One Gloucestershire
Transforming Care, Transforming Communities

NHS

Joint Forward Plan
2024-29

Appendix

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Our Transformation Programmes:

The table below shows **key** contributions transformation programmes are making to the 3 pillars of the Integrated Care Strategy & 10 strategic priorities.

Integrated Care Strategy Pillar	**Pilar 1 - Making Gloucestershire a better place for the future.**	**Pilar 2 - Transforming what we do.**					**Pillar 3 - Improving health & care services today.**		**Conditions for Change.**	
Strategic Objective #	1	2	3	4	5	6	7	8	9	10
Strategic Objective / Transformation Programme	Increase prevention & improve long-term health outcomes.	Take a community and locality approach to the delivery of care.	Provide the right care in the right place when it is needed most.	Improve quality and outcomes across the whole person journey.	Achieve equity in access, experience and outcomes across health and care.	Create a One Workforce for One Gloucestershire.	Ensure the services we deliver today are sustainable and safe.	Improve the timeliness of care and treatment.	Transforming care through technology and estates.	Create a financially sustainable health and care system.
Enabling Active Communities & Individuals	✓				✓					✓
Health Inequalities Programme					✓					✓
Sustainability Programme					✓				✓	✓
Integrated Locality Partnerships		✓			✓					✓
Life-Course Programmes (Children and Older People)		✓		✓	✓					✓
CPGs – Condition-Based Programmes (eg. Diabetes)		✓		✓	✓			✓		✓
CPGs – Needs-Based Programmes (eg. Frailty)		✓		✓	✓					✓
Primary Care, Pharmacy Optometry & Dental		✓			✓		✓			✓
Diagnostics Programme		✓			✓					✓
Medicines Optimisation					✓		✓			✓
Planned Care & Elective Recovery Programme			✓		✓			✓		✓
Working as One (Urgent & Emergency Care)		✓	✓		✓		✓	✓		✓
Mental Health Programmes (Adults & Children)		✓	✓		✓		✓	✓		✓
Estates Programme					✓				✓	✓
Digital & Population Health	✓	✓		✓	✓				✓	✓
People / Workforce Programme					✓	✓				✓
Quality Improvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Enabling Active Communities and Individuals Programme

Our long-term ambition

We are committed to taking a more preventative approach to health and care. A system-wide focus is required to enable a preventative approach. Our ambition is two-fold:

- Weave prevention, early intervention and support that is focused on helping people stay healthy and live well with any long-term conditions, through all that we do.

- Address the wider social determinants of health outcomes including social networks, employment, housing and the environment.

We are committed to continuing work promoting and supporting people adopt positive health behaviours, through enacting new models of delivery, in new settings and targeted work with those in greatest need.

These healthy behaviours occur in the context of people's lives. Therefore, we recognise tackling the social determinants of health requires us to create the conditions which enable change – facilitated by the building of true partnership work between VCSE and statutory sector organisations and communities.

We are prioritising moving into tackling the social determinants of health – enabled by building of true partnership work between VCSE and statutory sector organisations and communities.

At its core our approach is all about partner and citizen engagement – shifting our system thinking to one where people and communities are at the very centre of how we approach health and care within the county.

This is long-term work requiring culture change in our whole approach to the creation of health in our communities. Putting the way we work on an equal footing with what we do, and consciously focussing effort and resource into developing our practice in that space.

The approach to transformational change is to experiment and learn. Our attention and investment is directed towards creating conditions for effective partnerships as we learn about what is needed in the system. Progress made in 2023/24 in developing our partnerships have laid the foundations upon which we are developing effective system working.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Improve life expectancy at birth and overall life expectancy including reducing the differential between different communities and different population groups.
- Slow the growth in people classed as obese amongst adults in Gloucestershire including reducing the differential between different communities and different population groups.
- Reduce smoking prevalence in adults in Gloucestershire including reducing the differential between different communities and different population groups.
- Reduce the number of physically inactive children and adults – including reducing the differential between different communities and different population groups.

Over the last year we have:

What we have done

- Put in place and spent time embedding a Memorandum of Understanding with the VCSE sector. This has led to an accountability representation model that solidifies the VCSE voice across One Gloucestershire Integrated Care System.
- Gloucestershire VCSE Strategic Partnership has been established to provide the overall direction and governance of VCSE sector engagement with ICS with members elected by the sector and all working within it.

- Secured investment and commenced a training and development upskilling programme for VCSE sector to support prevention and tackling inequalities.
- Continued investment in a range of community-based initiatives through our Strengthening Local Communities Grant.
- Delivered support to treat tobacco dependency for patients in Acute Inpatient and Maternity settings (the latter went live in October 23 in the most deprived areas of Gloucester).
- Continued to play a place-shaping role in improving healthy weight through initiatives such as We Can Move and locality-based initiatives such as Inner-City Gloucester Primary Care Network that has increased referrals in weight management and associated support.

What impact it has had

- Helped build the conditions for partnership working.
- Through our work to build partnerships with the VCSE sector, we have seen innovation across our system to involve more people, communities and organisations in our shared vision for a healthier county. The examples can be seen throughout our system as described within this Joint Forward Plan.
- Improved conditions for partnership have enabled a fuller contribution from VCSE in the commissioning in a CPG (Pain) particularly around co-production and development of peer support.
- More people have been supported to stop smoking.

Over the next 2 years we will:

What we are aiming to achieve next

- Increase the number of people being referred to digital weight management (healthy weights) service.
- Increase the number of people supported through stop smoking programmes – particularly in acute, maternity *(to 6% by 2025)* and mental health inpatient settings.
- Increase the number of people supported through the creative health programme – with a focus on engagement in more deprived communities and racially deprived communities.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Healthy Weight					
Continue to act as a key partner to increase physical activity levels across the county with We Can Move.	✓	✓	✓	✓	✓
Smoking					
Expand the tackling tobacco dependency programme in acute, maternity and mental health inpatient settings.	✓	✓			
Community Wellbeing					
Scope, engage and remodel the Community Wellbeing Service in Gloucestershire	✓	✓			
Social Value and Cultural Commissioning					
Develop a Cultural Commissioning Strategy to support an increase in capacity and capability across the Integrated Care System.	✓	✓	✓		
Work with partners to develop and embed a Social Value Policy that help us to evaluate the long-term work on improving heath and wellbeing outcomes for our population.	✓	✓	✓		

Health Inequalities Programme

Our long-term ambition

As a system we are prioritising our work to address health inequalities which are differences in health status, access to care, treatment and outcomes between individuals and across populations that are systematic, avoidable, predictable and unjust.

Whilst Gloucestershire's good overall level of health and wellbeing conceals large disparities. We know that we have a persistent, long-term health inequalities gap in our county.

The One Gloucestershire Integrated Care Strategy sets out our 5-year ambition that all staff working in our system, supported by our maturing Population Health Management approach and data, will understand health inequalities – what they are, why they matter and what action they could take within their roles.

It is a role for all transformation programmes to prioritise improving health equity. This includes addressing health inequalities in experience, access and outcomes and inequalities between different groups of people such as those with protected characteristics, socio-economic groups and geography.

This is the responsibility of all transformation programmes and has been embedded throughout the Joint Forward Plan.

We also have a programme of work that is helping to coordinate and bring leadership to our work in this area as described below. This includes improving data quality and completeness in order to improve how we assess whether improvements are being made to different population groups in access and outcomes.

Our long-term outcomes over the next 5 years and beyond are:

Through our coordinating work on health inequalities:

- To embed a commitment across all transformation programmes to tackle health inequalities – with a particular focus on a). the contributory activities they are making; b). the targeted interventions they are making to improve health and remove barriers and c). improving the equity of mainstream service delivery.

Through the work of our transformation programmes:

- To improve health equity for the 20% of most deprived areas in Gloucestershire (CORE20): Of the 373 Lower Super Output Areas (LSOAs) in Gloucestershire, 31 count amongst the most deprived 20% in England (8.2% of our county's population).
- To improve race relations across Gloucestershire (PLUS): Following an independent Commission report into race relations in Gloucester City we are prioritising work in this area, while ensuring that we consider a wider range of inclusion health groups who are more likely to experience poorer-than-average health access, experience and/or outcomes in our work.
- To improve outcomes across 5 clinical areas for adults & children across Core20PLUS5.

Over the last year we have:

What we have done

Our overall approach to improving health inequalities:

- Appointed two SROs for health inequalities including Director of Public Health for Gloucestershire County Council and CEO for Gloucestershire Health and Care NHS Foundation Trust.
- Developed a framework for considering health inequalities, using this as a mechanism for programmes to report back against the work they are doing to tackle health inequalities. This framework enables our focus on health inequalities to be visible throughout all of our work.

- Worked with research and VCS partners to deliver a project aimed at more proactively engaging with people and communities in health research with a specific focus on those impacted by health inequalities.
- Recruited over 1,000 local residents to join the One Gloucestershire People's Panel – people recruited are representative of the Gloucestershire population and engagement work has already been undertaken with the Panel to understand their views of health and care areas.

The specific contribution that transformation programmes are making to improving health equity as outlined within this Joint Forward Plan.

Looking to the future we will:

What we are aiming to achieve next

- Embed the framework of health inequalities enabling programmes and organisations to be able to report on their contribution to addressing health inequalities and through this ensure that there is a clear understanding of opportunities for improvement.
- Support transformation programmes in better understanding the actions they could be taking to improve health inequalities through communications and engagement, including promoting the Prevention and Health Inequalities Hub.
- Improve reporting of health inequalities within programmes – promoting data completeness and providing reports that highlight improvements and gaps in improving access, outcomes and experience for different population groups.
- Continue our commitment to Core20PLUS5 across our transformation programmes.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Programme Leadership and Governance					
Further develop our approach to health inequalities including system wide governance arrangements	✓	✓			
Carry out a stock-take to understand the breadth of work and identify gaps and opportunities for improvement	✓	✓			
Embedding Health Inequalities within Programmes					
Develop the approach to Equality and Engagement Impact Assessments across the system to ensure that service changes further describe the impact on health inequalities	✓	✓	✓	✓	✓
Launch the Gloucestershire Prevention and Health Inequalities Hub to help our staff better understand actions to improve health equity	✓				
Improving the equity of mainstream service delivery					
Produce an annual review of inequalities in particular areas to encourage better quality data, completeness, and transparency	✓	✓	✓	✓	✓
Develop a system outcomes dashboard to identify progress on reducing inequalities in life expectancy	✓	✓			

Sustainability Programme

Our long-term ambition

The NHS vision is to deliver the world's first net zero health service and respond to climate change, improving health now and for future generations. This means improving healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere.

In Gloucestershire, we share this ambition and our Green Plan (2022-25) serves as our shared proposals for how we will collectively reduce our emissions and support the delivery of our wider sustainability objectives.

Our six sustainability priorities to deliver against these ambitions are:

- **Transport and Travel**
- **Estates and Facilities**
- **Climate Adaptation**
- **Sustainable Models of Care**
- **Medicines and Procurement**
- **Workforce and System Leadership**

We will contribute to these long-term outcomes over the next 5 years and beyond:

- For the NHS to reach net zero by 2040 (Carbon Footprint) – achieving an 80% reduction in emissions between 2028-32 (against 1990 baseline)
- For the NHS to reach net zero by 2045 (Carbon Footprint Plus) – achieving an 80% reduction in emissions between 2036-39 (against 1990 baseline)

Over the last year we have:

What we have done

- Secured funding for the expert third-party review of our system estate to install Electric Vehicle charging points for fleet cars and district nursing teams, and formed a system project group, including the Local Authority, to develop An EV charging plan.
- Promoted the use of public transport with staff – seeking to reduce business mileage.
- Introduced automated meters and leak detection devices into community trust facilities.
- Introduced digital monitoring technologies enabling us to monitor patients more effectively through the new "Virtual Ward".
- Increased the green space and garden areas around Cheltenham General and Gloucestershire Royal Hospitals.
- Developed and launched shared education materials across all partner induction programmes, to deliver a consistent and ambitious message to all new staff members.
- Implemented sustainability initiative within primary care building on the previous year's scheme.
- Significantly increased the number of low dose inhalers in use within the County and reduced the emissions from anaesthetic gases (nitrous oxide).

What impact it has had

- More staff are using the shuttle bus for transport to our acute hospital sites in the county.
- Reduced nitrous oxide use saving 430 tonnes of CO2 per annum (equivalent of driving a family car 1.6 million miles or 65 times around the globe).
- Continued to reduce the environmental impact of inhalers.
- Our community and mental health provider reduced their carbon footprint by 33% (against the 19/20 baseline) in 22/23.

Over the next two years we will:

We will continue to deliver against our six sustainability priorities set out in our Green Plan. Our key commitments are set out below:

What we are aiming to achieve next

- Develop and start to implement sustainable travel plans across the county building on initiatives already in place.
- Reduce the use of single use plastics across the county including gloves and aprons.
- Work with System partners on a climate risk adaptation assessment and develop plans following this to mitigate risks.
- Continue to reduce emissions from our buildings.
- Continue to reduce emissions from medicines and procurement including further reduce the prescribing of CFC inhalers across Gloucestershire and medical gases such as Entonox.
- Continue to reduce emissions from fleet vehicles (initially through new electric vehicles).

