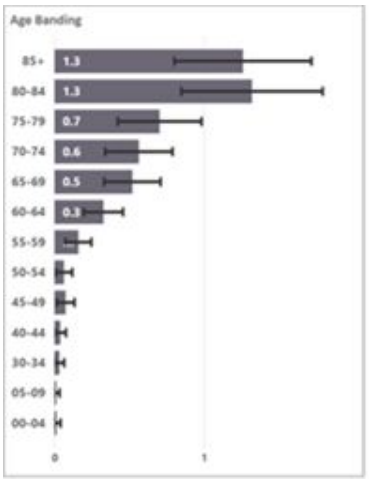


Figure 52: Non-elective admissions for stroke for people living in IMDs 1 and 2 as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

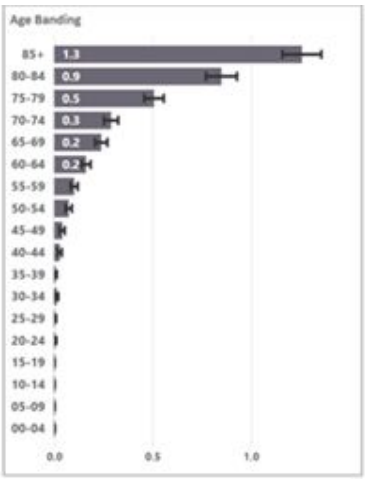


Figure 53: Non-elective admissions for stroke as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

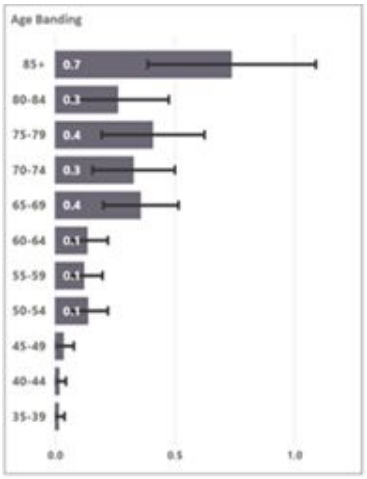


Figure 54: Non-elective admissions for myocardial infarction for people living in IMDs 1 and 2 as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

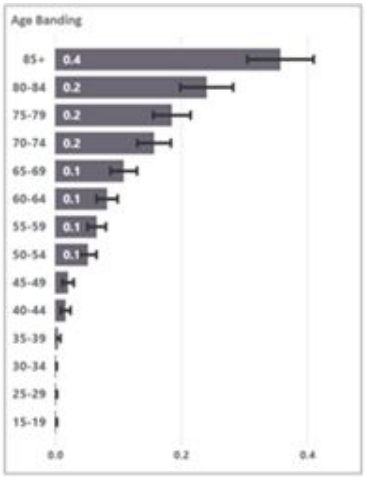


Figure 55: Non-elective admissions for myocardial infarction of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

It is well document that people from some ethnic backgrounds have an increased risk of CVD compared with those from White backgrounds, for example, people of South Asian or sub-Saharan African origin[33]. This is reflected in the stroke data for Gloucestershire, with people from Black or Black British backgrounds having a higher rate of admissions compared to all other ethnic groups, and a statistically significantly higher rate than those from Asian or Asian British,

[33] CVD risk assessment and management: what are the risk factors?

Mixed, and White backgrounds despite the small sample sizes. Admission rates for myocardial infarction are significantly higher in people from Other ethnic groups, however, this relates to 10 admissions out of 515 in total across 2024/25.

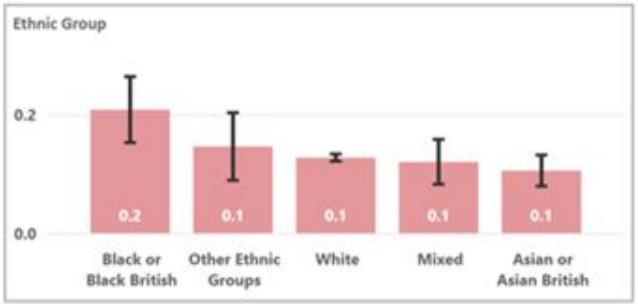


Figure 56: Non-elective admissions for stroke as of February 2025, age standardised. Broken down by ethnic group. Source: SUS Admitted Patient Care Data.

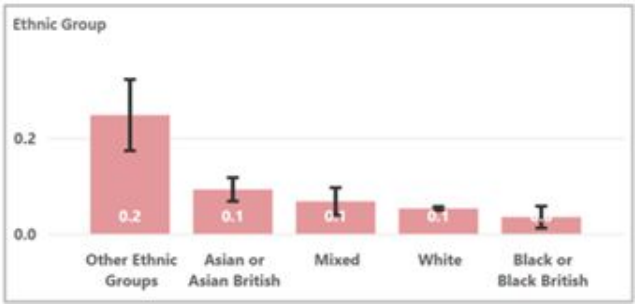


Figure 57: Non-elective admissions for myocardial infarction as of February 2025, age standardised. Broken down by ethnic group. Source: SUS Admitted Patient Care Data.

The age profile of people who have been admitted for stroke shows that rates of admissions are higher in younger age groups in the Black or Black British ethnic group compared to the ICB population (0.7 per 1,000 people compared to 0.2 per 1,000 people respectively for the 60-64 age group). Rates of admissions for myocardial infarction are higher in younger age groups in Other ethnic groups compared to the ICB population (0.5 per 1,000 people compared to 0.1 per 1,000 people respectively for the 60-64 age group). There are large error bars around this data due to the small numbers in the cohort. People who are admitted for myocardial infarction from the Other ethnic group are significantly more likely to live in Gloucester compared to other districts, which is in line with the population profile of Gloucestershire whereby Gloucester has the highest proportion of people from ethnic minority backgrounds[34].

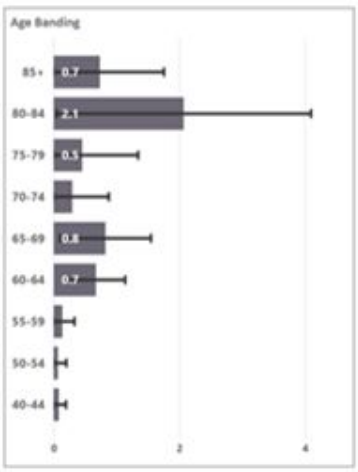


Figure 58: Non-elective admissions for stroke for people from the Black or Black British ethnic group as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

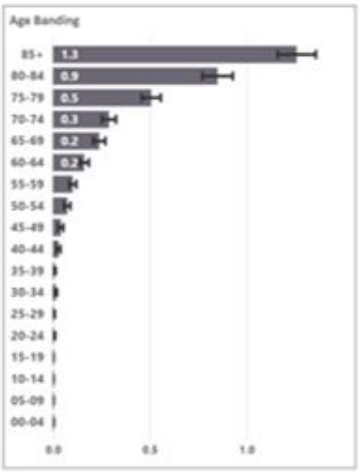


Figure 59: Non-elective admissions for stroke as of February 2025, age standardised. Broken down by ethnic group. Source: SUS Admitted Patient Care Data.

[34] Gloucestershire County Council population profile 2025

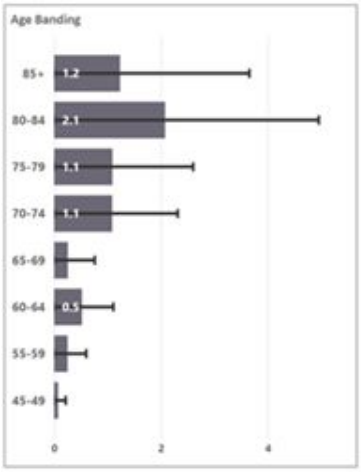


Figure 60: Non-elective admissions for myocardial infarction in people from the Other Ethnic Group as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

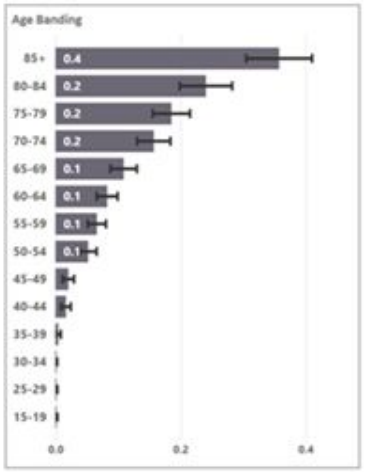


Figure 61: Non-elective admissions for myocardial infarction as of February 2025, age standardised. Broken down by age banding. Source: SUS Admitted Patient Care Data.

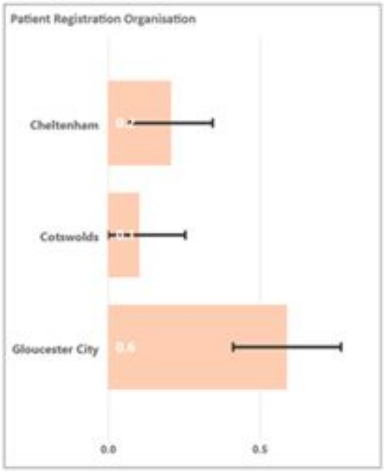


Figure 62: Non-elective admissions for myocardial infarction in people from the Other Ethnic Group as of February 2025, age standardised. Broken down by district. Source: SUS Admitted Patient Care Data.

2.6.2 Treatment using prescribed CVD drugs – Data and analysis

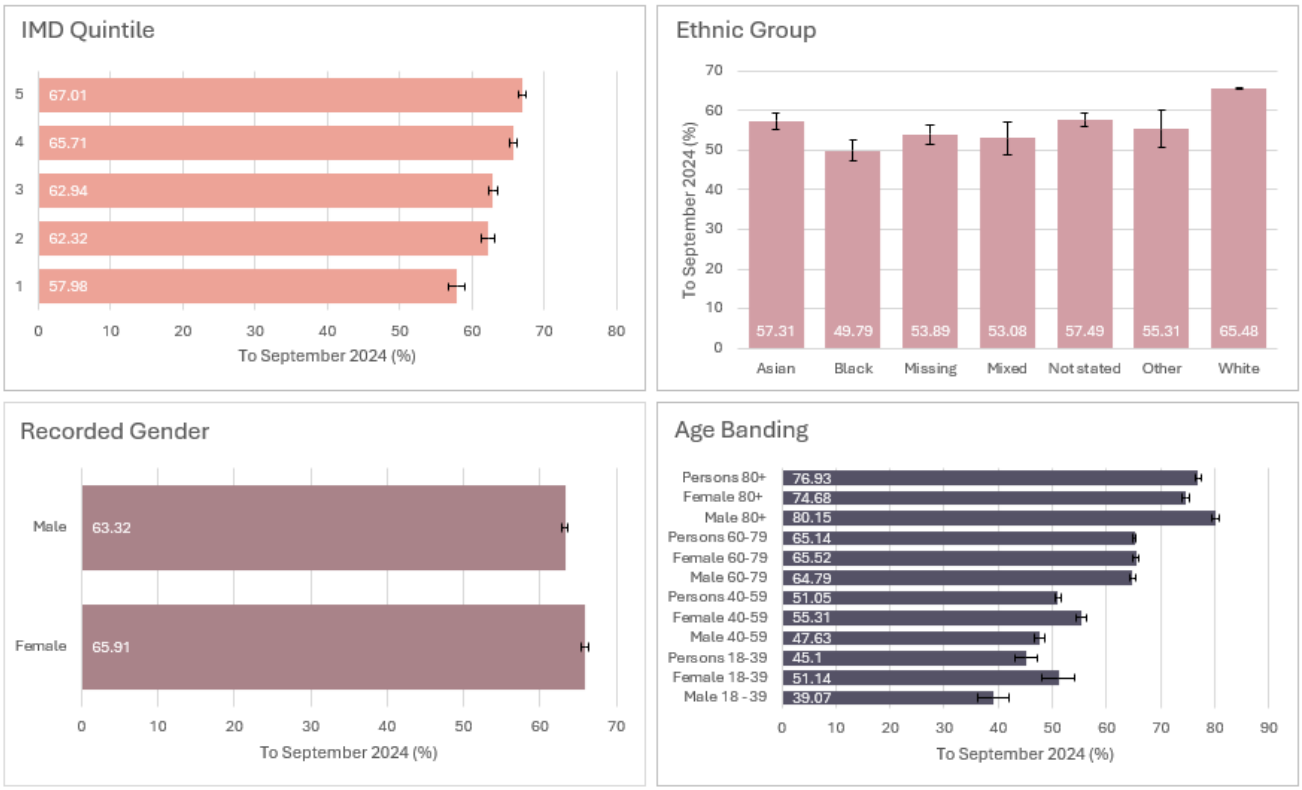


Figure 63: Treatment to target for CVD related conditions. Proportion of people with diagnosed hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold in people aged 18 and over. Broken down by a) deprivation, b) ethnic group, c) gender, d) age banding. Source: Cardiovascular Disease Prevention Audit (CVDPREVENT), Office for Health Improvement and Disparities and the NHS Benchmarking Network (to December 2024).

Adults with diagnosed hypertension living in the most deprived quintile of Gloucestershire are significantly less likely to have been treated to target compared to those living in all other quintiles, and the proportion of adults who have not been treated to target decreases as affluence increases, for example, 67.01% of adults in IMD 5 with hypertension were treated to target compared to 57.98% of those in IMD 1. This trend remains unchanged since last year, but the gap has narrowed slightly. The British Heart Foundation have reported that people in the most deprived areas have the least confidence in managing long-term conditions[35].

In line with the last year's data, adults from White backgrounds with diagnosed hypertension are significantly more likely to be treated to target compared to those from all other ethnic groups, and those from Black backgrounds are least likely to be treated to target. A study of ethnic differences in hypertension management and their contribution to blood pressure control shows poorer control of hypertension in people of African/African Caribbean compared to European ethnicity[36], but also shows better control for those of South Asian ethnicity and this is not replicated in the Gloucestershire data.

The proportion of adults who have been treated to target have decreased in all ethnic groups since last year. The proportion of people recorded as Missing or Not Stated has also decreased, which indicates that ethnicity recording is improving.

Females with diagnosed hypertension are significantly more likely to treated to target at a younger age compared to males (51.14% compared to 39.04% respectively in the 18 to 39 age group).

Figure 64: Treatment to target for CVD related conditions. Proportion of people with diagnosed atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy in people aged 18 and over. Broken down by a) deprivation, b) ethnic group, c) gender, d) age banding. Source: Cardiovascular Disease Prevention Audit (CVDPREVENT), Office for Health Improvement and Disparities and the NHS Benchmarking Network (to December 2024).

[35] How inequalities contribute to heart and circulatory diseases

[36] Ethnic differences in hypertension management, medication use and blood pressure control in UK primary care, 2006-2019: a retrospective cohort study

The data shows that performance in terms of treatment for adults with atrial fibrillation in Gloucestershire is high, and there have been improvements in the proportion of adults with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of two or more who are currently treated with anticoagulation drug therapy across all deprivation deciles since last year. While in the Gloucestershire data there is no significant difference between deprivation quintiles, research that shows people in the least deprived areas have the highest diagnosed prevalence of atrial fibrillation and a higher rate of prescriptions for drugs that treat atrial fibrillation compared to more deprived areas[37].

The proportion of adults with GP recorded atrial fibrillation who are being treated with anticoagulant drug therapy has decreased in all ethnic groups since last year, with the exception of people from the White group in which the proportion has increased from 91.72% in 2024 to 92.1% in 2025.

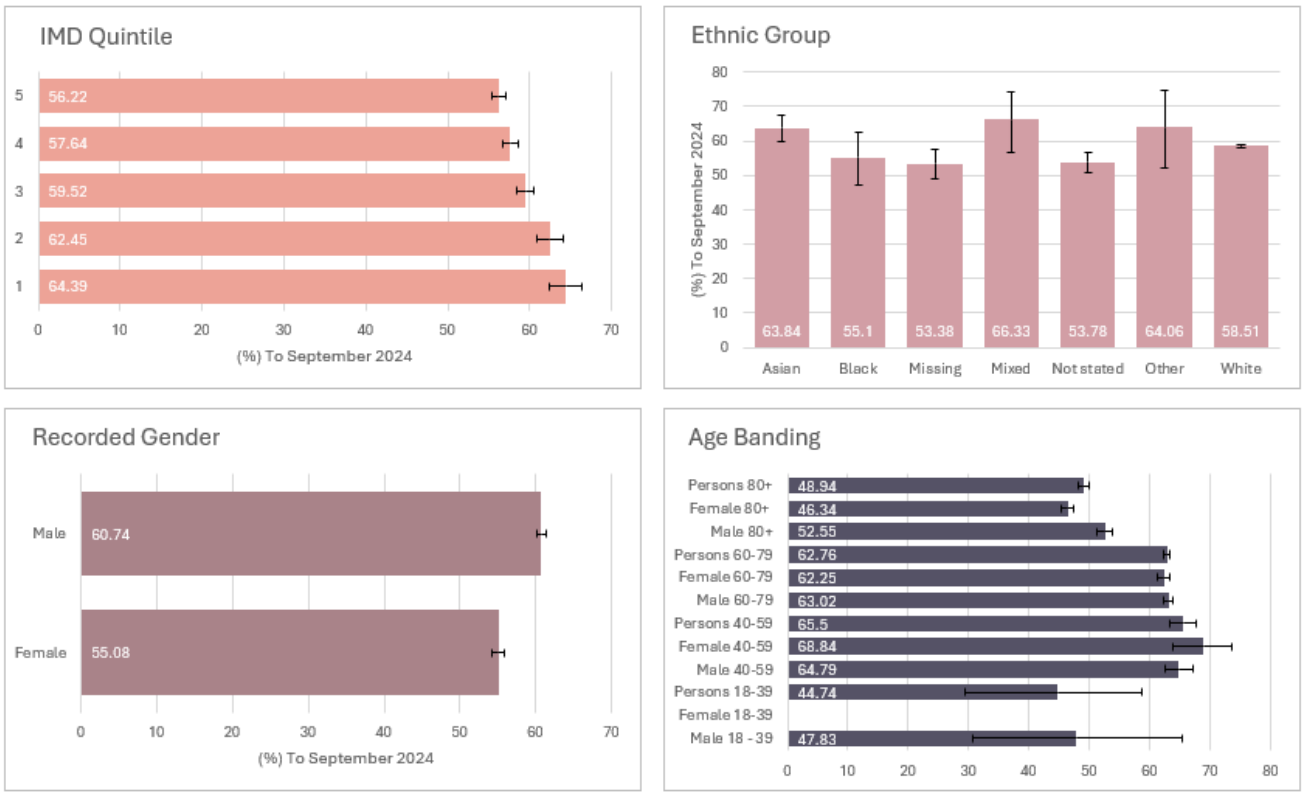


Figure 65: Treatment to target for CVD related conditions. Proportion of people with no GP recorded CVD and a QRISK score of 20% or more who are currently treated with lipid lowering therapy in people aged 18 and over. Broken down by a) deprivation, b) ethnic group, c) gender, d) age banding. Source: Cardiovascular Disease Prevention Audit (CVDPREVENT), Office for Health Improvement and Disparities and the NHS Benchmarking Network (to December 2024).