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Transport and Travel					
Develop sustainable travel plans by 2026 including the development of e-bike, a bus incentive scheme and salary sacrifice schemes to support the move to electric vehicles.	✓	✓			
Ensure that all new vehicles in the NHS by 2027 will be zero emissions (excluding ambulances).	✓	✓	✓		
Estates and Facilities					
Introduce a new recycling contract to help reach our commitment to recycling of non-clinical waste.	✓	✓			
Develop a heat carbonisation plant & remove the oil fire central heating boiler at Gloucester Royal Hospital.	✓	✓	✓	✓	
Sustainable Models of Care					
Rollout a new patient portal to reduce paper copies of letters and other printing.	✓				
Implement electronic ordering of food to reduce waste (both GHFT and GHC).	✓	✓			
Medicines and Procurement					
Switch to low carbon inhalers and scope an inhaler recycling scheme.	✓	✓	✓	✓	✓
Continue to reduce the amount of anaesthetic gases we use in hospitals.	✓	✓	✓	✓	✓
Reduce the inappropriate use of single plastics such as gloves and aprons in operating theatres and across GP Surgeries.	✓	✓	✓	✓	✓
Workforce and System Leadership					
Relaunch the Green Champions programme during 2024/25 to help embed sustainability	✓	✓	✓		
Develop a Climate Risk and Vulnerability Assessment with Climate Leadership Gloucestershire	✓				

Review adaptation measures including heat wave plans, over heating events, assessment of flood risks to our sites with the development of actions as appropriate.	✓	✓			

Integrated Locality Partnerships

Our long-term ambition

In Gloucestershire we want to ensure we support communities to be empowered to build on the strengths and assets they have.

At the heart of this are the 6 Integrated Locality Partnerships across Gloucestershire. We are committed to the development of strong, mature partnerships in every locality with wide membership from partners and communities.

They are about bringing together partners to help:

- Proactively reduce the impact of root causes of health inequalities.
- Improve health and wellbeing.
- Work collectively to redesign care for people in localities and supporting them to live well at home.

Many of our ILPs are having a significant contribution to improving children and young people's mental health and wellbeing and supporting cohorts of pre-frail and mildly frail people to live and age well across the county.

Over the next two years, we aim to make sure we increase the involvement of people, the Voluntary, Community and Social Enterprise (VCSE) sector and communities more generally in projects across the county with a focus on increasing independence and health equity.

Our long-term outcomes over the next 5 years and beyond are:

- Support people and communities to be empowered to build on the strengths and assets they have and enable people to live well at home.
- Ensure that there is a close alignment between priorities and resource allocation within localities.
- Ensure strong, mature partnerships in each locality with wide membership from partners and communities.

Over the last year we have:

During 2023/24, we have built on the strong foundations created across the county with each of our six ILPs reviewing its membership and consolidating their priority projects. The work continues to be informed by a Population Health Management approach.

What we have done

- Supported projects in all localities through Strengthening Local Communities Funding
- Supported the delivery of the three exemplar themes in the One Gloucestershire Integrated Care Strategy – employment, smoking and blood pressure monitoring.
- Committed funding to the delivery of Community Health and Wellbeing Hubs in deprived areas of Gloucestershire that are designed to be flexible to meet the local needs in communities.
- Additionally, work in localities has achieved the following:
  - **Cheltenham**: Focused on projects falling within the Core20+ group such as such as substance misuse screening, a befriending scheme for people struggling with loneliness, and mentoring young people who are awaiting mental health interventions.
  - **Cotswolds**: Supporting people living with frailty - including offering strength and balance classes, healthy cooking and eating sessions.
  - **Forest of Dean**: Focus on projects that improve children and young people's mental health and educe obesity, support for drug and alcohol misuse and also pre-diabetics.
  - **Gloucester**: Delivering against 3 priority areas of Active Places; Active Spaces; and Active People.
  - **Stroud & Berkeley Vale**: Supporting people with frailty as well as their carers and developing a programme of activities for children to Get Active, Get Creative and Get Outdoors.

- **Tewkesbury**: Delivering against priorities of children and young people's mental health and employment.

What impact it has had

Some examples of the impact of the work in localities are:

- **Cheltenham:** Offering health, housing benefit and job support to over 40 people in West Cheltenham and supporting over 15 parents and carers to access support for children and young people in the locality.
- **Cotswolds:** 102 socially isolated and frail people have been supported via signposting to VCSE organisations such as Cotswolds Friends. In addition, healthy cooking and eating classes have been attended by 106 people with 27 families cooking over 25 different meals.
- **Forest of Dean:** 30-40 people have attended meals at the Lunch Club/Warm Space in the Forest of Dean. Additionally, welcoming 25-30 people to the Forest of Dean community hub, together with a growing number of Volunteers
- **Gloucester:** Use of the Strengthening Local Communities Grant in Gloucester has resulted in funding for 27 organisations supporting 14,000 individuals with 121 volunteers providing 1,457 hours of time.
- **Tewkesbury:** 117 young people (aged 12-16) took part in the Tewkesbury Youth Voice Forums.
- **Stroud and Berkeley Vale:** Over 3,000 carers have been supported in the locality with over 600 new carers being identified. 525 attendances to Harmony singing classes, 40 attendances to craft and arts sessions and a similar number of attendances to natural wellbeing and mindful photography sessions.

Over the next 2 years we will:

During 2024/25, each ILP will prepare an annual workplan which describes the work they will do to deliver their priorities and continue to involve local people in developing projects which promote independence and health equity.

What we are aiming to achieve next:

- Contribute to supporting pre frail and mildly frail people to live well at home.
- Contribute to supporting Children and Young People to live well in their communities.
- Ensure a greater involvement of people, VCSE and communities in priority projects across localities with a focus on improving independence and health equity.
- Support strong local governance (as non-statutory partnerships) with accountability for transformational change over the medium to longer-term.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Support delivery in ILPs against local and system priorities					
Contribute to supporting pre frail and mildly frail people to live well at home.	✓	✓			
Contribute to supporting Children and Young People to live well in their communities.	✓	✓			
Support the identification of priorities within ILPs ensuring alignment with Strengthening Local Communities Grant funding	✓	✓	✓	✓	✓
Contribute to the ICP exemplar themes – blood pressure, employment and smoking	✓	✓	✓	✓	✓
Support greater involvement of people & communities					

Consider where ILPs can strengthen their links to people and communities	✓	✓			
Strengthening links with Know Your Patch networks and VCS Forums	✓	✓			
Involve people with lived experience that help sharing ideas and aligning priorities.	✓	✓	✓		
Support strong local governance					
Periodic (likely annually) member surveys to inform our future direction	✓	✓	✓	✓	✓
Develop annual workplans with each ILP – commencing from 24/25 and report to EAC-I.	✓	✓	✓	✓	✓

Children and Young People, Ageing Well and End of Life Care Programmes

Our long-term ambition

Our One Gloucestershire vision is to make Gloucestershire the healthiest place to live and work – championing equity in life chances and the best health and care outcomes for all. Our programmes have areas of focus across all phases of the life journey, from childhood through to frailty and end of life care so that we can ensure that the services we provide, regardless of age are effective.

For children and young people we remain committed to early help and support, working together to improve health and care outcomes. This means integrating services so they are better connected (with a particular focus on children living with long-term health needs) and also support young people with transition to adulthood.

In line with our focus on SEND, we are committed to the development and implementation of a SEND Commissioning Strategy, to promote our joint approaches to meeting the needs of children and young people with SEND in a timely manner across universal, targeted and specialist provision.

For older people we are committed to interventions that build resilience, helping maintain independence - minimising periods of ill-health and the impact of frailty. We will facilitate networks of support within communities to support people to live longer in good health. Our future Proactive Care Strategy will set out our response to the National Proactive Care Framework. Our focus will be on maximising the number of years each person spends in good health adding quality to life, reducing crisis and unplanned care.

We know that over the next 5 years the largest increase in our population will be those living over the age of 85. We also know we have a growing number of children and young people living with life limiting and lift threatening conditions who also require palliative care. We will take a proactive approach to end-of-life care, promoting the importance of early identification and shaping services so that people receive the care and support they need to live well and die well. Our Palliative and End of Life Care Strategy (2021-2025) describes our aim to deliver good end of life care, so that the last stages of peoples' lives are they best they can be, and the people important to them are also cared for and supported.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Ensure that the services we provide, regardless of age, are timely, effective and accessible – with reduced waiting times for assessment and support.
- Provide personalised care and prevention services in the community that promote health and wellbeing for all and make every contact count.
- Slow the growth in attendances, admissions and length of stay for children and young people (with specific life limiting conditions) and patients living with frailty.
- Reduce the number of unplanned acute admissions in the last years of life for older people.

Over the last year we have:

Invested in a number of ways to improve outcomes for children and young people as well as older adults. We are increasing early help and support for children including in schools as well as proactively identifying older people to support them to remain at home for longer.

What we have done

- Designed an end-to-end pathway for children's weight management ensuring that there is a medical offer alongside existing voluntary and community sector provision for young people.
- Expanded medical needs in schools training provision - supporting teaching staff in special schools to support children and young people.
- Implemented a 'Personalised Proactive Whiteboard' to 13 of the 15 Primary Care Networks to identify adults in their last year of life.

- Established a Rapid Home to Die pathway with a discharge facilitator in the hospital enabling people to leave hospital quicker if their choice is to die at home
- Expanded the High Intensity Users Service in order to provide intensive support to adults who use health and care services disproportionately to their needs with evaluation showing a 50% reduction in hospital admissions.

What impact it has had

- More people requiring a 2-hour urgent response (via our Rapid Response Service) are receiving it now within that time frame and more than 80% of those treated do not require onward conveyance.
- More care homes now have Falls Champions – over 30% of care homes for older people now have this in place and bespoke support is being provided to the top 20% of homes with the highest rate of ambulance conveyances.
- More people on the end of life register now have a preferred place of death recorded a slight increase from 9.4% in 21/22 to 9.7% in 23/24.
- Fewer people are dying in an acute hospital compared to last year. In 2021/22 28% died in an acute hospital, in 2023/24 23% died in the acute hospital.

Over the next two years we will:

We will develop and pilot new ways of working while continuing to focus on reducing waiting times, especially for children and young people with higher needs.

What we are aiming to achieve next:

- Increase the number of children supported at school or in early years with speech, language and communication needs.
- Reduce waiting times for assessments and support in key services for children and young people.
- Increase the numbers of people accessing a 2-hour urgent community response service
- Improve the experience of young people transitioning from children to adult health services
- Increase the number of people with personalised care and support plans in place.
- Reduce the number of conveyances to hospital from residential care and nursing homes.
- Improved the identification of people who are approaching the end of life, ensure they have a recorded end of life care preferences and support them to die in their preferred place - therefore reducing the number of people dying in hospital.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Children and Young People Clinical Programme Group					
Continue the integration of health services for children in care (mental health with physical health)	✓	✓			
Pilot and evaluate the new children's integrated healthy weight service.	✓				
Pilot the Early Language Support for Every Child (ELSEC) to support language and communication	✓	✓			
Older People (Ageing Well Programme and Frailty Clinical Programme Group)					
Deliver a system wide Proactive Care Strategy to enhance our integrated neighbourhood team approach	✓				
Implement the refreshed National Enhanced Health in Care Homes Framework focusing on improving the quality of life for people living in care homes.	✓	✓			
Improve our delivery of proactive care to reduce geographical variation so more people living with	✓				

frailty and other long-term conditions receive support to remain at home for as long as possible.					
Increase the number of care homes receiving support including the falls programme and provide bespoke assistance for homes where conveyances are greatest	✓	✓	✓	✓	✓
Fully rollout and evaluate the Personalised Care Whiteboard to support proactive care deliver personalised proactive care in the community	✓	✓			
End of Life & Palliative Care Clinical Programme Group					
Introduce an urgent care hub that provides advice and support for families and carers at end of life	✓				
Review our commissioning arrangements for adult hospice provision across the county.	✓				

Clinical Programme Groups (Diabetes, Respiratory, Cancer and CVD/ Circulatory Programmes)

Our long-term ambition

Similar to other areas in the country, we have more people in Gloucestershire living longer with multiple long-term conditions.

Our well-established Clinical Programme Approach is our local response to the national ambitions set out in the national Major Conditions Strategy. This section describes our response to four of these areas – cancer, CVD (including stroke), diabetes and respiratory conditions.

Across these areas, we want to do educate people about preventing serious conditions before it occurs (primary prevention), diagnose and treat people earlier (secondary prevention), support people to live well with long-term conditions and where possible support them to manage their conditions at home (tertiary prevention).

Whilst our response here describes the work we are doing on addressing individual diseases, we are also shifting more towards integrated care – recognising that many people in Gloucestershire are living with multiple-long-term conditions.

Our 5-year ambitions are stretching, given that many of these changes will take time to deliver. But there is a commitment from across all partners to both prevent as well as support people living with these long-term conditions.

We will contribute to the following long-term outcomes over the next 5 years and beyond:

- Continue to increase early diagnosis in primary care for key long-term conditions including type 2 diabetes, CVD, cancer and respiratory conditions such as COPD and asthma.
- Slow the growth in A&E attendances, ED admissions and acute length of stay for major long-term conditions – diabetes; CVD (including heart attack, stroke, heart failure) and respiratory conditions - and the number of patients diagnosed with cancer following an emergency admission.
- Contribute to slowing the growth in people living with long-term conditions including diabetes, CVD, cancer and respiratory. Empowering people to live well and self-manage conditions.

Over the last year we have:

What we have done

Diabetes

- Widened access to diabetes technology in line with NICE guidelines through our promotion and funding of Continuous Glucose Monitoring.
- Commissioned the creation of Diabetes Champion roles in primary care to support the upskilling of the primary care workforce.
- Participated in initiatives to improve outcomes for people with early onset Type 2 diabetes (aged 18-39).

Respiratory

- Increased the number of quality assured diagnostic tests for COPD and asthma conducted in primary care which are helping to ensure that people get the correct treatment at an earlier stage and optimise their medications.
- Launched two Acute Respiratory Infection (ARI) Hubs in January 2023 in some of the most disadvantaged communities in Gloucestershire, reducing secondary care related attendances, providing more effective management of acute presentations and optimising referrals into the virtual ward.

- Embedded COPD and Asthma diagnostic testing within Primary Care and the ongoing development of the Respiratory Champion role to support the upskilling of Primary Care respiratory workforce.
- Continued to provide Integrated Community Clinics with a view to reviewing complex respiratory and other breathlessness patients to improve their management plans within the community which would include medicines optimisation.
- Undertaken in depth audits of patients on nebulisers with clear outcomes that will influence ongoing pathways which will support the financial sustainability of this contract.

CVD/Circulatory

- Begun to develop a partnership approach to identifying challenges and solutions for and with our population relating to hypertension as part of the Exemplar Themes work.
- Ran public awareness events to help raise awareness about the importance of managing Hypertension as part of the 'Know Your Numbers' campaign. This included undertaking over 500 blood pressure checks with members of the public.
- Established a new Community Neurology Service which will give us more capacity and choice to support people to rehabilitate after a stroke.

Cancer

- Made changes to our cancer pathways to provide a more personalised approach and to ensure everyone can receive the diagnosis and treatment they need in a timely way.
- Ran public awareness events to help people recognise the signs and symptoms of skin, lung, colorectal and breast cancers.
- Piloted a prehabilitation service to help patients prepare for cancer treatment leading to a reduction in length of stay, admissions and use of the helpline post treatment.
- Completed roll out of the non-site-specific symptom pathway to help diagnose rarer cancers early and reduce the number of these cancers diagnosed following an emergency admission.
- Delivered a series of GP Masterclasses covering Lower GI, Gynae, Prostate, Haematology and Sarcoma cancers to over 143 GPs, nurses and other HCPS across 46 practices from all 16 PCNs.

What impact it has had

- Offering education on referral pathways to GPs and nurses to ensure practice teams knowledge is up to date, any local challenges on referral pathways are understood, to support clinical decision making and appropriate referrals. Improved relationships between GP practices and the hospital teams and peer support.
- Increased the quantity of prescribed continuous glucose monitoring (increase of 18% between June and August 2023).
- Ensured that 75% of people have a cancer diagnosis in 28 days (performance above target for 6 of 9 months of the year) and reducing time to diagnosis.
- Over 80% of Lower GI 2-week wait referrals are accompanied by FIT result improving triage times to diagnostics.
- Treated 65% of cancer patient referrals in 62 days (December 2023) – although this remains lower than the target of 85%. Unfortunately, the number of patients waiting (248 in January 24) has also remained higher than the target of 170 caused primarily by industrial action.
- Over in 600 complex patients with respiratory needs have been reviewed in primary care (since the implementation of the clinics) by a holistic team including a consultant who would have otherwise sought expert advice from secondary care.
- Over 12,700 patients seen in ARI hubs. The evaluation shows that there has been an impact on ARI ED attendances, showing a 7.1% difference in attendances from ARI hub areas compared to other non-ARI localities (lower attendances in ARI hub areas).
- Over 7400 FeNO tests have been undertaken in 23/24 in Primary Care as per best practice for the review and diagnosis of asthma, pre-covid there were 0 FeNO tests undertaken in county and therefore asthma was being diagnosed without any assured form of testing.
- Our diagnosis rate for hypertension is at 60.3% (June 2023) and our treated to target rate is 65.2% (June 2023).

- Feedback from the Know Your Numbers campaign was positive and over 100 people were signposted to additional support after having their Blood Pressure checked on the bus.

Over the next 2 years we will:

What we are aiming to achieve next

Diabetes

- Increase the number of individuals who are receiving annual diabetes reviews and completing the 8 care processes and three treatment target attainment.
- Support more people to access and complete the National Diabetes Prevention Programme
- Support more people to access structured education for self-management of their condition.
- Embed and develop the Diabetes Champion role in Primary care to improve diabetes care delivery.

Respiratory

- Increase the number and holistic quality of asthma and COPD annual reviews carried out in primary care.
- Implement a diagnostic complex breathlessness pathway with up to 1000 tests undertaken per annum and a comprehensive onward referral system.
- Increased referrals and completions to Pulmonary Rehabilitation.
- Develop a community offer to support patients to prevent or delay their deterioration prior to referral to pulmonary rehab.
- Improve integrated working across the respiratory pathway by improving and verifying the skill mix of the wider team to manage more complex patients in the community.
- Aim to introduce integrated community clinics within all 15 PCN's prioritising those with a higher clinical need or health inequalities.

Cancer

- Support more people to be diagnosed earlier for cancer (cancers diagnosed at stages 1-2).
- Maintain high numbers of people being diagnosed/given an all clear within 28 days of referral.
- Increase the number of people receiving treatment within 62 days of referral.
- Follow up and Surveillance (for potential reoccurrence and management of treatment related side effects)
- Improve the number of eligible patients attending invitation for cancer screening.
- Raise awareness of cancer signs and symptoms though a number of public engagement events.

CVD and Circulatory

- Increase the percentage of hypertension patients whose blood pressure reading is below the target treatment threshold *(ambition of 80% by 2029)*
- Increase the proportion of people aged 25-84 with a CVD risk score greater than 20% on lipid lowering therapies *(ambition of 60%).*
- Increase the percentage of patients receiving a medical thrombectomy as a percentage of all stroke patients *(target of 10% by end of 25/26).*

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Diabetes Clinical Programme Group					
Continue to widen access to diabetes technology (Continuous Glucose Monitoring & Hybrid Closed Loop Technology)	✓	✓	✓		
Improve access to structured education for people living with type 1 and 2 diabetes	✓	✓			
Improve access to national diabetes prevention programme	✓	✓			
Embed and evaluate the impact of the Diabetes Champion Role within Primary Care	✓	✓			

Respiratory Clinical Programme Group					
Create Asthma Friendly Schools in Gloucestershire including school training	✓	✓			
Deliver improvements to the Pulmonary Rehabilitation.	✓	✓			
Introduce wider skill mix to integrated community clinics within all 15 PCN's.	✓	✓			
Solidify diagnostic LES in Primary Care with a view to making it BAU by end of 24/25	✓				
Deliver complex breathlessness diagnostic activity from the Community Diagnostic Hub.	✓	✓			
Continue to support delivery of ARI hubs alongside the development of a cohesive winter resilience plan (subject to 24/25 funding).	✓	✓			
Cancer Clinical Programme Group					
Continued Best Practice Timed Pathway actions for cancer areas to improve waiting times.	✓				
Take part in the national pilot to carry out blood tests for early cancer screening (multi cancer blood test programme)	✓	✓			
Commence Targeted Lung Health checks to identify people with lung cancer before becoming symptomatic	✓	✓			
CVD/Circulatory Clinical Programme Group					
Launch an MOU to support primary care to continue to prioritise CVD prevention (e.g. carry out blood pressure checks and treat patients to target)	✓	✓	✓	✓	✓
Embed and evaluate the delivery of the Community Neurological Service	✓	✓			
Review the stroke pathway with the aim of developing an Integrated Stroke specification and pathway	✓				
Deliver Improvements across the Heart Failure Pathway (including via a Heart Failure Virtual ward).	✓	✓			

Dementia, Frailty, SEND, Learning Disabilities & Autism and Maternity and Neonatal Programmes

Our long-term ambition

We have a commitment to support people with different health and care needs.

In maternity services we will support implementation of the national Maternity and Neonatal Three Year Delivery Plan by 2026. We are developing a single system action plan that will better enable us to monitor progress of CQC, Safeguarding, Ockenden and Saving Babies Lives' action plans. We will concentrate efforts on four themes:

- Listening to and working with women and families with compassion.
- Growing, retaining, and supporting our workforce.
- Developing and sustaining a culture of safety, learning, and support.
- Standards and structures that underpin safer, more personalised, and more equitable care.

Both our Frailty Strategy (2022-27) and Dementia Strategy describe our plans for people living with these specific health needs. In both of these areas our emphasis is on:

- Prevention through education and awareness
- Early diagnosis through work in primary care and the community
- Supporting people to live well through support and integrated services
- Dying well through advanced care planning

Similarly, for children / adults living with Autistic spectrum conditions we published our All-Age Autism Strategy in 2023.

In line with national programme for LDA We are developing integrated models of care in the community that reduce the need for hospital wherever possible and to continuously improve pathways of support. By doing this, we aim to not only to minimise our need for hospital stays and out of area placements, but more importantly to improve quality of life.

Our long-term outcomes over the next 5 years and beyond are:

- Continue to increase early diagnosis for frailty and dementia in primary care.
- Slow growth in A&E attendances, ED admissions, inpatients and acute length of stay for frailty, dementia and for people living with learning disabilities and/or autism.
- Ensure quicker assessment and support for children and adults living with neurodiversity. Contribute to slowing the growth of people living with severe frailty and dementia in the county
- Continue to invest in SEND services working closely alongside education and social care to improve experience and outcomes for children and young people with SEND

Over the last year we have:

What we have done

Frailty and Dementia

- Commissioned the Dementia Adviser Service with Alzheimer's Society for 3 further years.
- Piloted a new approach to Dementia Co-Diagnosis in Forest of Dean which has helped people achieve timelier diagnosis and support.
- Developed a Frailty & Dementia Toolkit to provide best practice advice for health and social care practitioners.
- Developed a frailty interventions framework to ensure consistency of approach in the management of frailty across Gloucestershire.

- Developed an education framework to further develop skills and competencies across the county for the identification and management of frailty.

Learning Disabilities and Autism

- Introduced a Key Worker team and Dynamic Support Register to support children and young people with Learning Disabilities and/or Autism at risk of hospital admission.
- Appointed an Adult Learning Disabilities Dietician to train our system workforce to ensure people with learning disabilities are supported to achieve a healthy weight.
- Provided additional capacity to support adult annual health checks for people living with Learning Disabilities and ensuring health action plans are in place.
- Invested in improving pathways for both adults and children living Neurodiversity services to reduce waiting times.
- Maximised capital grant funding opportunities to develop bespoke housing solutions for people with complex environmental and support needs minimising risk of community breakdown.
- Recruiting an Autism Liaison Nurse to support those individuals accessing Gloucestershire's acute hospital.
- Learning into action from LeDeR reviews to reduce the health inequalities experienced by people with a learning disabilities and autistic people.

Maternity and Neonatal

- Put in place a Recruitment and Retention Team in Maternity services and developed a strategy to improve the retention and recruitment of midwives
- Rolled out a new Maternity Electronic Patient Records system across maternity services, giving women access to electronic maternity records and personalised care plans
- Continuing to monitor safety and quality in maternity services through the Local Maternity Neonatal System (LMNS) and established peer review arrangements with Bath, Swindon and Wiltshire LMNS.

Special Educational Needs and Disabilities (SEND)

- We have invested in our SEND workforce including recruiting a full time Designated Clinical Officer (DCO) and SEND Programme Lead.
- We have invested in our SEND Health advice service to improve experience and outcomes.

What impact it has had

- Ensured that there will be no commissioning learning disability out of county inpatient beds by end of March 2024 and reducing specialist inpatient activity.
- The Forest of Dean co-diagnosis project has increased dementia diagnosis from 59.9% to 67.4% - exceeding the national target.
- Increased our dementia diagnosis rate across Gloucestershire from 63% in March 2023 to 64% (national target is 66.7%).
- Reduced midwifery staffing vacancy rate from 14.8% (June 2023) to 7.8% (December 2023).
- The LMNS has established a dashboard to improve oversight of quality and safety outcomes.

Over the next 2 years we will:

What we are aiming to achieve next

Frailty and Dementia

- Increase the number of Comprehensive Geriatric Assessments for people living with frailty.
- Support the systematic identification of frailty across the 65 + population.
- Increase the diagnosis rate for dementia to achieve the national target of 66.7%.
- Roll out the dementia co diagnosis model across the county.
- Continue to deliver dementia public awareness focusing on minimising risk and how to get a diagnosis.
- Continue to deliver dementia education and training sessions to carers.
- Continue to deliver dementia education and training to staff.

Maternity and Neonatal

- Deliver safety ambitions for stillbirth, brain injury and neonatal mortality.

- Support recruitment and retention of the maternity workforce.
- Continue to develop a number of quality improvement projects to reduce health inequalities in maternity and neonatal, with a particular focus on women from ethnic minorities and the most deprived areas of the county.

Learning Disabilities and Autism

- Increase the percentage of people with learning disabilities receiving annual health checks and health action plans *(target of 75% and 100% respectively)*
- Reduce waiting times for assessments for ADHD & Autism.
- Reduce reliance on inpatient care for adults living with learning disabilities.
- Develop housing solutions to meet the needs of people with complex environmental and support needs.

Special Educational Needs and Disabilities (SEND)

- Work to reduce SEND waiting times improving access to services.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Dementia Clinical Programme Group					
Scope work to include a dementia awareness and prevention component in NHS health checks for the over 40s.	✓	✓	✓		
Determine the future model for dementia co-diagnosis across the county – learning from the pilot in Forest of Dean.	✓	✓			
Undertake a review of the Memory Assessment Service with a view to understanding waiting times and the service model.	✓				
Frailty Clinical Programme Group					
Engage and promote across the system the important of Comprehensive Geriatric Assessments for people with frailty needs.	✓	✓			
Continue to develop the Frailty and Dementia toolkit, bring together a range of resources and materials for practitioners.	✓	✓			
Support the systematic identification of frailty that will enable the targeting of interventions to build resilience and reduce the risks associated with ageing.	✓	✓			
Learning Disabilities and Autism Clinical Programme Group					
Continue to bring together pathways for autism and ADHD and recruit into the services to reduce wait times.	✓	✓			
Reducing our use of inpatient care by ensuring there are clear pathways of support and suitable housing options available in the community.	✓	✓			
Review enhanced LDA Pathway offer building resilient and robust community infrastructure to support people in their own homes.	✓	✓	✓	✓	✓

Reduce health inequalities experienced by people with a learning disability and autistic people through increased uptake of annual health checks and better access to good quality and accessible health action plans	✓	✓	✓	✓	✓
Analysis of the thematic issues arising from LeDeR Learning into Action to ensure implementation of strategic service improvements across the system.	✓	✓	✓	✓	✓
Maternity & Neonatal					
Develop a single action plan for maternity services enabling us to monitor key national and local objectives and deliver transformational change	✓				
Work with system partners to deliver safe, high quality and equitable care	✓	✓			
Special Educational Needs and Disabilities					
Delivery of SEND programme objectives which aim to deliver to deliver timely, effective, accessible, services.	✓	✓	✓	✓	✓

Primary Care, Pharmacy, Optometry and Dental Programmes

Our long-term ambition

We are committed as a system to supporting the sustainability of primary care whilst supporting appropriate access models for patients.