The proportion of adults with no GP recorded CVD and a QRISK score of 20% or more, who are currently treated with lipid lowering therapies is highest in the most deprived quintile and decreases with affluence. This follows the same trend as was found last year, but the proportion of people treated has increased across all deprivation quintiles since then.

While there is no significant difference in the proportion of adults with a QRISK score of 20% or more who are currently treated with lipid lowering therapy between ethnic groups, performance has increased since last year across all groups.

There has been a national focus on increasing hypertension diagnosis in deprived populations in recognition of the significant impact of underdiagnosis with hypertension being a major risk factor for stroke, heart disease, and chronic

[37] How inequalities contribute to heart and circulatory diseases

kidney disease[38]. This may contribute to the higher treatment of our most deprived decile with lipid lowering therapy. We potentially see lower treatment to target adherence for hypertension in this population as they may have poorer blood pressure control and are less likely to adhere to hypertension treatment[39].

2.6.3 Spotlight on hypertension

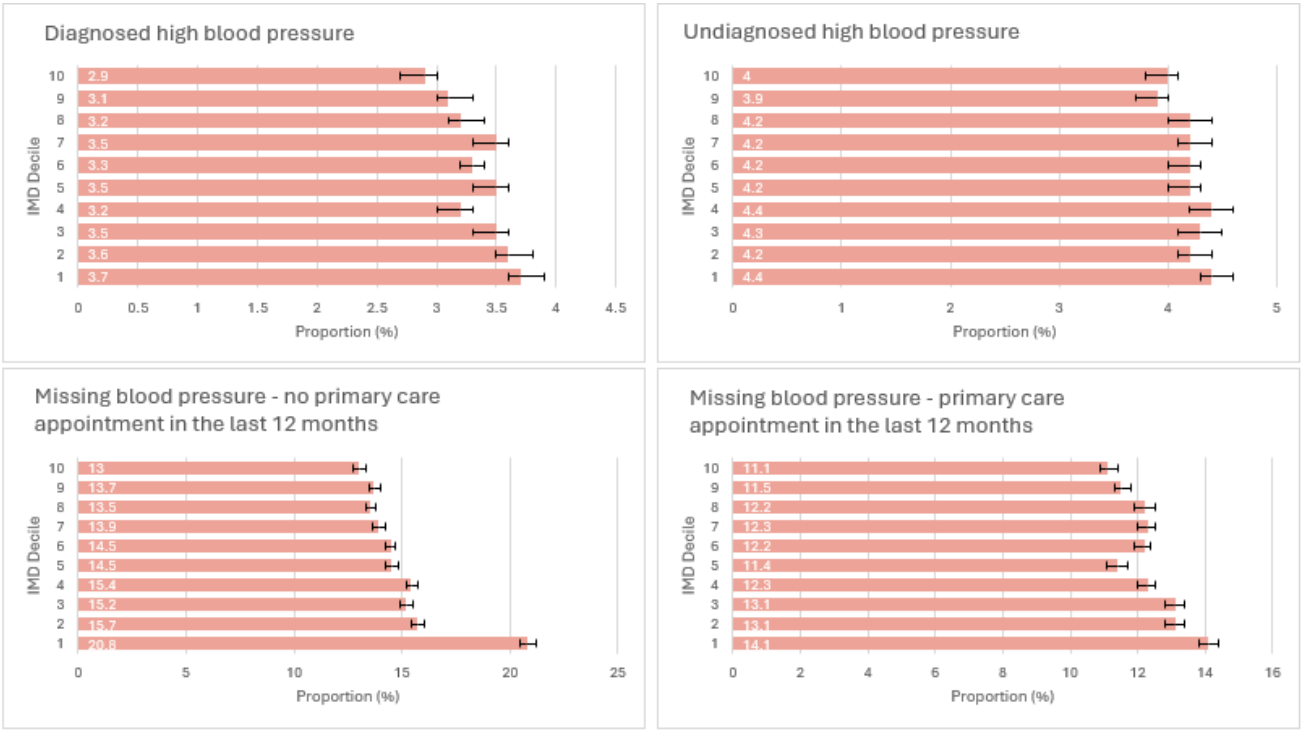


Figure 66: Blood pressure measurement and hypertension diagnosis as of March 2025. Proportion of people with a) a confirmed hypertension diagnosis that have had a blood pressure reading in the last 12 months that is over the age-appropriate threshold, b) no confirmed diagnosis but their latest blood pressure readings are above the age-appropriate threshold, c) no diagnosis of hypertension and no blood pressure reading in the last 5 years who have not had a primary care appointment in the last 12 months, d) no diagnosis of hypertension and with no blood pressure reading in the last 5 years who have had a primary care appointment in the last 12 months. Broken down by deprivation. Source: Local Primary Care Data.

People living in the most deprived areas of Gloucestershire are significantly more likely to have a missing blood pressure reading compared to those living in the most affluent areas, whether they have had a primary care appointment in the last 12 months or had no primary care appointment in the last 12 months. For those who have not seen their GP in the last 12 months, the proportion of people who have a blood pressure reading is 7.8% higher in people living in IMD 10 compared to those living in IMD 1; for those who have seen their GP in the last 12 months, the difference is only 3%, showing the importance of increasing uptake of GP appointments in deprived populations.

People living in IMDs 1 and 2 are significantly more likely to have a diagnosed high blood pressure compared to those living in IMD 10, meaning that they have had a blood pressure reading in the last 5 years that is over the age-appropriate threshold and therefore have a confirmed hypertension diagnosis.

People living in poverty are less likely to visit their GP, according to The King's Fund. However, Gloucestershire data shows that when individuals from the most deprived communities do attend appointments, their blood pressure is being measured. Despite this, they are significantly more likely than those in the least deprived areas (IMD 10) to

[38] What works: Improving case finding of long-term health problems in disadvantaged communities
[39] Combined effect of income and medication adherence on mortality in newly treated hypertension: nationwide study of 16 million person-years

remain undiagnosed with hypertension, even when their latest readings exceed the recommended threshold for their age. This suggests missed opportunities to diagnose and treat hypertension in deprived populations.

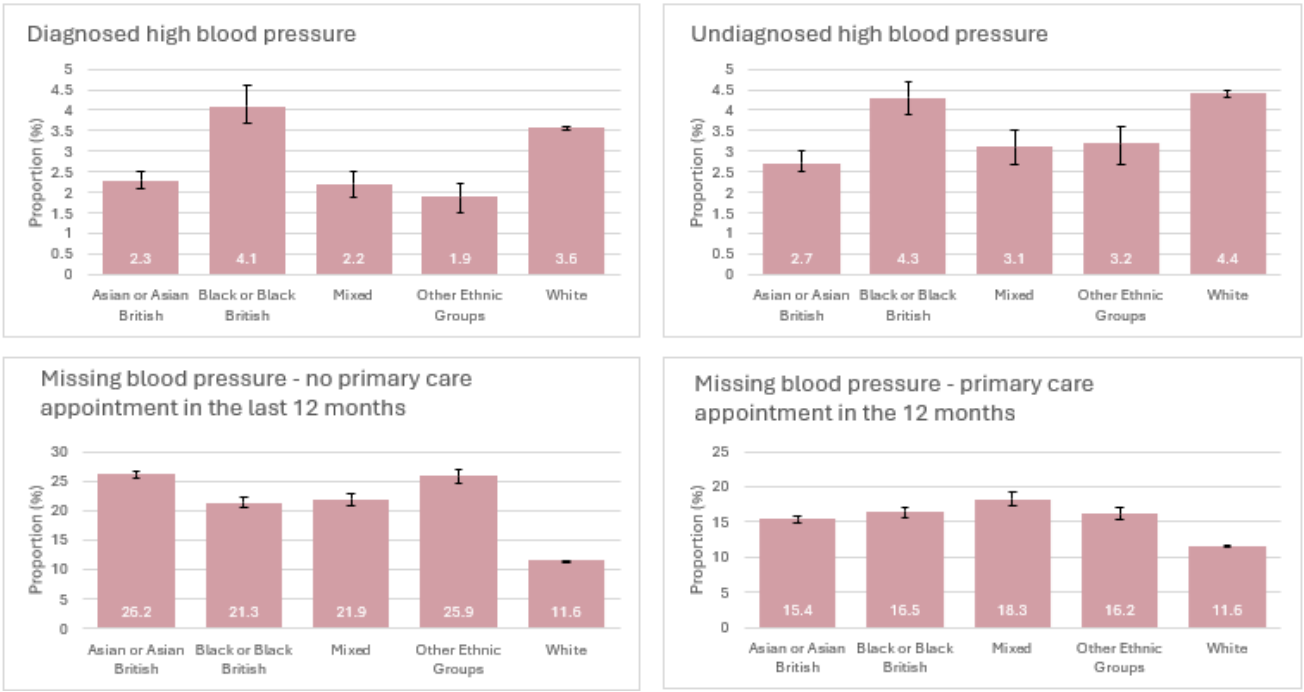


Figure 67: Blood pressure measurement and hypertension diagnosis as of March 2025. Proportion of people with a) a confirmed hypertension diagnosis that have had a blood pressure reading in the last 12 months that is over the age-appropriate threshold, b) no confirmed diagnosis but their latest blood pressure readings are above the age-appropriate threshold, c) no diagnosis of hypertension and no blood pressure reading in the last 5 years who have not had a primary care appointment in the last 12 months, d) no diagnosis of hypertension and with no blood pressure reading in the last 5 years who have had a primary care appointment in the last 12 months. Broken down by ethnic group. Source: Local Primary Care Data.