In 2023 as a system we took on responsibility for Pharmacy, Optometry and Dental Services. In 2024 we will be publishing a new Primary Care Strategy covering these services as well as primary care with the following commitments:

- Primary Care Sustainability
- Access
- Prevention and Proactive Care
- Health Inequalities
- Improving Quality
- Integrated Neighbourhood Teams

This strategy will also set out our commitments to delivering against the NHS England 'Delivery Plan for Recovering Access to Primary Care'.

In Gloucestershire, we have a strong track record of embracing new ways of working to enable us to offer the kind of care and access that people need. We know though, that pressures on services like General Practice are intense including significant financial pressures so we are working to ensure practices are sustainable while also delivering access, retaining our workforce and supporting people in their own communities.

Our Primary Care Networks have been introducing new ways of working to it easier for patients to make appointments with the most appropriate member of the team. Clinical pharmacists, physiotherapists, mental health practitioners, paramedics and other professionals working within or alongside practice teams, are also helping to meet the individual needs of patients.

Our long-term outcomes over the next 5 years and beyond are:

- Maximise the benefits of primary care working as integrated neighbourhood teams at scale –i.e. both between GP Practices and with wider community partners
- To continue to improve access to primary care – including urgent primary care when it is needed.
- To continue to work together to address population health needs within PCNs and improve outcomes for people.
- To develop a sustainable general practice model and workforce to support resilience.

Over the last year we have:

What we have done

- Taken on delegated responsibility for Pharmacy, Optometry and Dentistry services.
- Continued the ongoing delivery of the Primary Care Access Recovery Plan to improve access and experience for patients in primary care.
- Supported all 15 Primary Care Networks to provide Enhanced Access appointments on weekday evenings and Saturdays.
- Developed the primary care out of hospital offer to include ARI same-day access hubs and a review of our 7-day urgent care service (Gloucester Health Access Centre).
- Facilitated the delivery of Quality Improvement projects across Gloucestershire's Primary Care Networks (PCNs)
- Supported the delivery of national contracts in Primary Care including the establishment of new roles through the Additional Roles Reimbursement Scheme.
- Provided training for the primary care workforce including Nurses, Allied Health Professionals and Administrative staff in order to support recruitment and retention.

What impact it has had

- When compared with October 2019, we have seen a 28% increase in General Practice appointments provided in Gloucestershire.
- The number of patients seen on the same day (urgent) has increased compared to pre-COVID levels (155,000 in October 2023 compared to 122,000 in October 2019) whilst 40% of appointments (October 2023) are provided in 14 days (compared to 32% in October 2019).
- Overall, we have increased our headcount in primary care by 107 people primarily through the Additional Roles Reimbursement Scheme.

Over the next 2 years we will:

What we are aiming to achieve next

- Maintain high levels of available GP appointments and continue to offer appointments based on clinical need, including same/next day.
- Increase the percentage of regular / routine practice appointments taking place within 2 weeks.
- Provide enhanced access in primary care and enable efficient appointment utilisation.
- Continue to support recruitment and retention of staff across primary care – increasing the primary care workforce and reducing vacancy rates. Continue to work with practices to develop a sustainable model for primary care in Gloucestershire.
- Increase UDAs and dental access across County.
- Ensure smooth implementation and good utilisation of Pharmacy First prevision.
- Work with our Patient Reference Group to gain patients feedback and understanding to support delivery of high-quality primary care in Gloucestershire.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 27/28)	Year 5 (28/29)
Primary Care Access Recovery					
Deliver against the commitments in the Primary Care Access Recovery Plan, including developing a sustainable model for general practice	✓	✓			
Integrated Proactive Neighbourhoods					
Co-produce the design of Integrated Neighbourhood Teams in Gloucestershire	✓				
Launch initial phase of Integrated Neighbourhood Teams: Cheltenham Central, Rosebank Gloucester and Inner City Gloucester	✓				
Learn from and widen the introduction of Integrated Neighbourhood Teams	✓	✓	✓	✓	✓
Primary Care Workforce					
Embed new staff roles, including the roles within the Additional Roles Reimbursement Scheme (ARRS), supporting retention and promoting development.	✓				
Expand the availability of our flexible workforce (e.g. Locum GPs) to support practices while we grow our workforce in the longer-term.	✓				
Pharmacy, Optometry and Dental					
Increase UDAs and dental access across county	✓	✓	✓	✓	
Ensure smooth implementation and good utilisation of Pharmacy First prevision.	✓				

Diagnostics Programme

Our long-term ambition

Over the next 5 years we aim to achieve an increase in the right diagnostic capacity that keeps pace with the increasing demand, with fewer patients waiting overall - and not longer than 6 weeks.

As part of this we are aiming to deliver an approach that focuses on high quality and clinically effective services.

We will continue to support and enhance our ability to meet longer term population needs, prioritising workforce, estate and equipment requirements, aligned to our values-based healthcare approach.

This will help us to meet our ambitions around addressing inequalities, with a locality focus and clinical pathway transformation.

Our long-term outcomes over the next 5 years and beyond are:

- Increase diagnostic activity which keeps pace with increased demand for diagnostics for the Gloucestershire population.
- Ensure that people receive diagnostics as quickly as possible (and as a maximum within 6 weeks).

Over the last year we have:

What we have done

- Opened the new Community Diagnostics Centre (CDC). The new facility at Quayside in Gloucester will offer an extra 80,000 diagnostic appointments a year by offering appointments 12 hours a day, seven days a week. Once fully operational, the centre will offer a wide range of diagnostic tests including X-Rays, MRI, CT, ultrasound, ECHO, DEXA, Phlebotomy, Sleep Studies and Lung Function .
- Mobilised MRI and CT scanners at Quayside House which has scanned over 6,000 patients so far this year.
- An ICS Diagnostic Workforce Strategy was developed and completed in 2023/24. The report focus was on the skills, competency, and capacity of the workforce now and what the anticipated future gaps and requirements will be.
- Endoscopy task and finish group established in 2023. The focus is to improve patient access and waiting times.
- CDC experience-based design data collection from patients and staff completed in 2023/24. This will help to inform the experience of people using and delivering the diagnostic services.
- The Gloucestershire Integrated Care Board is fully engaged with the West of England Networks to create and develop opportunities for optimising diagnostic delivery across the region. There is an ICS lead in post for each network.

What impact it has had

- Community Diagnostic Centre activity against plan has been delivered in the majority of modality areas and overall achieving 90% of agreed plan in 23/24.

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure that 95% of people have a diagnostic assessment within 6 weeks by March 2025.
- Deliver diagnostic activity levels to support the addressing of backlogs in elective care (planned care and cancer).

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Diagnostics					
Pilot an Ambulatory Blood Pressure Monitoring pathway through the Community Diagnostic Centre	✓				
CDC programme: continue to develop service improvement plans and pathway changes.	✓				
Support of the implementation of the Forest of Dean community hospital in 2024, opening additional diagnostic services at that site.	✓				
Continue endoscopy T&F group to improve access and waiting times for service.	✓				
Develop plans to improve turnaround time reporting in imaging and pathology to ensure results are communicated to patients in a timely way.	✓				
Support local hearing services to achieve accreditation for paediatric audiology.	✓				
Accreditation to be progressed across diagnostic modalities.	✓	✓			
Maximise our use of digital infrastructure to support intelligent booking and scheduling of patients.	✓	✓			
Implement a new ICS diagnostic workforce strategy so we develop a workforce with the right knowledge, skills and competencies now and in the future.	✓	✓			
Diagnostic Networks					
Procure and implement the Network image sharing solution to ensure effective scanning and reporting.	✓				
Continue to work with the diagnostic networks across imaging, pathology, healthcare science and endoscopy.	✓	✓	✓	✓	✓
Genomics					
Support mainstream teams to request genomics tests.	✓				

Medicine Optimisation Programme

Our long-term ambition

We want to work collaboratively across the ICS to develop a person-centred approach to safe, effective and sustainable medicines use.

We want to ensure a long-term approach which uses medicines to achieve better outcomes for our residents as well as improve health equity associated with the prescribing of medication and to ensure we achieve these outcomes within the available NHS resources.

In 2023-24 we have undertaken a review of activities to address inappropriate over-prescribing in primary care and are planning to deliver an Over-prescribing strategy to address recommendations from this review.

Our long-term outcomes over the next 5 years and beyond are:

- Ensure medicines are used in a way that improves outcomes for residents of Gloucestershire.
- Ensure we use medicines in a cost-effective way.
- Ensure that medicines are prescribed, used and disposed of in a way that reduces harm to the environment.
- Reduce avoidable harm associated with high-risk medicines.
- Reduce unnecessary prescribing (overprescribing).

Over the last year we have:

What we have done

- Drafted an overprescribing strategy which will inform the development of local implementation planning to address overprescribing in agreed priority areas of focus.
- Made significant savings for the ICS (on track to deliver £3.8m savings) by ensuring that we use the most cost-effective medicines whilst maintaining or improving outcomes.
- Significantly reduced CFCs in the environment by switching inhalers to more environmentally friendly versions.
- Provided a Gloucestershire service to ensure patients at high-risk of serious complications of COVID have access to medicines to reduce their risk.
- Reviewed patients in the community who are prescribed oral nutritional supplements to ensure they are still receiving benefits from the supplements.
- Updated clinical guidelines to ensure patients in Gloucestershire achieve better outcomes based on evidence-based reviews.
- Established a system wide medication safety group with a focus on high-risk medication (anticoagulants and sodium valproate).
- Worked closely with Clinical Programme groups to support their transformation programmes, including supporting the medicines element of the Virtual Wards.
- In order to reduce waste and improve outcomes we have worked with partners across the ICS to design a new way of ensuring nurses and patients have access to the dressings they need in a timely manner.

What impact it has had

- Reduced harm associated with inappropriate drug use, for example anticoagulants and over-prescribing.
- Savings generated have been used by the ICS to support patient care.
- Decreased our environmental impact associated with medicines.
- Reduced the risk associated with Covid infection for some high-risk patients.
- Reduced the impact caused by the over prescribing of oral nutritional supplements.
- Ensured patients have access to medicines most likely to improve outcomes.

- Reduced harm associated with high-risk medicines.
- Supported Clinical Programme Groups to achieve their transformation goals.
- Reduced the antibiotic burden in Gloucestershire.

Over the next 2 years we will:

What we are aiming to achieve next

- Continue to deliver financial savings through efficient purchase and use of medications.
- Improve the uptake of the most clinically and cost-effective medicines.
- Use the best value biologic medicines.
- Continue to reduce our environmental impact by focusing on inhalers and dressings initially.
- Continue to provide access to medicines for patients at high risk of Covid.
- Improve our antimicrobial stewardship by improving the documentation of penicillin allergy, reducing the number of broad-spectrum antibiotics prescribed and ensuring antibiotics are used for the most appropriate duration and reduce the number of times we use IV antibiotics in hospitals.
- Continue to reduce avoidable harm associated with high risk medicines.
- Plan for new medicines and treatments.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Continue our rolling programme of projects to ensure we use medicines in a cost-effective way (including biologic medicines)	✓	✓	✓	✓	✓
Implement NICE TAs (across all 5 years)	✓	✓	✓	✓	✓
Inhaler project to switch to more environmentally friendly inhalers	✓	✓	✓	✓	✓
Implement new way of providing dressings to patients and nurses (wound care project)	✓	✓			
Undertake a series of antibiotic associated projects (based on data)	✓	✓	✓	✓	✓
Complete actions associated with our Sodium Valproate implementation plan	✓				

Planned Care and Elective Recovery Programme

Our long-term ambition

Our overall ambition is to recover elective activity and performance targets back to, and better than, pre-pandemic levels.

Reducing elective waiting times and improving access while reducing health inequalities for specific cohorts of our population such as children and young people, ethnic minorities and areas of deprivation will require continuous improvement, service redesign, workforce planning and culture change.

This will be a challenge but one that all partners are committed to delivering.

Understanding the needs of our population and giving them the tools to better manage their health and care is also important, in particular through digital developments such as the patient portal and the NHS app.

This will enable patients to better navigate the health system and avoid unnecessary waste of clinical resources while empowering them to take more control of the health and wellbeing.

Our long-term outcomes over the next 5 years and beyond are:

- Continue to reduce the number of people waiting for elective care in Gloucestershire.
- Maximise our elective performance both within Gloucestershire Hospitals NHS Foundation Trust and the independent sector where needed - maximising productivity and efficiency of elective care services.

Over the last year we have:

What we have done

- The Gloucestershire referral pathway web-platform, G-care, has been revamped and relaunched to provide quicker and easier access to support GPs to manage patients in primary care and refer to the right service at the right time when specialist support is required.
- Made significant infrastructure improvements and ward reconfigurations as well as delivered a new day surgery unit and two new adjacent theatres in Cheltenham General Hospital.
- Via the Elective Care Hub, continued to proactively contact patients waiting for treatment to offer support and to identify patients who could either be safely removed from the list or who needed to be escalated for review. This year also included validation of overdue follow ups.
- Improved the utilisation of theatre time by initiatives to provide a retrospective and prospective look at theatre bookings using a new BI dashboard. Focus also on late starts and full booking of available theatre time.
- Optimised follow-up appointments to ensure that all appointments add value for the patient and free up capacity in the system. Patient-Initiated Follow-Up (PIFU) has been rolled out across all major specialties and GHFT now has the third-highest PIFU rate in the country.
- Introduced new ambulatory hip and knee pathway improvements with some patients now going home on the day of surgery.

What impact it has had

- Delivered value weighted elective activity above the revised 103% target compared to 2019/20 levels, a figure which we forecast will reach over 105% by the end of 2023/24.
- Whilst elective recovery continues to meet target levels, the number of people waiting over 65 weeks has not yet met target (819 waiting in early January 2024).
- Increased capped theatre utilisation of over 81% in November 23 compared to a low of 76% in June ’23 (against the target of 85%).

- The Elective Care Hub has safely removed 2,800 patients from waiting lists and escalated 1,100 patients where there were concerns about potential deterioration.
- Hip and knee surgery patients now recover more quickly from surgery (the average length of stay for hip patients has reduced from 4.5 days to 2.5 days on average. Similarly, knee patients' time in hospital has reduced from 5.4 days to 2.7 days).

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure that no-one is waiting longer than 65 weeks for treatment (by September 24) and reduce the number of people waiting longer than 52 weeks for treatment.
- Deliver a minimum of 107% value weighted activity (compared to the 19/20 baseline).
- Increase productivity of elective surgery (increasing the number of day cases as well as utilisation of theatres to a minimum of 85%).
- Increase the utilisation of outpatient clinic rooms and appointments while also reducing the number of DNAs.
- Reduce the number of outpatient follow ups without procedure and increase the percentage of outpatient follow-ups given a patient initiated follow-up appointment while also increasing the volume of follow ups who can be dealt with virtually.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Referral Optimisation					
System agreement of primary/secondary care interface principles and exploration of a primary care interface role within GHFT	✓				
Develop new G-Care pathway content as well as educational resources for GPs, helping to avoid unnecessary hospital appointments	✓				
Waiting Times and Waiting List Management					
Expand support to GPs by providing high-quality educational resources, including podcasts, videos, and formal training sessions	✓				
Elective Care Hub validation of follow ups and consultant note reviews pilots and roll-out	✓	✓			
Outpatient Transformation					
Introduce and optimise a new patient portal to make it easier for patients to contact the hospital if they need to cancel or change appointments	✓	✓			
Undertake clinic template reviews and develop clinic room utilisation reports to maximise use of existing resources	✓				
Inpatient and Daycase Services					
Embed the new ambulatory hip and knee pathways to maximise the benefits of a new day unit and theatres	✓				
Continue our theatre improvement programme with workstreams aimed at improving theatre utilisation, productivity and efficiency	✓				

Working as One Programme (Urgent and Emergency Care)

Our long-term ambition

Through our Working as One programme within Urgent and Emergency Care our vision is to deliver quality, integrated care for the people of Gloucestershire to support delivery of the best possible physical and mental health outcomes following access to urgent and emergency care service. The programme brings together key strategic partners across the One Gloucestershire system to redesign the way care is provided in our system by all partners working together to deliver the right care, in the right place, at the right time.

For the people of Gloucestershire, it will mean:

- Support for people to stay as healthy and independent as possible, preventing the need for care in the first place.
- Making it easier to get the help people need closer to home; with access to treatment at home or in a community-based setting as our first priority where a hospital attendance is not necessary.
- High quality services to help people recover independence after a hospital stay – with home as the preferred route.

For our staff, it will mean:

- Working in an integrated way to provide care.
- Empowering staff to make decisions that put the patient at the centre of the services we deliver and provide an environment to be innovative and provide quality care.
- A more connected system that enables us to flex our services to meet the needs of people as close to home as possible and facilitate access to the right urgent care services in a timely way.

The programme is further complemented by extensive improvement focus across our health and care system to improve performance delivery of our Urgent and Emergency services.

Our ambitious programme of work is based around five key workstreams: Prevention; Urgent Community Response and Front Door; Acute Hospital Flow and Decision Making; Intermediate Care and Access to Care packages.

Our long-term outcomes over the next 5 years and beyond are:

- Ensure a greater focus on prevention and anticipatory care.
- Ensure that there are effective alternatives to hospital within the community so that care can be provided when it is needed most as close to home as possible.
- Ensure that our urgent and emergency care services are accessible and timely when people need it.
- Ensure that effective discharge arrangements are in place with people supported and enabled to return home as often as possible, or to the most suitable discharge setting to deliver the best long-term outcomes focusing on independence.
- Maximise people's opportunities for independence, ensuring services are available to quickly support those who need it when they need it.

Over the last year we have:

What we have done

- We have provided a System Control Co-ordination Centre 7 days per week including bank holidays, to support partners through periods of escalation and increased demand across urgent care services to ensure that people require high quality timely care across Gloucestershire.

Prevention

- Provided clear information for primary care so they are informed about available alternatives to attending hospital Emergency Department (ED) in an urgent situation.
- Promoted the use of community-based services and pharmacies to support people to remain well and access urgent treatment for minor illness and injury.

Urgent Community Response and Front Door

- Developed proposals and commenced procurement for a Clinical Assessment Service which will enable people to access the most appropriate urgent care service at the most appropriate time to receive care and treatment.
- Consistently delivered improving standards of 2-hour urgent community response through our use of the Rapid Response service supporting delivery of urgent clinical assessment and treatment in peoples home where appropriate to do so and providing streamlined onward referral where necessary.
- Launched our Virtual Wards (respiratory and frailty) to enable patients to be monitored remotely and reviewed by specialist clinicians rather than require admission to hospital.

Acute Hospital Flow and Decision Making

- Carried out estate improvements at Gloucestershire Royal Hospital, increasing the available space and environment in the Emergency Department for adults and children and young people.
- Expanded Same Day Emergency Care within Surgery from December 2023 that will enable more people to be seen on the day through direct referral to surgical specialties, reducing congestion in the Emergency Department.
- Continued to expand the use of the discharge lounge at the hospital enabling 27% more beds to be released before midday on our Gloucester site (December 23 compared to December 22).
- Conducted Test and Learn trials to develop new ways of working at our hospital 'ED front door', to optimise access to members of the wider multi-disciplinary team early and maximise GP out of hours access to prevent admission to hospital where at all possible and improve the patient journey through our hospitals.
- Commenced Model Ward trials within Care of the Elderly wards in our acute hospital sites; aiming to improve and streamline the decision making of the multi-disciplinary team to make patient centred discharge decisions and reduce the time spent in hospital once people no longer require acute treatment.

Intermediate Care

- Put in place a range of options to support patients to be discharged from hospital in a timely way, including:
  - Additional home-based domiciliary care provision, to increase focus on discharging patients home with support as opposed to remaining in a bedded setting.
  - Implementation of the Forest of Dean Community hospital changes with a focus on providing rehabilitation care.
  - Maximising the use of the Community Assessment and Treatment Unit in Tewkesbury hospital, to step people up into a care setting for immediate bed based treatment not requiring acute hospital admission and facilitate timely discharge with appropriate support.

Access to Care Packages

- We have seen significant improvement in the time to arrange domiciliary care packages for people once they are ready to leave hospital.

What impact it has had

- Increased utilisation of our Minor Injury and Illness Units (attendances are up 5.5% over the period July 23-December 23 compared to the same time last year). This is supported by telephone triage and advice that continues to provide an alternative to attendance to an acute hospital.
- Reduced our use of Discharge to Assess beds by supporting more people to return home after a hospital stay with therapy support.

- Significantly reduced the time taken to arrange a package of home care from 16.8 days in January '23 to 5.5 days in December '23.

Over the next 2 years we will:

What we are aiming to achieve next

- Ensure 70% of people requiring urgent community response services are responded to within 2 hours of asking for help; improving care closer to home and avoiding hospital attendance.
- Expand the number of people supported at home through Virtual Ward monitoring in partnership with primary care.
- Ensure that 80% of people attending our Accident & Emergency and Minor Injuries & Illness Units are assessed and treated within 4 hrs and either admitted transferred or discharged with appropriate support within these 4 hours.
- Support our ambulance service to respond to urgent calls more effectively (Category 2 calls) to ensure the most unwell patients in our community receive urgent treatment in line with national standards.
- Reduce the number of people ready, but unable to leave hospital and reduce inpatient stays longer than 21 days for all people to improve longer term outcomes and independence.
- Reduce general and acute bed occupancy in Gloucestershire Hospitals to improve efficiency of the patient journey.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Prevention and Anticipatory Care: Reduce or delay people getting to a point of urgent need					
Launch initial phase of Integrated Neighbourhood Teams	✓	✓			
Develop a trial focusing on falls prevention	✓				
Community Urgent Door Response & Front Door: Use other options to ED wherever possible					
Launch and embed the Clinical Assessment Service (CAS)	✓	✓			
Review and increase utilisation of the Rapid Response Service & meet the full requirements of Urgent Community Response	✓	✓	✓		
Hospital Flow & Decision Making: Optimise hospital length of stay and support onward discharge					
Continue to expand the Virtual Ward in Gloucestershire to support remote monitoring of patients who would otherwise be in hospital	✓	✓			
Embed the Same Day Emergency Care (SDEC) service and evaluate impact	✓				
Continue to expand the Model ward trial in order to achieve the optimal length of stay for a hospital admission	✓				
Intermediate Care & Reablement: Improve availability, flow & outcomes of care in the community					
Review the Discharge to assess bed approach to improve efficiency and reduce demand for bed based options	✓	✓			
Develop the Intermediate Care model for the Gloucestershire system	✓	✓			
Access to Care Packages: Ensure availability of long-term care for those who require it					
Review the approach to the provision of double handed care	✓	✓			

Adult and Childrens Mental Health Programmes

Our long-term ambition

Our ambitions are to ensure timely, effective and accessible mental health services for people across different population groups.

We aim to provide personalised and integrated models of care in the community that reduce the need for hospital wherever possible and to continuously improve the pathways of support for people with mental health needs and living with learning disabilities and/or autism, to minimise our inpatients and out of area placements.

Children and young people up to the age of 25 will be able to access mental health support within their community and schools from any trusted adult who will be confident in supporting them to access the right help.

We will provide earlier support for children, young people and families through digital interventions, train the trainer models, 1:1 and group support, reducing the need for referrals to our specialist services.

For those young people who present in crisis, support will be available within their local community preventing the need for unnecessary out of county placements.

By improving the experience of getting earlier help for all of our diverse communities across Gloucestershire, it will de-stigmatise accessing mental health support and help reduce health inequalities.

Our long-term outcomes over the next 5 years and beyond are:

- Contribute towards reducing premature mortality due to serious mental illness in adults and self-harm in children.
- Support the improved mental health and wellbeing of children and young people in Gloucestershire.
- Ensure timely, effective and accessible services for people across different population groups.
- Provide personalised and integrated models of care in the community that reduce the need for hospital and inpatient care for adults and children.

Over the last year we have:

Invested to improve access and outcomes for people with mental ill health. Our focus has been on reducing waiting times for children and young adults and on ensuring that care is available in local communities.

What we have done

- Implemented a place-based community mental health approach particularly for adults experiencing severe mental health. We have adopted DIALOG, a holistic questionnaire to measure quality of life of individuals and this is now central to the place-based approach we are taking for mental health.
- Local Community Partnerships are on the way to being established in all localities in Gloucestershire - bringing together partners to discuss how best to support people with a serious or enduring mental illness.
- Recruited in new roles to support people with mental health needs including people to work directly with Primary Care.
- Enhanced early support for children and young people including targeted provision of myHappymind placing importance on building resilience and promotion of good mental health and wellbeing as well as free, countywide access to Lumi Nova, a digital therapy app to help reduce anxiety.

- Piloted a multi-agency single point of access for children and young people experiencing mental health difficulties and educational barriers within Gloucester City encapsulating the approach that there is “no wrong door.”
- Continued the rollout of the Mental Health in Schools Trailblazer programme (Young Minds Matter) to over 130 schools in the county.
- Investment in increased capacity in existing services to so that children and young people experience earlier access to appropriate help and support.
- Commenced a review of provision for Eating Disorders including pathway re-design so that individuals are identified and able to access intervention earlier such as TEDS, a new counselling service for young people by TiC+, avoiding unnecessary deterioration.

What impact it has had

- Increased the number of patient contacts with community mental health services and ensured that wait times are within 4 weeks.
- Continued with improvements in Improving Access to Psychological Therapies (IAPT) – exceeding recovery and wait time ambitions.
- Reduced the reliance on out of area mental health placements.
- Begun to reduce NHS waiting times for eating disorder services.
- Reduced the number of referrals to Child Adolescent Mental Health Services - nearly 80% of children have an assessment in 4 weeks of referral.
- Increased recruitment into patient facing roles including as part of the place-based Community Mental Health approach.
- The Children & Young People's Multi-Agency Navigation Hub pilot has improved joint working across health, education, social care and voluntary sectors resulting in children, young people and their families accessing the right care, at the right time for Gloucester City.

Over the next 2 years we will:

We will develop and pilot new ways of working while continuing to focus on reducing waiting times, especially for children and young people with higher needs.

What impact are we aiming to have

- Increase recovery rates for people accessing IAPT services and increase reliable recovery and improvement rates for people completing courses of treatment.
- Increase access to transformed community mental health services (for children and young people as well as adults with serious mental illness).
- Increase the number of people with a serious mental illness who access an annual health check to improve their health outcomes.
- Maintain a low number of people placed inappropriately out of area for adult mental health support.
- Reduced waiting times for services including eating disorder services.

How we are planning to achieve this	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Children’s Mental Health					
Continue the rollout of Young Minds Matter into schools across the County (8th team in Sept. ’25).	✓	✓			
Provide additional capacity in TiC+ and Young Gloucestershire to support children and young people with mental health needs.	✓	✓			

Countywide expansion of the Children & Young People's Multi-Agency Navigation Hub.	✓	✓	✓		
Adult Mental Health					
Expand and embed the place-based community mental health offer.	✓	✓			
Continue the transformation of eating disorder services.	✓	✓	✓		
Rebrand Talking Therapies services, promote the service and recruit and train new staff.	✓	✓			
Implement improvements in urgent and emergency mental health services including review of Crisis Resolution and Home Treatment.	✓	✓			
Implement the Right Care, Right Person framework to assist the Police in decision making.	✓	✓			
Re-model therapeutic services for victims of sexual abuse and assault.	✓	✓	✓		

Estates Programme

Our long-term ambition

Across the Integrated Care System, we will prioritise capital (including estates) commitments and deliver against this – including backlog repairs maintenance.