People from Black or Black British backgrounds have the highest proportion of diagnosed high blood pressure compared to all other ethnic groups; they also have a significantly higher proportion of undiagnosed high blood pressure than those from White backgrounds.

The proportion of people with a missing blood pressure who have had a primary care appointment in the last 12 months is higher in people from Mixed and Other ethnic groups

Other ethnic groups and Asian or Asian British ethnic groups have the highest proportion of missing blood pressures.

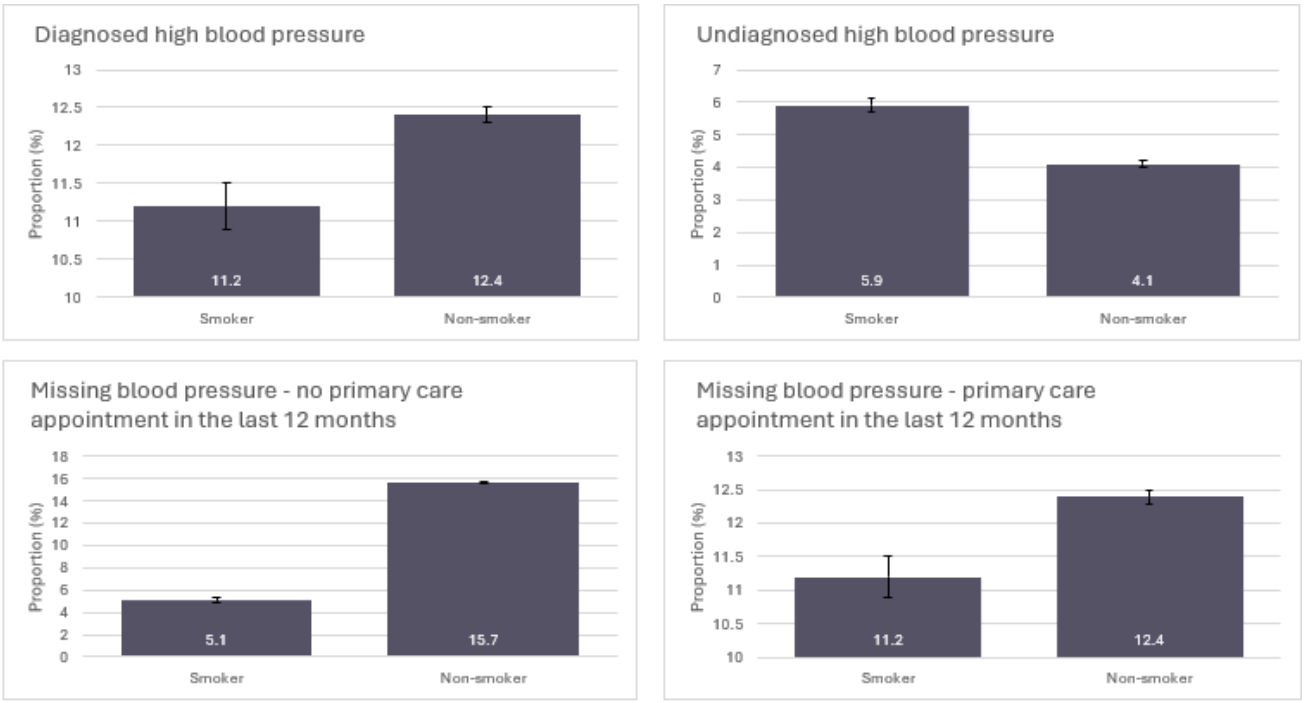


Figure 68: Blood pressure measurement and hypertension diagnosis as of March 2025. Proportion of people with a) a confirmed hypertension diagnosis that have had a blood pressure reading in the last 12 months that is over the age-appropriate threshold, b) no confirmed diagnosis but their latest blood pressure readings are above the age-appropriate threshold, c) no diagnosis of hypertension and no blood pressure reading in the last 5 years who have not had a primary care appointment in the last 12 months, d) no diagnosis of hypertension and with no blood pressure reading in the last 5 years who have had a primary care appointment in the last 12 months. Broken down by smoking status. Source: Local Primary Care Data.

Smokers are significantly less likely to have a missing blood pressure reading compared to non-smokers, whether they have had a primary care appointment in the last 12 months or not. However, they are also significantly more likely than non-smokers to have an undiagnosed high blood pressure, and less likely to have a confirmed hypertension diagnosis. This suggests that while GPs are in an optimal position to provide patient education and treatment to improve blood pressure, hypertensive smokers may be less likely to receive that education and treatment than non-smokers. Smokers may be less likely to be diagnosed with hypertension by their GP because regular smoking can lead to temporary blood pressure spikes that mask underlying hypertension, and long-term smokers tend to have slightly lower blood pressure than non-smokers possibly due to differences in body weight[40]. This can make it harder for GPs to detect hypertension, especially if smokers do not undergo regular monitoring or if their blood pressure fluctuates due to smoking related effects.

[40] How smoking affects blood pressure

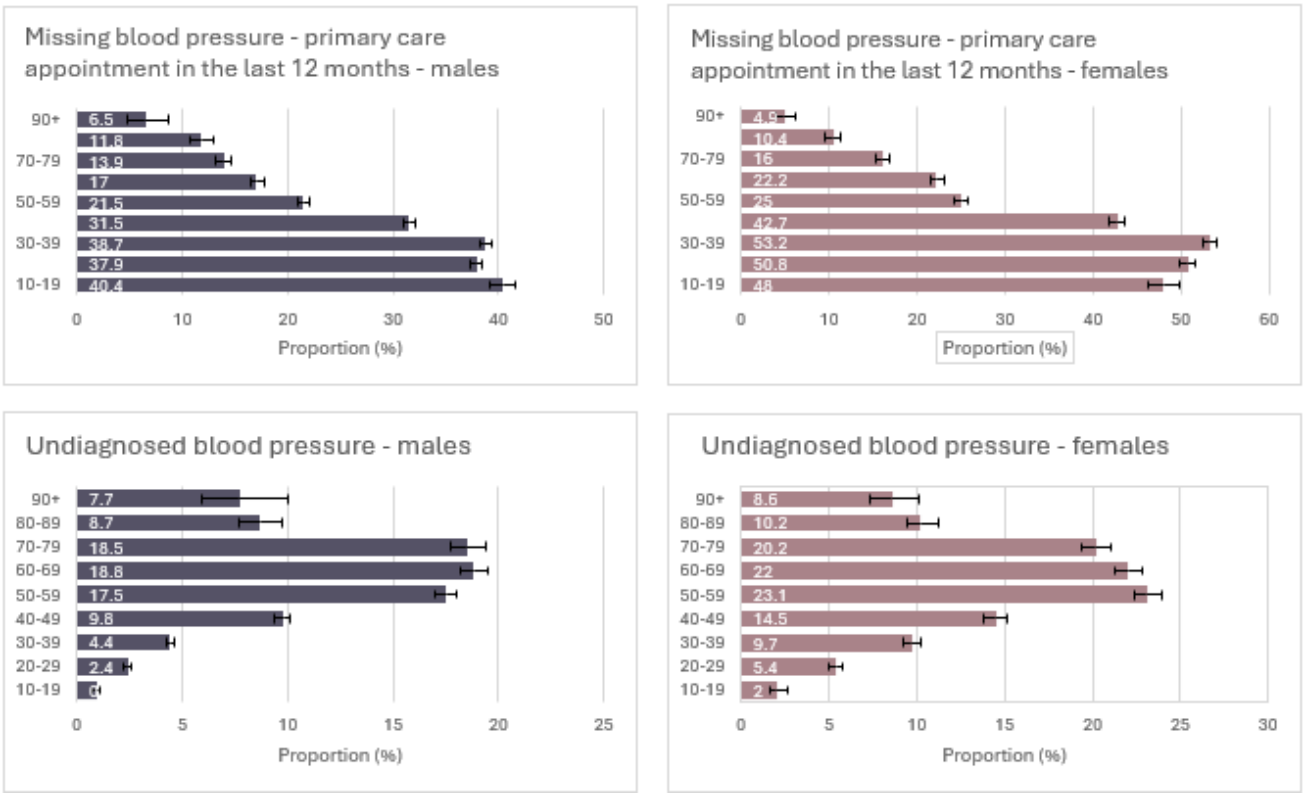


Figure 69: Blood pressure measurement and hypertension diagnosis as of March 2025. A) Proportion of males with no diagnosis of hypertension and with no blood pressure reading in the last 5 years who have had a primary care appointment in the last 12 months, b) Proportion of females with no diagnosis of hypertension and with no blood pressure reading in the last 5 years who have had a primary care appointment in the last 12 months, c) proportion of males with no confirmed diagnosis but their latest blood pressure readings are above the age-appropriate threshold, d) proportion of females with no confirmed diagnosis but their latest blood pressure readings are above the age-appropriate threshold, Broken down by age banding. Source: Local Primary Care Data.

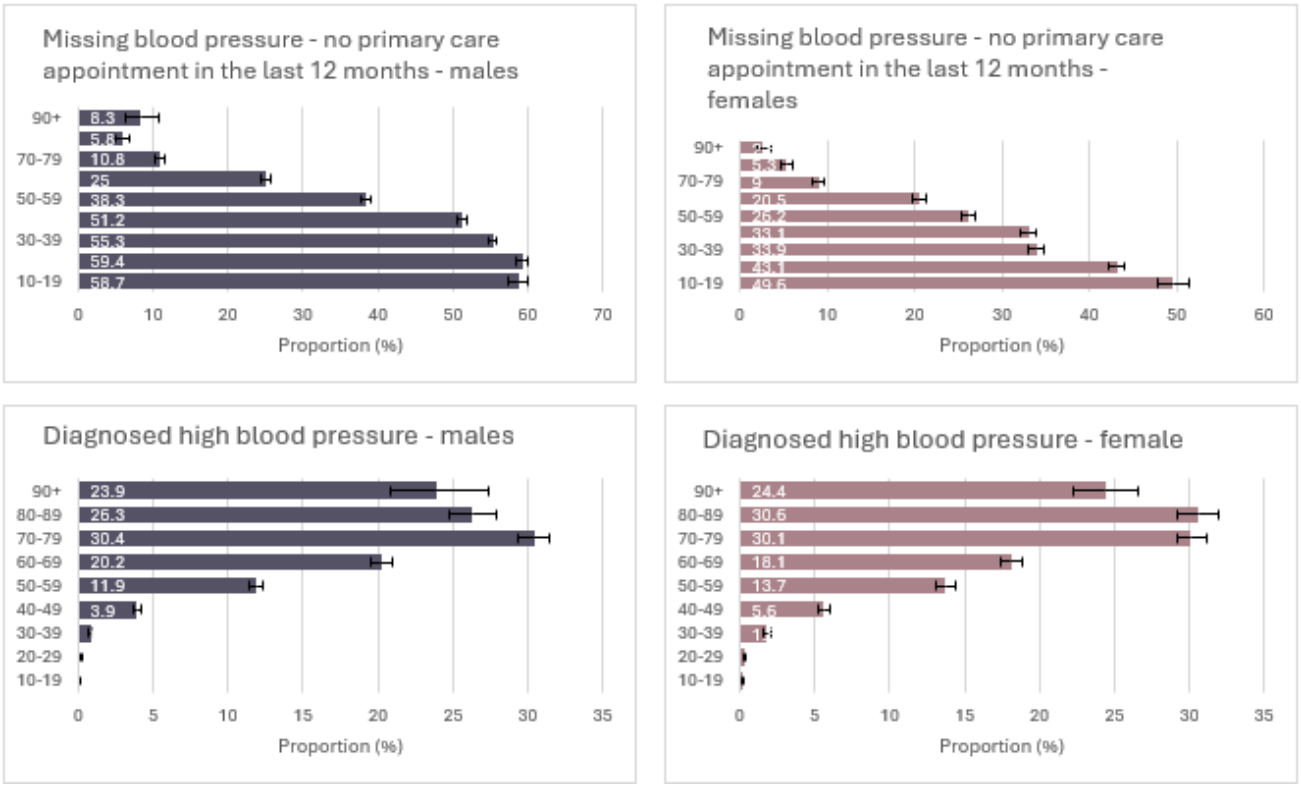


Figure 70: Blood pressure measurement and hypertension diagnosis as of March 2025. A) Proportion of males no diagnosis of hypertension and no blood pressure reading in the last 5 years who have not had a primary care appointment in the last 12 months, b) proportion of females with no diagnosis of hypertension and no blood pressure reading in the last 5 years who have not had a primary care appointment in the last 12 months, c) proportion of males with a confirmed hypertension diagnosis that have had a blood pressure reading in the last 12 months that is over the age-appropriate threshold, d) proportion of females with a confirmed hypertension diagnosis that have had a blood pressure reading in the last 12 months that is over the age-appropriate threshold. Broken down by age banding. Source: Local Primary Care Data.

Across all age groups from 10 to 69 years, women who have had a primary care appointment in the last 12 months are more likely to have a missing blood pressure reading than men. However, they are more likely to have an undiagnosed high blood pressure than men, suggesting that as with smokers, more women are visiting their GP and having their blood pressure taken, but they are not receiving a confirmed hypertension diagnosis.

The proportion of diagnosed high blood pressure is generally higher in women compared to men across all age groups, with the exception of the 60 to 69 years and 70 to 79 years groups. More women are diagnosed with hypertension at a younger age compared to men, for example, 1.8% of women in the 30 to 39-years age group have a confirmed diagnosis compared to 0.8% of men, whereas the variation between men and women is less pronounced in the older age groups. This is in contrast to known trends in hypertension by sex, as reported by NHS Digital, where the prevalence of hypertension is greater among men than women, and increases more steeply at a younger age among men than women[41]. However, a review of gender differences in clinical features and determinants of hypertension[42] found that men often have lower awareness meaning their hypertension may go undiagnosed or untreated for longer

Men who have not had a primary care appointment in the last 12 months are more likely to have a missing blood pressure reading than women across all age groups, indicating that they are less likely to visit their GP, which is reported in research[43].

[41] Health Survey for England, 2022 Part 2
[42] Gender differences in hypertension
[43] Do men consult less than women? An analysis of routinely collected UK general practice data

2.6.4 Associated programmes of work

People from deprived communities are diverse ethnic communities are less likely to access blood pressure checks in traditional settings such as GP surgeries, so we are engaging with communities about blood pressure and the barriers they face to accessing support and treatment, and working with Primary Care Networks and VCSE organisations to develop and implement both long and short term interventions to improve blood pressure checks in underserved communities, such as:

- Funding PCN level CVD champions to support General Practices to stratify and identify patients with high blood pressure.
- Offering blood pressure checks outside of traditional health settings.
- Working with high-risk communities to encourage healthy lifestyles and hypertension medication compliance.

2.7 Diabetes

2.7.1 Diabetes – Data and analysis

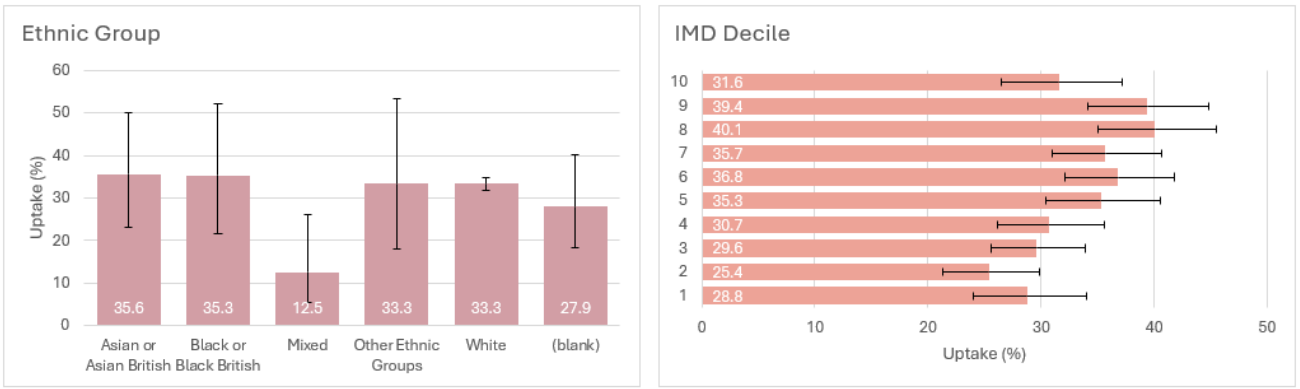


Figure 71: Proportion of people with Type 1 diabetes receiving all 8 care processes. Broken down by a) ethnic group, b) deprivation. Includes people of all ages with diabetes. Source: National Diabetes Audit (NDA), NHS England (2024/25)

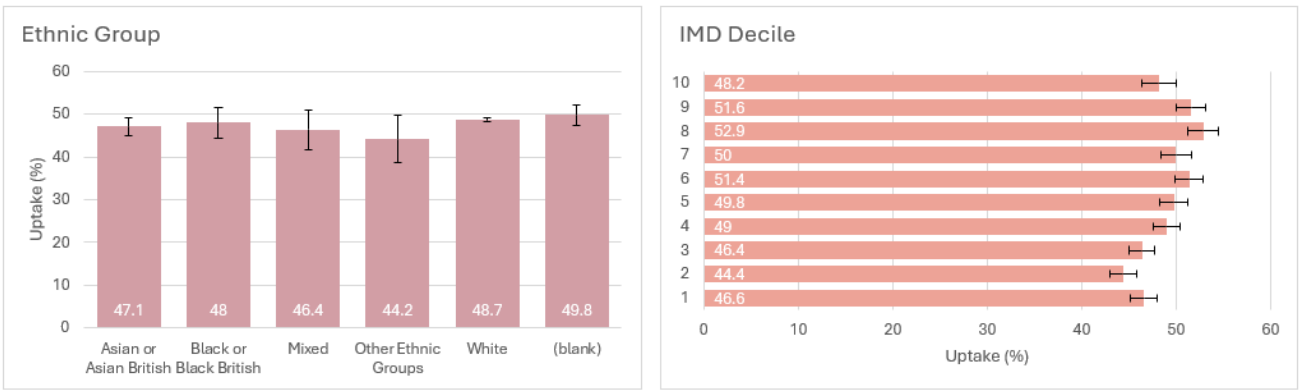


Figure 72: Proportion of people with Type 2 diabetes receiving all 8 care processes. Broken down by a) ethnic group, b) deprivation. Includes people of all ages with diabetes. Source: National Diabetes Audit (NDA), NHS England (2024/25)

The proportion of people with type 1 and type 2 diabetes who have had all 8 primary care processes has decreased across all deprivation deciles and ethnic groups since 2023.