In 2023/24 we have worked with primary care to develop a Service and Estates Plan for Primary Care Networks. Over the next year system partners will be coming together to develop a System Estates Strategy for Gloucestershire.

We have made significant achievements in 2023/24 to improve our use of estates and facilities across the system including:

- The development of a new Forest of Dean Hospital which will open in Spring 2024
- A new Community Diagnostic Centre that opened in January 2024 in Gloucester
- Continued work on the Gloucestershire Hospitals NHS Foundation Trust Strategic Site Development.
- Introduction of multiple new primary care premises and continued ongoing development across the County.

Our long-term outcomes over the next 5 years and beyond are:

- Support the move to ICS buildings across Gloucestershire being EPC B rated by 2030.
- Meet the need for a flexible, integrated estate that can be used by primary care, secondary care and community organisations.
- Deliver a revenue benefit from reducing building running costs and capital benefit from relevant building disposals.

Over the last year we have:

What we have done

- Gloucestershire Health & Care have focused on delivery of the New Forest of Dean Community Hospital which will phase going live in early 2024. It will include provision for community space within the hospital itself and which achieve BREAAM excellence (energy efficiency) benefitting from Solar PV, Air Source Heat Pumps, excellent insulation and other energy efficient solutions.
- Progressed a large extension at Quedgeley Medical Centre.
- Started building work for a new £6m Minchinhampton surgery in October 2023 which is due to open in October 2024.
- Completed significant work across our estate in respect to Fire Safety, Water Mains replacement (Cirencester), Alarm Systems (Charlton Lane), Lighting and Heating systems to address maintenance backlogs and to support patient safety.
- To make the best possible use of ICS property, to enable better system working and to reduce our carbon emission, the ICB moved into new offices within Gloucestershire County Council's Shire Hall in Gloucester.

What impact it has had

- In respect of the ICB office project reduced spatial requirements by around 50% from 2,200m2 to around 1,100m2.
- An absolute reduction in co2 emissions by 62.4% compared to Sanger House. Down from total carbon emissions of 105,732kgsco2 to 39,952kgsco2.
- Reduction in kgco2/m2 by 24.4% compared to Sanger House. From 48.06 kgco2/m2 to 36.32 kgco2/m2.

- Recurrent annual saving running costs of around £550k per annum in unneeded accommodation.
- Increased utilisation of an existing public sector asset by around 5.5%.
- Over the life of the 10-year lease, approximately £3.12m income remain within the ICS rather than being lost to the commercial sector.
- Increased capacity in primary care premises to deliver a wider range of services to an increased population by around 597m2 gross internal area- extra capacity for around 6,700 patients.

Over the next 2 years we will:

What we are aiming to achieve next

- Complete Phase 1 and 2 of Fit for the Future and Strategic Site Development and realise the benefits stated in the Programme.
- Complete key estates initiatives that support the separation of emergency and planned care and acute and community diagnostics.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Strategy and Framework Development					
Complete the development of a system estates strategy across Gloucestershire.	✓				
Produce a revised GP Premises Development Plan.	✓				
Develop an estates plan that will support the development of Integrated Neighbourhood Teams in the County.	✓				
Developing new facilities					
Open new surgeries including Minchinhampton, Coleford, Brockworth, Hucclecote, Lydney and Tetbury.	✓	✓	✓		
Opening of new Forest of Dean Community Hospital	✓				
Addressing backlog maintenance					
Continue a rolling programme of refurbishments in both the community/mental health provider and hospital.	✓	✓	✓	✓	✓
Releasing our assets					
Sell a number of NHS buildings contingent on new developments being delivered.	✓	✓	✓	✓	✓

Digital and Population Health Management Programmes

Our long-term ambition

As a system we approved our Gloucestershire ICS Digital Strategy in June 2023.

The strategy outlines our approach to supporting our citizens and staff to make the best use of technology as well as increasing the digital maturity and joining up care across our system.

The development of the Strategy was informed by comprehensive digital maturity assessments undertaken with partner organisations. As a system we remain committed to increasing digital maturity of both individual organisations and as a system.

The Digital Strategy is based around five key themes:

- **Delivery Framework**: establishing a delivery framework, plan and governance;
- **Data and Information Sharing:** Including procuring and implementing a new shared care record;
- **Levelling Up**: continuing to improve the digital maturity of our systems and continue to unify our infrastructure and systems;
- **Innovation and Growth**: Developing patient-facing technology that provides people with a less intrusive and alternative approach to managing their health and care needs.
- **Population Health Management (PHM)**: Enabling people to have population health insights that inform decision making. We remain committed to embedding a PHM approach across the system through our refreshed programme that takes a 'matrix' approach to contributing to the delivery of improvement and efficiencies across other programmes of work.

Our long-term outcomes over the next 5 years and beyond are:

Digital

- Ensure there is simplicity in how people access services and support through the use of digital technologies.
- Ensure that staff have access to the information they need to enable them to deliver the best possible care.
- Level up digital maturity across all organisations in the NHS in Gloucestershire.

Population Health Management (PHM)

- Ensure that all organisations in the ICS take a PHM approach: working in a way that uses data to proactively identify people and patients with the most capacity to benefit, supporting the most appropriate intervention design, and using evaluation to inform how the system addresses need.

Over the last year we have:

What we have done

Digital

- Developed a system-wide cyber security remediation plan which will enable health and care staff to safely have seamless network connectivity across the system.
- Over 1 million views of Gloucestershire ICS's Local Shared Care Record (Joining Up Your Information) have been undertaken by clinicians since it went live.
- Procured a new local shared care record. This record will mean that we are able to share real-time information across our system, improving the care and support we are able to offer.
- Increased local uptake and usage of the NHS app in Gloucestershire to 54% of the registered population aged 13 and over.

- Introduced a new maternity information sharing record system in our acute provider to support patient care for birthing people.
- Embedded digital monitoring as part of the rollout of the Virtual Ward hospital in the county to enable people to have their health monitored safely outside of a hospital setting.
- Approved a Digital Inclusion Plan which includes digital inclusion hubs provided by the VCSE in communities around the county.

Population Health Management

- Undertaken a strategic review of our approach to Population Health Management, using the resulting recommendations to drive forward our programme of work and investment.
- Undertaken a survey of skills across our analytical teams; this will inform training and development programme to support our developing PHM toolkit to share case studies and lessons regarding PHM with programmes.
- Linked health and social care datasets (for population health purposes) and continued analysis of this data to support targeted work within transformation programmes.
- Supported work on evaluation across key projects and programmes.

What impact it has had

Digital

- 43% of patients are enabled for online booking, amending and cancelling of appointments.
- 51% of patients are enabled to order repeat prescriptions and 35% of patients are enabled to view their detailed coded record.
- More people are enabled to make use of the variety of digital tools we will be rolling out.

Over the next 2 years we will:

What we are aiming to achieve next

Digital

- Support increased use of key digital applications by both staff and patients – including Joining Up Your Information (JUYI – our local shared record) as well as the NHS app.
- Increase the take up of digital services - increase the number of people able to book, amend or cancel appointments.
- Increase the use of Cinapsis to support smart referrals and enable easy access to advice and guidance.

Population Health Management

- Continue to support PHM projects within priority clinical programmes such as Urgent and Emergency Care, Frailty and condition-based programmes such as hypertension, diabetes, respiratory and cancer.
- Support local partners across the ICS in GP practices, PCNs, ILPs, and CPGs to initiate, establish, test, adopt and scale PHM approaches across the system.
- Invest in the development of analytical and wider workforce to enable PHM to be taken up across the system.
- Drive the use of our health and social care linked dataset, and work towards expanding and improving it to include partners who are responsible for tackling wider determinants of health.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Delivery Framework					
Develop a clear, costed roadmap for our whole system to allow us to shift resources and drive improvement across health and care by making sure	✓	✓			

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Delivery Framework					
that all system organisations have the digital foundations to support innovation and growth.					
Levelling Up					
Invest in improving the digital literacy and skills of our staff and communities so that people are easily able to access the timely and accurate information they need and we are able to make the best use of scarce resources.	✓	✓			
Innovation and Growth					
Launch and rollout the Person Held Record in our Acute provider enabling patients to have access to the information about their appointments	✓				
Data and Information Sharing					
Fully rollout the upgrade to the shared care record in Gloucestershire (*Joining Up Your Information*)	✓				
Population Health Management					
Invest to develop ICS-wide analyst capability to support the PHM approach	✓	✓	✓		
Drive implementation and impact of PHM including: wider workforce training and development; promoting evaluation; developing a PHM pipeline to support matrix work across clinical programmes and local organisations	✓	✓	✓		
Continue to analyse our existing linked dataset, and develop a clear roadmap to expand and improve the dataset with partners	✓	✓	✓	✓	✓

People Programme (Workforce)

Our long-term ambition

Our commitment is to create 'One workforce for One Gloucestershire' developed through our shared strategic priorities which are articulated in our One Gloucestershire People Strategy which was developed and published in September 2023.

Our People Strategy is based around the following 4 foundation themes followed by 4 pillar themes:

- Leadership and Culture
- Equality, Diversity and Inclusion
- Data, Digital and Technology
- Workforce Planning
- Recruitment and Retention
- Innovation
- Valuing our Staff
- Education, Training and Development

We want our workforce to be supported by a compassionate culture and experience an inclusive working environment which inspires, motivates and rewards everyone with the values, behaviours, skills and opportunity to deliver high-quality care and support every day.

Our long-term outcomes over the next 5 years and beyond are:

- Identify our talent and develop and support leadership at all levels across the ICS.
- Simplify and transform recruitment processes to improve accessibility and reduce the time to recruit.
- Grow our workforce for the future through continued efforts to attract and recruit new staff and their families to come and live and work in here.
- Develop new roles and ways of working including opportunities for rotation of staff and movement across our system.
- Retain staff through great induction, mentoring, learning and development, wellbeing support and flexible working options.
- Build a safe, compassionate and inclusive culture for all our staff.

Over the last year we have:

We have made good progress in working towards our goals, developing strong relationships with our ICS partners and ensuring we are in a position to grow a skilled, diverse and supported workforce which meets the needs of the people of Gloucestershire.

What we have done

- Developed the 'Be in Gloucestershire' project to promote Gloucestershire as a place to live and work as a GP.
- Developed the 'We Want You' project to promote health and social care careers in schools.
- Created an initiative to create a staff housing support hub and developed actions plans with our provider trusts to focus on retaining nursing staff.
- Developed a project to recruit 100 international domiciliary care workers to address a high vacancy rate in this important sector.
- Continued the development of system leaders including further cohorts of our 'systems thinking' programme and coordinating the One Gloucestershire Leadership Development alumni programme for the ICS
- Completed a system-wide nursing retention diagnostic and developed individual Trust action plans to address identified priorities.
- Both NHS providers have achieved Gold Employer Recognition status for Armed Forces veterans and reservists and the ICB has achieved Bonze status

What impact we had

- Increased staff recruitment – particularly into key roles such as in primary care, maternity services and mental health services
- Improved staff retention, reducing staff turnover and the number of staff leaving within 12 months
- Reduced agency usage and increased in Bank usage following visibility of agency booked shifts to bank staff (Nursing and HCA agency use has decreased by up to 50% in our community and mental health provider).
- Improvements across key staff survey measures.

Over the next 2 years we will:

We will continue to work towards our ambition of creating 'One Workforce for One Gloucestershire' across all of its 8 area themes.

What we are aiming to achieve next:

- Increase our focus on retention of staff, reducing staff turnover and the number of staff leaving within 12 months.
- Develop our ICS-wide Health and Wellbeing Strategy to provide staff support.
- Support strategic ICS priorities (such as neighbourhood working e.g. by facilitating staff to work across organisational boundaries and taking 'whole-system' perspective)
- Build our approaches to creating an inclusive and compassionate culture together with the HR and management processes that will improve the diversity of staff at all levels.
- Reduce the use of agency, temporary and off-framework staffing across Gloucestershire.
- Show an improvement across key staff survey measures.

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Leadership and Culture					
Develop a system-wide leadership delivery plan and subsequently implement it	✓	✓	✓	✓	✓
Develop system capability and culture through leadership events and systems thinking masterclasses	✓	✓	✓	✓	✓
Workforce Planning					
Assess the implications and develop local plans to respond to the NHS LTWP	✓	✓	✓	✓	✓
Recruitment and Retention					
Launch and expand the "Be in Gloucestershire" campaign	✓	✓			
Facilitate staff moving & working across the system to enable strategic priorities	✓	✓	✓		
Improve recruitment processes (from EDI and efficiency perspectives)	✓	✓			
Reduce agency spend and use of off-framework in line with operational planning requirements	✓				
Valuing our Staff					
Develop and implement a system-wide HWB strategy and review of existing service offers (also links to retention)	✓	✓	✓		
Develop a Housing Hub service to support staff in securing accommodation	✓	✓			

Education, Training and Development					
Raise awareness of Health and Social Care career opportunities through school engagement, T-Levels, apprenticeships	✓	✓	✓	✓	✓
Strengthen relationships with research partners and increase the research capability and delivery	✓	✓	✓	✓	✓
EDI					
Develop and implement our EDI High Impact Actions	✓	✓	✓		

Quality Improvement Approach

Embedding an improvement approach across health and care.

Our long-term ambition

We are committed to embedding improvement approaches into our core strategy and operations at all levels within our organisations and in how we collaborate as health and care partners.

Improvement approaches provide systematic tools for delivering measurable benefits for the people we serve, staff, organisations, and our wider system. They enable us to effectively deliver improvements within care settings, across care pathways and when tackling large-scale service delivery challenges.

Our ambition is to create a system-wide culture of improvement, where everyone is an improver, collaborating with people and communities.

The benefits of an improvement approach are:

- **For people and communities:** improved care outcomes, experience, and safety. Better access, earlier diagnosis, and more streamlined care.
- **For our staff:** positive and collaborative culture, support to improve services, job satisfaction and development of professional skills.
- **For our organisations:** consistent delivery of high-quality care, effective allocation of scarce resources, removal of delays, duplication, and waste. Designing sustainable services.
- **For our system**: stronger collaboration, improved flow, scaling of innovation within new models of care.

Over the last year we have:

We have a strong track record of nurturing Quality Improvement in our organisations, with thriving educational programmes developing the capability and capacity within our teams. In October 2022 we formed a system-wide Improvement Board which brought senior leaders together and guides how we create the conditions for improvement across our system. In March 2023, we produced our first Improvement Community Strategic Approach, and an associated delivery plan which is now rapidly building momentum in line with the recommendations of NHS Improving Patient Care Together.

Over the last 12 months, our work as an Improvement Community has developed within our organisations and we have successfully designed and tested new approaches to supporting cross-system improvement.

What we have done

- Delivery of a tailored capability building offer across our system to meet the needs of all colleagues, spanning from foundation levels through to advanced practitioners. Our training programmes reached over 1600 participants this year.
- Developed our collective expertise through internal and external accreditation to ensure we meet the needs of staff in our system.
- Facilitated the delivery of system design work in the areas of highest strategic priority including urgent and emergency care, frailty, mental health crisis for both adults and children and young people, virtual wards, integrated neighbourhood teams and lower limb care.
- Worked in partnership to support the delivery and evaluation of improvement project work in primary care, in collaboration with business intelligence and engagement colleagues.
- Designed a new Adult Social Care quality strategy that embeds commitment to a quality improvement approach.
- Elevated the importance of improvement, with the launch of the ICB Improvement Story feature.

- Prepared for the delivery of ICB board and ICS leadership development sessions, incorporating the Health Foundation's new Improving across Health and Care: a framework.
- Communicated our progress as a case study in the NHS Confed & Health Foundation Paper 'Improving Health and Care At Scale: Learning From Experience Of Systems'
- Achieved recognition Gloucestershire through Health Service Journal awards, and other national and regional awards.
- Celebrated the achievements of improvers locally with regular in person celebration events.

What impact has it had

- Strengthened our ability to deliver continuous improvement, transform models of care across organisational boundaries and to adopt innovation.
- System staff survey data indicates people feel able to make improvements to their work.
- Supported our teams to deliver improved outcomes for quality of care, reduced health inequalities and better health and wellbeing.

Over the next 2 years we will:

Area and Key Scheme	Year 1 (24/25)	Year 2 (25/26)	Year 3 (26/27)	Year 4 (27/28)	Year 5 (28/29)
Convene					
Mobilising our collective leadership to connect with our shared vision, evolving our effective system improvement approach.	✓	✓			
Integrate					
Embedding an improvement approach into One Gloucestershire's strategic planning, prioritisation and transformation delivery programmes.	✓	✓	✓		
Learn					
Delivering a range of education programmes for our workforce, consistently founded on the Model for Improvement. Application to practice is enabled through Improvement Coaching.	✓	✓	✓	✓	✓
Facilitate					
Provide bespoke system facilitation for partners delivering complex change to design programmes which deliver positive outcomes. Targeted on ICS Priorities.	✓	✓	✓	✓	✓
Connect					
Bring together a unified community, with a cohered identity, enabling networking, connections and continued learning.	✓	✓			
Collaborate					
Partner in Organisational Development to build our collaborative culture and leadership for improvement.	✓	✓	✓		
Celebrate					
Recognising and share successful improvements and lessons learnt through celebration events and system-wide showcase opportunities.	✓	✓	✓	✓	✓

Delivering our legislative requirements

Duty	How we have / are delivering this requirement
1. Describe the health services for which the ICB proposes to arrange to meet needs	The refresh of this Joint Forward Plan describes what we are doing to improve the health needs of the population in Gloucestershire. In 2023/24 we have continued to monitor delivery of this plan through the Integrated Performance Report to our Integrated Care Board. Our Operating Plan (delivered in 2023/24 and being finalised for 2024/25) provides more information on the planned performance of our services. In addition, more detailed information can be found on our websites: • Gloucestershire Health and Care NHS Foundation Trust • Gloucestershire Hospitals NHS Foundation Trust • South-Western Ambulance Service NHS Foundation Trust • Voluntary, Community and Social Enterprise (VCSE) partners (VCS Alliance) • Gloucestershire County Council • NHS Gloucestershire Integrated Care Board
2. Duty to promote integration	We remain committed to providing health services in an integrated way with our system partners. Our long-term plans are set out within this Joint Forward Plan and our Integrated Care Strategy **Over this last year we have:** • Continued our commitment to bring services together around the needs of local people. For example, the Community Mental Health Transformation Programme is bringing together multi-disciplinary teams within communities to support people with severe mental illness. • Continued to progress with our wider Integrated Neighbourhood Team ambitions with a particular focus on proactively supporting patients with frailty needs. This will remain a key priority for Gloucestershire as we go into 2024/25. • Continued to show our commitment to addressing health inequalities. Our ICS Transformation Programmes are prioritising work with specific population groups or deprived communities. For example, we are prioritising mental health work in schools with areas of higher deprivation. • Continue to work together as system partners at a strategic level. Gloucestershire County Council and wider health partners are represented on the Integrated Care Board. We also have well established Joint Commissioning Partnership arrangements that are responsible for the management of Section 75, 76 and 256 funding. We remain committed to this principle as we look forward to 2024/25.

3. Duty to have regard to the wider effect of decisions	As a system in 2023/24 we have continued to ensure that all our transformation and development focuses on the triple aim of improving population health, improving quality and improving value. This year our System Resources Committee has led work on shaping our approach to value. As a system we have defined value as “achieving our priority outcomes within the resources that are available to us”. Our approach continues to focus on: • **Improving population health:** This Joint Forward Plan sets out the work we have done and the outcomes that we have achieved to improve population health for our local communities. Our six Integrated Locality Partnerships are central to this work alongside the role of GP Practices and 15 Primary Care Networks. • **Improving quality**: Our Quality Committee and System Quality Group have continued, over this last year, to assess the quality of health and care services across Gloucestershire based on the three principles of experience, effectiveness and safety. This is underpinned both by quantitative and qualitative data. • **Improving value**: Our System Resources Committee provides both support and challenge on our approach to delivering value across the system. In this last year we have established an evaluation task and finish group that is focused on assessing the value delivered by our investments. Regular monitoring of benefits is taking place across key schemes including those outlined within our Joint Forward Plan.
4. Financial duties	Over this last year we have demonstrated our commitment to meeting the financial duty requirements of Integrated Care Boards. The national financial framework requires a collective responsibility to not consume more than the agreed share of NHS resources. We believe that working together towards common goals rather than competition is the best way to join up services to meet people’s needs, tackle inequalities and improve outcomes. In 2023/24 we have continued to work towards a set of guiding values and behaviours – making decisions collectively together around the financial position and risk. Budgets of all our organisations are going to be challenging given the economic position and demand on our services. Our System Resources Committee has played an important role in providing support and challenge to delivery of our financial duties in 2023/24 and we have undertaken work across the system to define and develop our approach to values- based healthcare. **Going into 2024/25 we will collectively continue to prioritise:** • Reviewing current resources, testing the value of current services and transforming services where better value can be identified.

	• Monitoring the benefits from programmes of work within the Joint Forward Plan to ensure that financial and non-financial outcomes are delivered. • Improving the productivity of services through benchmarking, identifying opportunities which can then lead to improvements in the way that we use our collective resources and release cost reductions where appropriate. • Prioritising – and challenging any investments so that they are delivering the strategic priorities outlined within our Joint Forward Plan. • Ensuring that we have effective governance and controls in place across the system to ensure resources are managed appropriately.
5. Duty to improve the quality of services	Everybody has the right to feel safe and have confidence in the services provided across Gloucestershire. We are committed to securing continuous improvement and will strive to ensure that our services, and those we commission, are high quality and that we have robust mechanisms in place to intervene where quality and safety standards are not being met or are at risk. In 2022 we published our first ICS Quality Strategy and Quality Framework. These two documents describe how we have arranged ourselves to deliver on our ambition for the services we commission or provide to be safe, effective and that people who use them have a good experience. Our Quality Strategy describes our shared commitment to improving quality across services in Gloucestershire. **In 2023/24 we have prioritised our work to improve the quality of services through**: • Regular coordination of the ICB Quality Committee and System Quality Group which play a strategic role in assessing and improving quality across the system. • Reporting on quality achievements and issues through our ICB Integrated Performance Report with key metrics for system oversight • Providing specific support and assurance in key areas such as maternity services across Gloucestershire. **In 2024/25 we will undertake the following:** • Review the Quality Strategy and Quality Framework, reflecting our experience since becoming an ICB. We will take note of our successes and focus on our Quality priorities, ensuring improved outcomes for patients and focusing on inequalities being the 'golden thread'.

	• Continue to refine and develop our Experience, Effectiveness and Safety groups, which help provide insight and assurance to both Quality Committee and System Quality Group. • Introduce the new Patient Safety Incident Response Framework (PSIRF), taking the opportunity to strengthen our collaborative approach with all partners to ensure learning is shared system wide and can positively impact on patient safety.
6. Duty to reduce inequalities	We remain committed to work across the system to reduce health inequalities and take seriously our statutory duty to lead oversight and assurance for the system. Our Joint Forward Plan sets this as one of our strategic priorities and we have made progress in 2023/24 against this. The One Gloucestershire Integrated Care Strategy sets out our 5-year ambition that all staff working in our system will understand health inequalities – what they are, why they matter and what action they could take within their roles. **In 2023/24:** • We have contributed to working on Exemplar Themes within the Integrated Care Strategy of smoking, blood pressure and employment – with a particular focus on addressing inequalities within this. • We contributed to the first Gloucestershire Health Inequalities and Employment Summit that bought together organisations whose purpose is to support people who are or are at risk of becoming unemployed or economically inactive. • We appointed two Senior Responsible Officers (SROs) for Health Inequalities - the Director of Public Health for Gloucestershire County Council and the CEO for Gloucestershire Health and Care NHS Foundation Trust. The SROs have the remit to draw wider attention to the health inequalities agenda across the One Gloucestershire Integrated Care System. • We have contributed to the launch of the Gloucestershire Prevention and Health Inequalities Hub across the system, which is an online compendium of information, resources, and practical tools designed to help the Gloucestershire ICS workforce better understand and take action to improve health equity in their areas of work **Looking towards 2024/25, we will:** • Continue to expand our knowledge and reporting of health inequalities in our system. This includes adhering to the requirements set out in NHS England's Statement on Information on Health Inequalities to collect, analyse and publish information on health inequalities to inform development and planning of targeted action to reduce inequalities in healthcare.

	• Routinely and robustly consider health inequalities as part of service development/change through the application of the organisational Equality and Engagement Impact Assessment, ensuring that we comply with the requirements of the Public Sector Equality Duty (Equality Act 2010). • Embed the Prevention and Health Inequalities Hub resource into business as usual so that health inequalities are widely understood and routinely considered.
7. Duty to promote the involvement of each patient	We are committed to promoting personalised care across all the services we deliver across our organisations. We have nominated a senior executive to facilitate a peer network of system leaders and experts by experience to work collaboratively, pledging commitment to coproduce innovative approaches and collect evidence to demonstrate effectiveness on implementing a universal recognise approach to personalised care through the One Gloucestershire Personalised Care Programme Board. Across our organisations we are updating our pledge commitment to use plain language and foster a culture shift for health and care professionals and people, valued as equal partners, providing choice and control on the way their health and care is delivered based on 'what matters to you' conversations, recorded in easily accessible care plans, digitally interoperable between system partners, held in a universally recognised folder owned by a person living with a complex/long term condition. Our approach is based on the seven components of the comprehensive model of personalised care. This includes: Other interdependent work includes personalised proactive (anticipatory) care working to co-develop risk stratification tools to support NHS partners to profile vulnerable people; facilitate multi-disciplinary (agency) team meetings to discuss and agree to proactively reach out to people; arranging to hold 'what matters' conversations and coproduce personalised care and support plans." **In 2023/24 we have:** • **Shared decision making** – we are committed to 'what matters' conversations and have procured accredited training with the Personalised Care Institute to upskill our workforce in competencies associated with the model of personalised care. • **Personalised care and support planning** – we have made good progress in mobilising branded personalised care and support plans (Me at My Best and ReSPECT) for people living with complex/long term conditions, hosted in a 'What Matters to Me' folder across services which enables us, with people, to capture information about what matters to them. Areas such as frailty, end of life care and maternity are regularly using these. • **Enabling choice including legal rights to choice** – See duty to patient choice (above).