While the proportion of people with type 1 diabetes who have had all 8 primary care processes tends to generally increase with affluence, there is no statistically significant difference between the deprivation deciles. However, for those with type 2 diabetes, people in the more affluent IMDs 8 and 9 are significantly more likely than those in the three most deprived deciles to have had all 8 care processes. These findings correspond to national data from the National Diabetes Audit showing that living in a more deprived area was associated with a reduced likelihood of receiving all 8 care process in people with type 1 and type 2 diabetes[44].

People from White backgrounds with type 1 diabetes are significantly more likely to have had all 8 primary care processes compared to those from the Mixed ethnic group; aside from this, there is no significant difference in the proportion of people with type 1 and type 2 diabetes who have had all 8 primary care processes by ethnic group. In contract to the Gloucestershire data, the National Diabetes Audit found that being from an Asian, Black, or Mixed ethnic group was associated with an increased likelihood of receiving all 8 care processes in people with type 1 diabetes[45]. This may be because there is a higher prevalence of diabetes in these populations, meaning that healthcare providers are more proactive in diagnosing and managing the condition[46] and due to increased awareness and the development of culturally tailored healthcare initiatives in these communities[47].

2.7.2 Associated programmes of work

Improving uptake of primary care processes for people with diabetes in deprived areas requires targeted outreach, improved accessibility, and culturally sensitive engagement. In response to this, we are:

- Carrying out patient stratification to identify those who need additional support to complete the 8 care processes, particularly Core20PLUS5 populations.
- Delivering structured education sessions for type 2 diabetes flexibly across the county to improve access for urban and rural communities, including delivery of sessions in languages suitable to the local population.
- Improving knowledge of diabetes in the Primary Care workforce, upskilling clinicians to identify those who experience barriers to diabetes support and completion of the 8 care processes.

2.8 Smoking cessation

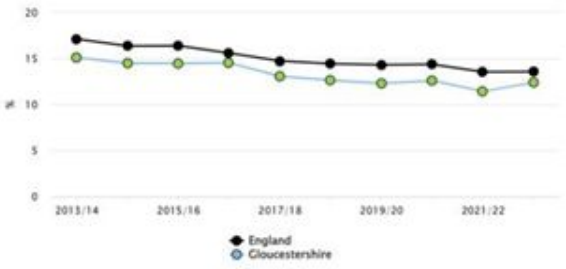
2.8.1 Data and analysis

Adult acute inpatient settings offering smoking cessation services	Maternity inpatient settings offering smoking cessation services
Gloucestershire Hospitals NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust

Figure 73: Adult acute inpatient settings offering smoking cessation services in Gloucestershire. Source: Gloucestershire Hospitals NHS Foundation Trust (2025)

Gloucestershire Hospitals NHS Foundation Trust offers tobacco dependency treatment services to inpatients whilst in hospital and subsequent referral to the Healthy Lifestyles Service (HLS) for continued support following discharge. Furthermore, all pregnant people have their smoking status recorded at booking and are referred to HLS on an 'opt out' basis. Gloucestershire Health and Care NHS Foundation Trust offers tobacco dependency treatment to those accessing inpatient mental health services and this support is continued with the community care teams.

[44] National Diabetes Audit 2021-22, Report 1: Care processes and treatment targets, detailed analysis
[45] National Diabetes Audit 2021-22, Report 1: Care processes and treatment targets, detailed analysis
[46] Health beliefs of black and minority ethnic groups and the implications for diabetes care
[47] A handbook for communicating with black and south Asian communities about Type 2 diabetes

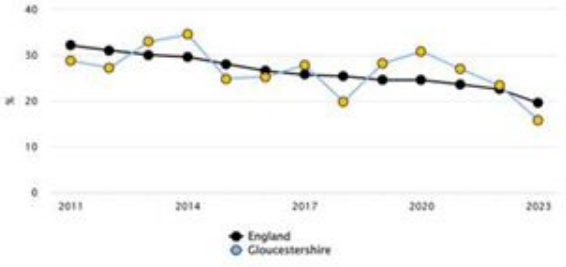


Period		Gloucestershire Count	Value	95% Lower CI	95% Upper CI	South West	England
2013/14		-	15.1%	14.4%	15.8%	16.2%	17.1%
2014/15		-	14.5%	13.8%	15.2%	15.4%	16.4%
2015/16		-	14.5%	13.7%	15.2%	15.1%	16.4%
2016/17		-	14.5%	13.8%	15.3%	15.1%	15.6%
2017/18		-	13.1%	12.4%	13.8%	13.7%	14.7%
2018/19		-	12.6%	12.0%	13.3%	13.7%	14.5%
2019/20		-	12.3%	11.6%	13.0%	13.2%	14.3%
2020/21		-	12.6%	11.9%	13.3%	13.6%	14.4%
2021/22		-	11.4%	10.7%	12.1%	12.1%	13.6%
2022/23		-	12.4%	11.8%	13.1%	12.9%*	13.6%

Source: NHS England

Indicator Definitions and Supporting Information

Figure 74: Smoking prevalence in adults (aged 18 and over) – current smokers (APS). Comparison between proportion of current smokers between England and Gloucestershire. Source: OHID, based on Office for National Statistics data (2013/14 – 2022/23).



Period		Gloucestershire Count	Value	95% Lower CI	95% Upper CI	South West	England
2011		-	28.7%	21.5%	36.0%	31.8%	32.1%
2012		-	27.2%	21.3%	33.2%	31.6%	31.1%
2013		-	32.9%	25.6%	40.3%	30.5%	30.1%
2014		-	34.5%	28.2%	40.8%	31.0%	29.6%
2015		-	24.9%	19.2%	30.6%	28.6%	28.1%
2016		-	25.2%	19.2%	31.2%	25.8%	26.5%
2017		-	27.8%	21.7%	33.9%	26.2%	25.7%
2018		-	19.8%	14.2%	25.5%	25.5%	25.4%
2019		-	28.2%	21.4%	34.9%	26.8%	24.5%
2020		-	30.8%	22.6%	39.0%	24.6%	24.5%
2021		-	27.0%	19.5%	34.4%	21.8%	23.6%
2022		-	23.3%	16.0%	30.7%	21.0%	22.5%
2023		-	15.8%	8.3%	23.2%	19.4%	19.5%

Source: OHID, based on Office for National Statistics data

Figure: 75: Smoking prevalence in adults (aged 18 and over) – current smokers (APS). Comparison between proportion of current smokers between England and Gloucestershire. Source: OHID, based on Office for National Statistics data (2011 – 2023).

Gloucestershire has a lower proportion of smokers compared to the England average and this has remained the case since 2013/14. When analysing the data on the proportion of smokers in routine and manual occupations, this has fluctuated since 2011 and at times has been higher than the England average, which is to be expected as the data for England includes people from all occupations.

The proportion of smokers in routine and manual occupations is 3.4% higher than the proportion of smokers in the rest of the population. This is in line with national data showing that in the UK, people in routine and manual occupations are 2.5 times more likely to smoke than people in managerial and professional occupations[48].

2.8.2 Associated programmes of work

Effective smoking cessation involves a comprehensive system approach and has been identified as one of three priorities for collaborative efforts by the Gloucestershire Health and Wellbeing Partnership (GHWP). Reducing the number of smokers in high-risk groups, such as those in routine and manual occupations, requires targeted approaches and tailored interventions to maximise effectiveness. In response to this, the work that we are doing includes:

- Community engagement to explore the barriers and enablers for stopping smoking among groups that are more likely to smoke and do not traditionally engage with support.

[48] Adult smoking habits in the UK: 2019

- The establishment of the Gloucestershire Tobacco Dependency Outreach Service, which aims to provide targeted, bespoke tobacco dependency support, with a focus on specific cohorts where smoking prevalence is high but engagement with the community service is low.
- Work with the Care Workers Association to address high smoking rates among people who work in the care sector, including the piloting of smoking support within workplaces.

2.9 Oral health

2.9.1 Data and analysis

Figure 76: Admissions for tooth extractions in children aged 10-years and under as of February 2025, age standardised. Broken down by a) district, b) deprivation, c). ethnic group, d) gender, e) age banding. SUS Admitted Patient Care Data.

There is some evidence that the rate of hospital admissions for tooth extractions due to decay for children aged 10-years and under increased over the last two years, but the small numbers of admissions make it difficult to identify trends in the data.

During the COVID-19 pandemic, there was a national decline in the proportion of children seeing NHS dentists within the recommended timeframe (every 12 months), and there have been increases in the number of decay-related tooth extractions in hospitals for children and young people reported in the following years[49]. Waiting times nationally have increased for tooth extraction, particularly those requiring general anaesthetic[50], and this has also been the case in Gloucestershire. During 2024/25, significant progress has been made in treating the backlog of children and young people on the Oral Surgery waiting list, which may account for the increase in rate of extractions that can be seen in

[49] Hospital tooth extractions in 0 to 19 year olds: short statistical commentary 2023
[50] Children waiting more than two years for tooth extractions

2024/25 compared to 2023/24. This will be kept under review as Gloucestershire continues to work on dentistry provision and wider promotion of oral healthcare across the county.

2.9.2 Associated programmes of work

Prevention plays a crucial role in reducing the demand for tooth extractions in children. Early intervention and improved access to dental care can significantly lower rates of tooth decay. Our aim is to improve the oral health of the county including among individuals at greatest risk of poor mouth health, with a focus on addressing health inequalities. We are utilising data intelligence to scope how we actively reduce the oral health inequalities experience by children. This includes:

- Providing oral health packs in community settings including children's centres to reduce the impact of hygiene poverty and ensure that those who need it can access the materials required for good mouth hygiene.
- Increasing dental access for children with a focus on Core20PLUS5 populations, possibly though the provision of Child Friendly Dental Practices.
- Commissioning an Oral Health Improvement Service with scope to reduce oral health inequalities through prevention and awareness raising through a variety of targeted initiatives, including awareness campaigns and community outreach.

2.10 Learning disability and autistic people

2.10.1 Health checks – data and analysis

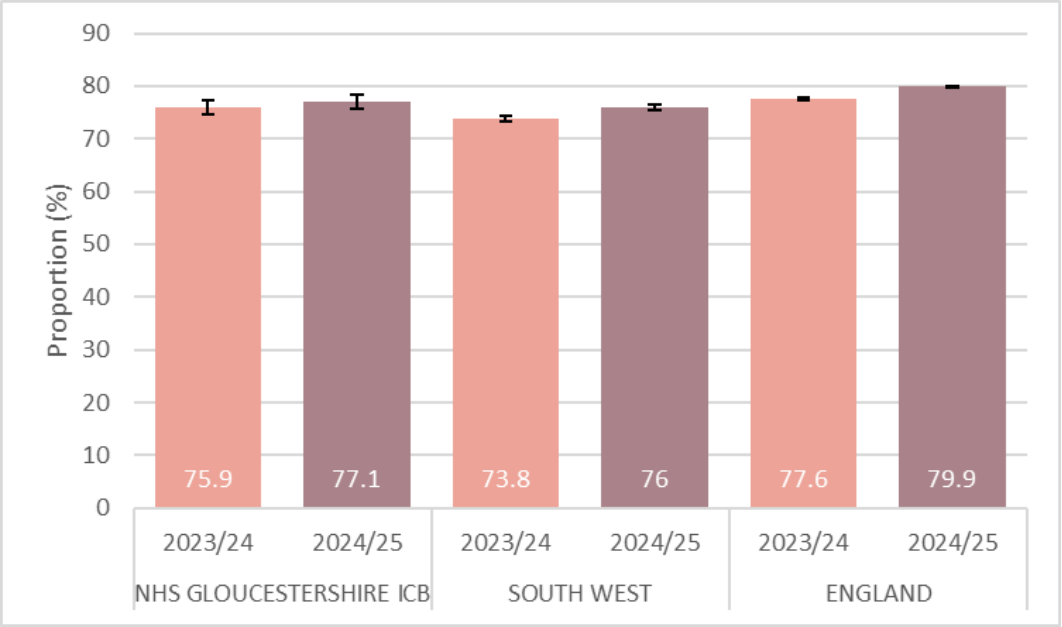


Figure 77: Learning Disability Annual Health Check. Comparison between the proportion of eligible people with a completed Learning Disability Annual Health Check in Gloucestershire, the South West, and England. Includes people aged 14 years and over with a learning disability. Source: Learning Disability Health Check Scheme Statistics, NHS Digital (2023/24 and 2024/25).

The proportion of eligible patients with a completed Learning Disability Annual Health Check in Gloucestershire increased between 2023/24 and 2024/25 but not significantly, whereas the South West and England averages have increased significantly during the same period. The 2024/25 shows that there is no significant difference in the

proportion of eligible patients with a completed Learning Disability Annual Health Check between Gloucestershire and the South West, but the proportion is significantly higher in England compared to Gloucestershire and the South West.

2.10.2 Inpatient Care – data and analysis

Figure 78: Adult Mental Health inpatient rates as of February 2025, age standardised. Broken down by a). district, b) deprivation, c) ethnic group, d) gender, e) age banding. Source: Mental Health Services Data Set.

Adult Mental Health inpatient rates for people with a learning disability and autistic people are significantly higher in people living in the most deprived areas of Gloucestershire. Since April 2023, the inpatient rates for people living in IMD 1 have consistently been higher than the rates for people living in all deciles. In IMD 1 the inpatient rates are highest in the 45-49 and 50-54 age groups, whereas in the general population the rates are highest in the 20-24 age group. While for the general population, mental health admissions are most common in the 20-24 age group, for patients with a learning disability or autism diagnosis, there is less variation according to age, suggesting there may be a lack of community-based support for older patients with these diagnoses, and that there is a greater need for inpatient care throughout their lifetime.

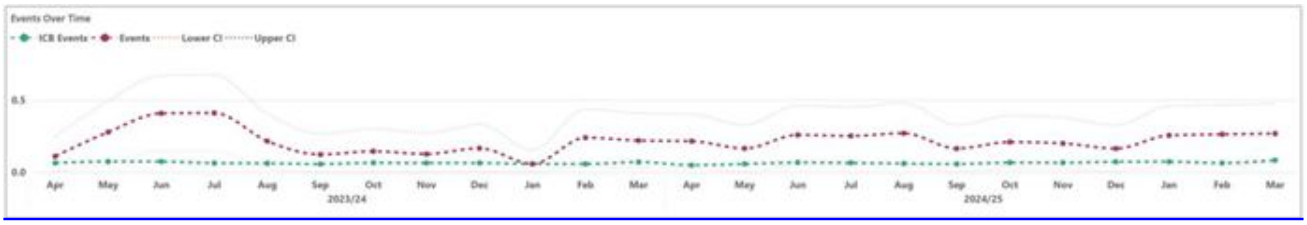


Figure 79: Adult Mental Health inpatient rates as of February 2025, age standardised. Comparison between ICB population (green line) and IMD 1 population (purple line). Mental Health Services Data Set.

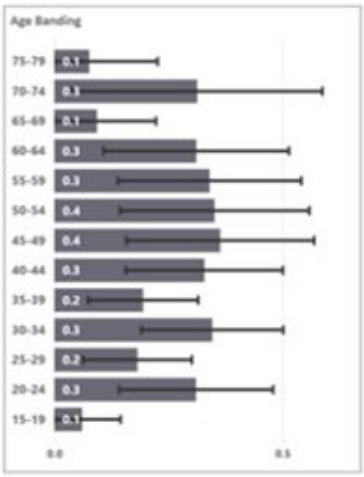


Figure: 80 Adult Mental Health inpatient rates for people living in IMD 1 as of February 2025, age standardised. Broken down by age banding. Mental Health Services Data Set.

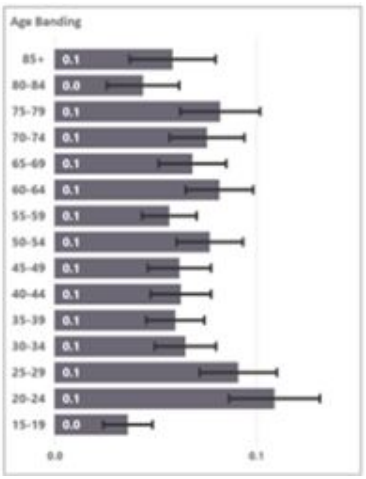


Figure 81: Adult Mental Health inpatient rates as of February 2025, age standardised. Broken down by age banding. Mental Health Services Data Set.

Mental health inpatient rates are higher in people with a learning disability and autistic people from Black or Black British backgrounds compared to people from other ethnic groups, although there are overlapping error bars around this data due to small numbers, making it difficult to identify whether there is a true variation. Mental health inpatients with a learning disability and autistic people from Black or Black British backgrounds are significantly more likely to live in IMD 1 compared to other deciles; this is likely to be due to higher proportions of people from ethnic minority groups living in Gloucester, which is the most deprived district in Gloucestershire.

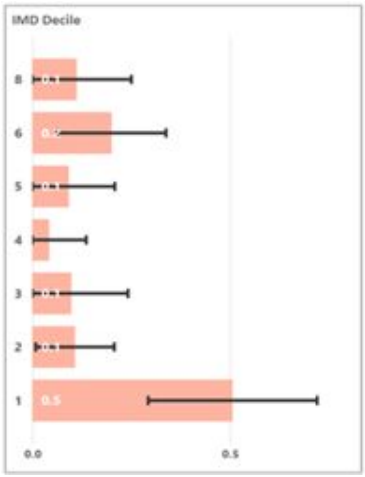


Figure 82: Adult Mental Health inpatient rates for people from the Black or Black British ethnic group as of February 2025, age standardised. Broken down by deprivation. Source: Mental Health Services Data Set.

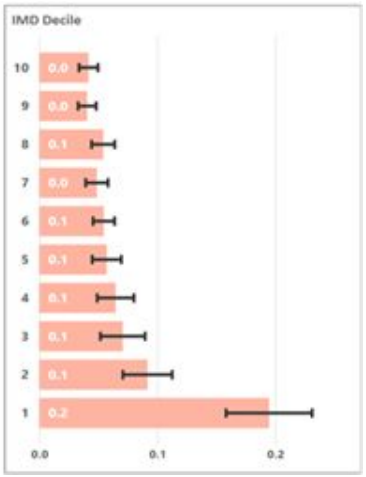


Figure 83: Adult Mental Health inpatient rates as of February 2025, age standardised. Broken down by deprivation. Source: Mental Health Services Data Set.