	• **NHS @ Home** – exploring the use of digital tools to support people maintain their unique wellness at home including Virtual Ward for Frailty and Respiratory care. • **Social prescribing and community-based support** and expansion of **personal health/wellbeing budgets** – these are a core part of our service offer to residents. For example, one-off personal wellbeing support budgets being used in partnership with Age UK to support timely hospital discharge and trialling of Frailty & Dementia Proactive Care Personal Wellbeing Budgets to support the integrated neighbourhood prevention agenda. • **Supported self-management** – with patients we are committed to continue to support self-management of health and care conditions. This includes the use of digital tools such as GetUBetter – a digital solution to support patients with a range of musculoskeletal conditions and My Concerns & Wellbeing (MyCaW) being deployed for people living with frailty. **Looking to 2024/25 we will be:** • **Shared decision making -** Exploring use of digital tools to reporting on real-time patient reported experience measures and patient reported outcome measures. • **Personalised care and support planning -** Continued expansion plans across the whole life cycle and we are exploring opportunities across clinical programmes as part of Living Well and Waiting Well in elective care. • **Enabling choice including legal rights to choice** – See duty to patient choice (above). • **NHS @ Home** – Exploring the use of digital tools to support people maintain their unique wellness at home. • **Social prescribing and community-based support** and expansion of **personal health/wellbeing budgets** - Expansion of personal health/wellbeing budgets and trialling of Frailty & Dementia Proactive Care Personal Wellbeing Budgets to support the integrated neighbourhood prevention agenda. • **Supported self-management -** Other offers include peer coaching through the Digital HOPE Programme and Live Better Feel Better
8. Duty to involve the public	In 2022 we published our ICB Working with People and Communities Strategy which sets out our principles, how we will work and the mechanisms we are putting in place to ensure that the people and communities of Gloucestershire are at the heart of all that we do. The Strategy is based around five commitments. **In delivery of this strategy, in 2023/24 we have:**

	• Introduced a new Citizens Panel with over 1,000 people – representative of the Gloucestershire population. This Panel is providing us with an opportunity to hear from different groups of people to shape health and care services in the County. We have engaged the Panel this year on priority areas for our strategy. • Undertaken focused engagement within our Core 20 communities as part of our commitment to tackle health inequalities. • Built and maintained relationships with previously underserved communities with the input of a dedicated resource. This working alongside partner organisations to collect individual and group experiences and liaise with ICS colleagues to ensure the insights gathered inform service development, delivery and evaluation of reducing health inequalities programmes. **Looking to 2024/25 we will be:** • Continuing to expand the engagement with the Citizens Panel on new areas that will support the delivery of our Integrated Care Strategy and Joint Forward Plan • Introducing an Insight Hub that will be an online library that will collate feedback from local people and communities. We will also use the learning from involvement activities such as Fit for the Future and a new community hospital in the Forest of Dean. The delivery of the Strategy is being overseen by our Working with People and Communities Advisory Group that is made up of community and public voice partners.
9. Duty as to patient choice	We remain committed to supporting our GPs to offer meaningful choice to people registered with their practice, as set out in the NHS Constitution for England and the NHS Choice Framework. Our commitments to patient choice can be found here. **In 2023/24 we have:** • Established a clear process for managing the national alternative choice (PIDMAS) programme, and successfully rolled this out to eligible patients in the nationally defined first cohort. This process will ensure that patients are offered the opportunity choose to transfer to an alternative provider if they have waited longer than agreed waiting times standards. We will roll this process out to further cohorts of patients in line with national requirements as an when further national guidance becomes available. • Put in place a robust provider accreditation process for services within the scope of choice to allow new providers to easily enter the NHS market or existing providers to deliver additional services in line with national choice guidance and the new NHS Provider Selection Regime.

	Looking to 2024/25: • We are working towards ensuring that patients are routinely offered an average of 5 choices of provider at the point of referral in line with Choice guidance issued in May 2023. Changes to the Electronic Referral System (eRS) are due to be implemented nationally in March 2024, which will enable our GPs to offer patients a mixed shortlist of both Directly Bookable and Referral Assessment Services. As soon as NHS Digital deliver this functionality we will work with our GPs to ensure that all patients are offered an appropriate provider shortlist in line with national guidance. • We will also continue to provide of GPs with accurate and accessible information via the ICB G-care platform on waiting times across local providers. This supplements the waiting time information available through public facing digital tools, including the NHS app.
10. Duty to obtain appropriate advice	As a system we continue to prioritise the importance of ensuring there is a strong clinical and care professional voice in advice and decision making across the system. We are continuing to implement the Clinical and Care Professional Leadership Framework that was published in 2022 – and our Clinical and Care Professional Council plays a key role in bringing together leaders from across Gloucestershire. **In 2023/24 we have further developed our approach in this area by:** • Appointing a new ICB Chief Medical Officer and ICB Chief Nursing Officer in Gloucestershire • Ensuring that our transformation programmes that are making improvements about health and care in Gloucestershire have strong care and clinical leadership. This year we have recruited into key roles to support our strategic ambitions. This includes clinical leadership for our Working as One (Urgent and Emergency Care Programme). • Our Clinical & Care Professional Council continue to work to deliver the intentions of the 2022 Framework and Action Plan. Membership of Council has been reviewed through 2023 to ensure a broader range of strategic system partners. • Continued to ensure that there is a strong clinical and care voice into the NHS Gloucestershire Integrated Care Board. This has included specific work on key areas such as children and young people and mental health. **In 2024/25 we will be:**

	• Undertaking a review of progress against the actions in our Clinical and Care Professional Leadership Framework including a refresh of actions. • Continuing to ensure that we embed a strong clinical and care professional voice through our transformation work across Gloucestershire. We remain committed ensure the breadth of expertise is drawn upon through formal governance structures to ensure the inclusive contribution of clinical and care leaders from across organisations in Gloucestershire.
11. Duty to promote innovation	Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. We remain committed to advance Gloucestershire's innovation profile and standing by actively seeking to adopt and spread new opportunities. **We are:** • Working with education and public sector organisations such as the University of Gloucestershire and Gloucester City Council in their regeneration of Gloucester City King's Quarter and the new Forum digital, innovation and social hub. • Playing an active role as NHS organisations in Gloucestershire in Health Innovation West of England (HIWoE - formerly the Academic Health Science Network) as they embark on their new five-year licence. This partnership provides a pipeline of opportunities to take part in 'adopt and spread' initiatives. We act as a pilot system for some of these innovations, again ensuring we are confident in the safety and potential benefit. • Prioritising research and innovation projects that address the health needs of our population drawing on the expertise of HIWoE and other groups such as National Health Innovation Network and the Accelerated Access Collaborative. • Working closely NIHR Applied Research Collaborative (ARC) West and with NIHR West of England Clinical Research Network to learn from and spread innovation. Gloucestershire also benefits from a range of existing locally commissioned innovation projects supported by HIWoE that tackle both healthcare challenges and improve our health equity. We also listen carefully to the good ideas that come from our own staff about how to improve their areas of work, or the wider life of their organisation and the system overall. Our approach and commitment to Quality Improvement helps take these ideas, clearly articulate the evidence for them, and helps implementation and monitoring of their benefits.
12. Duty in respect of research	There has been a significant increase in research interest in Gloucestershire that we will continue to build on in 2024/25.

	In 2023/24 we have: • Appointed a part-time Director lead for research with the aim of facilitating the joining up of research activity across the county and implementing the research strategy. The ICS research team has also made connections with Norfolk & Waverly ICB who have a well-developed community and primary care research resource. The aim is to learn from their experience. • Launched an ICS evaluation advisory group to provide advice on undertaking project and service evaluations. The group also provides expertise that has been assessing where investment has been made into projects with a view to informing decisions on whether these should be funded. • Supported Research 4 Gloucestershire who have expanded membership to include public health, adult and child social care as well as an independent health & care provider representative. The aim is that research should be multi-disciplinary and follow the patient's journey rather than being undertaken in service or professional silos. A draft research strategy has been prepared and from this strategy an operational plan will be developed to drive forward research and evaluation activities across the county. **Looking towards 2024/25,** • The ICB will continue to work with the University of Gloucestershire to establish an ICS research hub. Together we will support several staff to undertake PhD research studies as well as providing small grants for local research and evaluation activity. Our aim is to increase the number of publications from ICS staff and share the learning both inside and outside the county. • The ICB are keen to involve local people in research, increase participation and undertake research that is of value to them. The ICB was successful in bidding for resources from NHSE from the Research Engagement Network Development (REND) funds. We have now established the 'Sharing the Power: Get involved in research in Gloucestershire' group and have appointed an insights research officer to support this work. • Continue to expand research activity into primary care and community services. Despite CRN funding largely focused on acute hospitals, we have put in 7 funding bids to increase research capacity during 2024/25 in out of hospital health and care services.
13. Duty to promote education and training	Education and training underpin our whole system, both for our staff and our patients and the public. We will continue to ensure our staff receive the development and opportunities they need to continue providing the best possible care. We will also continue to deliver more education to patients to help with prevention and self-care, and to support their loved ones.

	Our Joint Forward Plan sets out our achievements and commitments in this area. **Our work in this area for staff includes:** • Continued to support training and development in primary care – including Spark (New to Practice scheme) that has provided mentoring, coaching, peer support and educational events to over 20% of the GP workforce in the County. • Continued with the development of system leaders through our 'systems thinking' programme and coordinating the One Gloucestershire Leadership Development alumni programme. • Continued to develop strong relationships with nearby Universities including University of Gloucestershire and University of Worcestershire. New pre-registration courses are starting, increasing the supply of newly qualified staff to the ICS in the coming years. • Supported cross-system education including hospital-based specialist teams providing high-quality materials including podcasts, videos, and formal training sessions. **Our work in this area for patients includes:** • Offering education and information about the services and support we offer for all patients with cancer. • Development of lifestyle, exercise and medication education programmes for patients with complex respiratory disease management.
14. Duty as to regard to climate change and adaptation to impacts	As partners (NHS Gloucestershire ICB, Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust) we approved our Green Plan in 2022. Our Green Plan serves as our central document for how we will collectively reduce our emissions and support the delivery of our wider sustainability objectives between now and 2025. As 'anchor organisations' we are committed to the two key targets that extend beyond the duration of this Joint Forward Plan: • **NHS Carbon Footprint**: Reaching net zero by 2040 • **NHS Carbon Footprint Plus**: Reaching net zero by 2045 The plan (which also sets out individual organisational targets) does not replace green plans published by individual organisations but is intended to confirm common and collaborative actions and timelines. Our sustainability priorities to deliver against these ambitions remain as: • Transport and Travel • Estates and Facilities • Climate Adaptation • Sustainable Models of Care

	• Medicines and Procurement • Workforce and System Leadership The Joint Forward Plan "Green and Sustainability" section highlights some of our achievements in 2023/24. The ICS Sustainability Steering Group oversees delivery of these ambitions. **In 2024/25 we will be:** • Launching a shared approach and information for staff induction covering green and sustainability objectives. • Developing a longer-term sustainability programme plan to advance our work in this area.
15. Addressing the particular needs of children and young people	Addressing the needs of children and young people remains a high priority of NHS Gloucestershire ICB. Our ambition for children, young people and their families in Gloucestershire is for them to experience integrated services that are holistic in their approach, supporting their mental, physical, emotional and social needs. Our Joint Forward Plan sets out a summary of what we have achieved and our ambitions in this area. Within the ICB leadership we have an Executive Lead for Children and Young People as well as for Mental Health and Special Educational Needs and Disabilities. **In 2023/24 we have:** • Undertaken comprehensive work with NHS Gloucestershire Integrated Care Board to understand the needs of children and young people and identify future priorities. • With wider partners, formalised a Special Educational Needs and Disabilities (SEND) programme to deliver improvements across health and care for children and young people • Invested in services to bring improvements in outcomes for children and young people including our ICB SEND workforce as well as a number of health and care services that support children and young people including Neurodiversity, School Nurse Trainers and Early Language and Support for Every Child (ELSEC). • Supported work to bring together mental and physical health services for children in care into one integrated offer. **Looking to 2024/25 we will be:** • Supporting the implementation of the SEND action plan to ensure that commitments within the plan are being delivered. • Support the development of a wider plan for children and young people being undertaken by system partners.

	• Continue to support improvements in services for children and young people – including being an ELSEC pathfinder in Gloucestershire. • Continue to embed co-production with parent carers, children and young people and joint working with education and social care partners.
16. Addressing the particular needs of victims of abuse	Strategic leadership and partnership working are key elements to proactively support the effectiveness of Gloucestershire's Safeguarding System. We work with health providers and partners to ensure the ICB and our commissioned services comply with the NHSE Safeguarding Assurance and Accountability Framework and have regard for our duty to protect and safeguard against abuse. **In 2023/24 we have:** • Continued to provide a comprehensive ICB Safeguarding Primary Care Offer to General Practice and their GP Safeguarding Leads – including safeguarding information sharing requirements, quality assurance visits, completion of an annual safeguarding assurance audit, attendance at safeguarding adult and children training and other statutory safeguarding duties. • Continued to deliver our safeguarding statutory requirements including active involvement in the Gloucestershire Safeguarding Children Partnership (GSCP), as well as Board level membership at the Gloucestershire Adult Safeguarding Board (GSAB). • Continued to play an active role in the Safer Gloucestershire Partnership including the Domestic Abuse Partnership Board (DAPB) – supporting delivery of the Domestic Abuse Delivery Plan and Strategy alongside our partners. This includes the commissioning of health services to meet the needs of victims of all ages in both acute and community services and an ICB Domestic Abuse Staff policy. • Supporting the delivery of Sexual Violence Delivery Plan and Strategy through the Sexual Violence Strategic Board. This Strategy builds on the work of the Sexual Violence Partnership (SVP) and works in conjunction with the County Domestic Abuse Local Partnership Board (DA LPB) and Strategy **Looking to 2024/25, our ICB safeguarding priorities include:** • Continued commitment to the integration of core functions within the current three safeguarding services of the Integrated Care Board (ICB), Gloucestershire Hospitals Foundation Trust (GHFT) and Gloucestershire Health and Care Trust (GHC). • Working with our ICB contract leads to understand and therefore ensure safeguarding standards are embedded in all contracts

	(large and small providers) and further work on how this is monitored. • Further embedding integrated safeguarding supervision across the ICS and monitoring compliancy of mandatory safeguarding and children in care training at all levels across the ICB. • Embedding learning from adult and children's statutory safeguarding reviews to ensure we prevent further harm to our most vulnerable. In the next few years, we are prioritising putting in a rolling programme of safeguarding assurance visits to all commissioned large providers, including Primary Care to support the adherence to safeguarding NHSE standards in contracts.
17. Implementing any Joint Local Health & Wellbeing Strategy	The Gloucestershire Health and Wellbeing Board is responsible for overseeing the development and delivery of the Joint Health and Wellbeing Strategy which aims to improve the lives of people in Gloucestershire. The Health and Wellbeing Strategy is focused on seven key objectives – physical activity; adverse childhood experiences; mental wellbeing; social isolation and loneliness; healthy lifestyles; early years and best start in life and housing. The NHS in Gloucestershire continues to play a role in all seven of these priority areas to a greater or lesser extent. Our Joint Forward Plan describes how we are contributing to areas such as physical activity and healthy lifestyles (see our commitment to "ensuring a healthy Gloucestershire", mental wellbeing (see our commitment to "better care for different groups of people" as well as early years and best start in life (see our commitment to "better care at every age").