2.10.3 Associated programmes of work

Following the completion of our annual Learning from Lives and Deaths – People with a Learning Disability and Autistic People report, which reviews the health and social care experiences of people with a learning disability and autistic

people, a new Health Inequalities Action Group is being developed to embed learning from the report into the Learning Disabilities and Autism programme. This will include a joint project addressing access to Annual Health Checks for people with a Learning Disability and Autistic people from ethnic minority communities.

2.11 Maternity and neonatal

2.11.1 Data and analysis

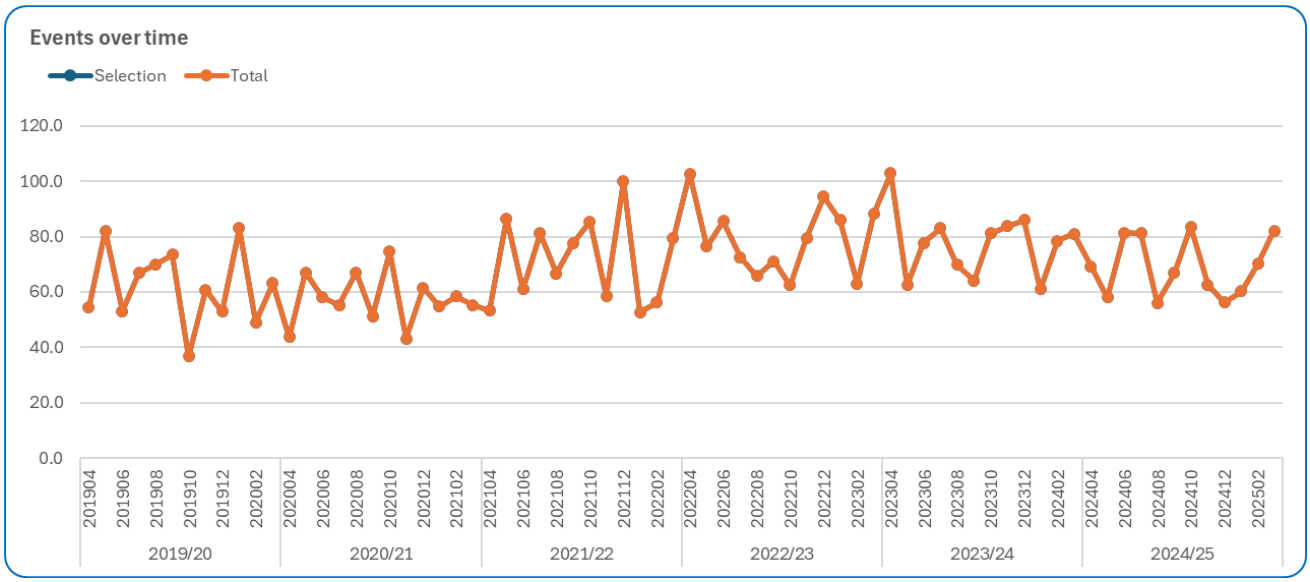


Figure 84: Preterm births under 37 weeks. Crude rate per 1,000 of babies who were born preterm (<37 weeks) between 04/2019 and 02/2025 recorded by Gloucestershire Hospitals NHS Foundation Trust Maternity Services. Source: Maternity Services Data Set, NHS Digital (2019/20 to 2024/25).

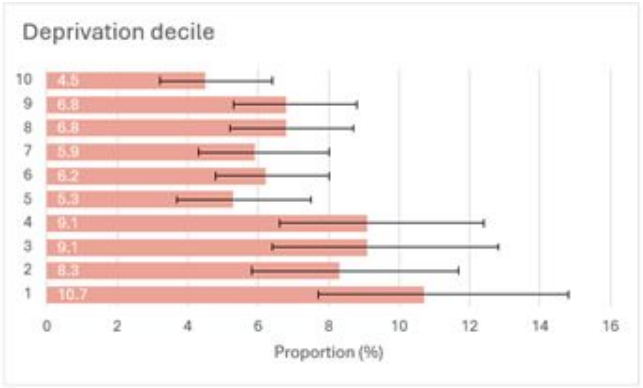


Figure 85: Preterm births by deprivation decile. Proportion of babies who were born preterm (<37 weeks) recorded by Gloucestershire Hospitals NHS Foundation Trust Maternity Services. Source: Maternity Services Data Set, NHS Digital (2024/25).

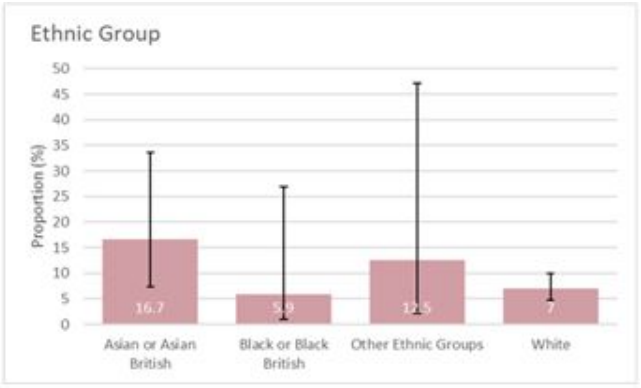


Figure 86: Preterm births by ethnic group. Proportion of babies who were born preterm (<37 weeks) recorded by Gloucestershire Hospitals NHS Foundation Trust Maternity Services. Source: Maternity Services Data Set, NHS Digital (2024/25).

The data shows that there has been an increase in the rate of preterm births in Gloucestershire since 2019/20.

Preterm birth is more common in women from socially deprived areas[51], and this is reflected in the Gloucestershire data, which shows the proportion of preterm births in women living in the three most deprived deciles was higher than those living in other deciles, although there are overlapping confidence intervals around some of the deprivation deciles due to small numbers. We know that in Gloucestershire, women living in the most deprived decile are more likely to book late (meaning their access to maternity care is delayed), to have a BMI over 30, to be smoking at booking, and to be smoking at delivery than all other deciles[52], and these are risk factors for premature births.

The Gloucestershire data does not show any significant difference in the of preterm births between ethnic groups, despite research showing starkly that people from minoritised ethnic groups in the UK are more likely to experience pre-term birth compared to White women[53]. However, this is likely to be driven by poor data quality and low numbers as the proportion of birthing women in some ethnic groups is very small. Data shows that people from diverse ethnic groups in Gloucestershire have a higher rate of late bookings compared to women from White British groups and are therefore more likely to experience poor outcomes[54].

2.11.2 Associated programmes of work

Equitable access to antenatal care for women from diverse ethnic groups and deprived areas requires culturally sensitive healthcare, improved outreach, and better communication strategies. We are analysing late bookings (after 10 weeks) to identify higher rate target groups. Our efforts to improve maternity services access for these groups include:

- Establishment of a maternity Continuity of Career team, perinatal mental health workers and outreach workers, and three perinatal support groups in our areas of highest deprivation and diverse ethnic communities.
- A maternity needs assessment to understand the changing patterns of demand for maternity services in Gloucestershire to inform the development of a new model of quality, equitable care.
- Staff working in maternity and neonatal services are receiving Black Maternity Matters anti-racism training to improve their engagement with women from these communities.

3.0 Conclusion and recommendations

This review, much like last year's, has highlighted ongoing health inequalities in Gloucestershire. People in the most deprived communities and those from diverse ethnic backgrounds continue to experience poorer access to healthcare, lower-quality experiences, and worse outcomes, patterns we had anticipated.

Since last year, we have observed notable improvements in several areas, including a significant reduction in long waits for elective care, increased uptake of the COVID-19 booster vaccination, and a higher proportion of adults with atrial fibrillation receiving treatment to target. However, some measures have remained unchanged, such as non-elective admissions for stroke and myocardial infarction and the proportion of individuals with hypertension being treated to target. In certain areas, the gap between population groups has increased, such as the rate of detentions under the Mental Health Act and the proportion of preterm births between people living in Gloucestershire's most and least deprived deciles. Furthermore, while more eligible patients have completed their Learning Disability Annual Health

[51] Socioeconomic and ethnic disparities in preterm births in an English maternity setting: a population-based study of 1.3 million births

[52] Gloucestershire Local Maternity and Neonatal System – Equity and equality health needs analysis and community assets map

[53] Socioeconomic and ethnic disparities in preterm births in an English maternity setting: a population-based study of 1.3 million births | BMC Medicine | Full Text

[54] Gloucestershire Local Maternity and Neonatal System – Equity and equality health needs analysis and community assets map

Check since last year, Gloucestershire's performance has fallen below the England average since 2022/23. By taking account of the age structure of our population in this year's analysis, comparisons with last year's data have become more challenging. However, moving forward, this improvement will allow for more consistent and meaningful comparisons.

Unexpected or harder to explain disparities between demographic groups have also emerged. Women are more likely to be on the elective care waiting list than men and we would like to understand more about the specific drivers in Gloucestershire. Also, residents of the Forest of Dean appear disproportionately affected, with higher elective care waiting times and increased A&E admissions compared to all districts with the exception of Gloucester. These trends warrant deeper investigation, and we will collaborate with the Elective Care and Urgent and Emergency Care programmes to understand the underlying causes and, where needed, implement targeted interventions to promote equity.

This review has also again demonstrated the need to enhance the quality and completeness of our datasets. This has already been taken forward as one of the main priorities of the Gloucestershire Health Inequalities Framework, ensuring that we are systematically collecting and analysing data to assess disparities in the population. We will continue our efforts to improve data accuracy and integration, aligning it more effectively with work programmes. To facilitate this, we are developing an internal health inequalities dashboard. This tool will enable all programmes to identify disparities within our population and ensure data-driven approaches to service design, delivery, and improvement.