Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 31st July 2024

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

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.00 – 2.02pm	**Welcome and Apologies** Apologies: Prof Sarah Scott, Prof Jo Coast	Information	**Chair**
2.	2.02 – 2.02pm	**Declarations of Interest** The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	**Chair**
3.	2.02 – 2.04pm	**Minutes of the meeting held 29th May 2024 & Extraordinary meeting on 26th June 2024**	Approval	**Chair**
4.	2.04 – 2.05pm	**Action Log & Matters Arising**	Discussion	**Chair**
		Business Items		
5.	2.05 – 2.10pm	**Questions from Members of the Public**	Discussion	**Chair**
6.	2.10 – 2.30pm	**Patient Story**	Discussion	**Becky Parish & Voluntary Sector**
7.	2.30 – 3.00pm	**Planned Care and Recovery Update**	Discussion	**Mark Walkingshaw Christian Hamilton**
8.	3.00 – 3.10pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	3.10 - 3.20pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.20 – 3.40pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Ellen Rule Tracey Cox Marie Crofts Cath Leech**
		Decision items		
11.	3.40- 3.50pm	**2024/25 Budget**	Approval	**Cath Leech**
12.		**2024-25 Capital Budget**	Approval	**Cath Leech**
13.	3.50 4.20pm	**Development of Health Services in Lydney, Forest of Dean**	Approval	**Ellen Rule**
		Information items		
14.1	4.20 – 4.25pm	**Chair's verbal & ARAC report from the Audit Committee** held on 24th June 2024 and approved minutes from 7th March 2024	Information	**Julie Soutter**
14.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** held on 6th June 2024 and approved minutes from 4th April 2024		**Ayesha Janjua**
14.3		**Chair's verbal report on the System Quality Committee** held on 5th June 2024 and approved minutes from 3rd April 2024		**Prof Jane Cummings & Julie Soutter**
14.4		**Chair's verbal report on the Resources Committee** held 4th July 2024 and approved minutes from 2nd May 2024		**Ayesha Janjua**
14.5		**Chair's verbal report on the People Committee** held 18th July 2024 and approved minutes from 16th May 2024		**Karen Clements**
15.	4.25pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 30th September 2024 – 2.00-4.30pm

Boardroom, Shire Hall

Withdrawal of the press and public

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

(for reasons of commercial in confidence discussions)

Extraordinary Public Gloucestershire Integrated Care Board Meeting

To be held 1.30 – 2.00pm on Wednesday 26th June 2024

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

Members Present:		
Dame Gill Morgan	GM	Chair, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, NHS Gloucestershire ICB
Kevin McNamara	KM	Chief Executive Officer, Gloucestershire Hospitals NHSFT
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Tracey Cox	TC	Director of People, Culture & Engagement, NHS Gloucestershire ICB
Marie Crofts	MCr	Chief Nursing Officer and Director of Quality
Douglas Blair	DB	Chief Executive Officer, Gloucestershire Health & Care NHSFT
Prof Jane Cummings	JCu	Non-Executive Director, NHS Gloucestershire ICB
Karen Clements	KC	Non-Executive Director, NHS Gloucestershire ICB
Ayesha Janjua	AJ	Non-Executive Director, NHS Gloucestershire ICB
Julie Soutter	JSo	Non-Executive Director, NHS Gloucestershire ICB
Participants Present:		
Nicola de Longh	NDL	Non-Executive Director, Gloucestershire Health & Care NHS Foundation Trust
Mark Cooke	MC	Director of Strategy and Transformation, NHSE
Deborah Evans	DE	Chair of Gloucestershire Hospitals NHSFT
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
Martin Holloway	MH	Senior Independent Director and Non-Executive Director of SWAST
In Attendance:		
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
Christina Gradowski	CG	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Officer, NHS Gloucestershire

1. Welcome and Apologies

1.1 The Chair welcomed those present. Apologies were received from Dr Jo Bayley, Ann James, Carole Alloway-Martin, Graham Russell, Sarah Scott, Ellen Rule and Siobhan Farmer.

1.2 The meeting was declared to be quorate.

2. Declarations of Interests

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

3. Final Accounts 2023-2024

3.1 The report provided an overview of the key statements included within NHS Gloucestershire's accounts covering the period 1st April 2023 – 31st March 2024.

3.2 The financial position for 2023/24 as of 31st March 2024 was a small surplus of £93k. This position remained unchanged from the draft accounts and the auditors anticipated issuing an unqualified opinion on the statements being a true and fair view, on the regulatory opinion and on value for money. There were five improvement recommendations; continuing to work on the medium term plan, continuing to work on the single savings schedule and some changes to improve reporting performance to the Board around some of the risks.

3.3 The Letter of Representation is to be signed and given to the ICB external auditors providing assurance to them that the ICB had prepared accounts in accordance with all guidance, used income and expenditure in line with regulation and disclosed all relevant matters to the auditors which would not influence the accounts. The Letter is to be signed by the Chief Executive once signed off by the Board.

3.4 The surplus of £93k is to be added to the cumulative surplus for the ICB and this is now £20.983m for the ICB. The ICB are unable to access that without a full Business Case to NHSE and it is dependent upon the affordability for NHSE.

3.5 The surplus from last year is based on the expenditure against the allocation. The allocation last year was £1.35bn.

3.6 From the 1st April 2023 responsibility for commissioning pharmaceutical, general ophthalmic services and dentistry (POD) in Gloucestershire was delegated from NHSE to ICB's. Gloucestershire ICB also moved its headquarters from Sanger House to Shire Hall; therefore there was a cessation of one lease under IFRS16 and the implementation of the new Shire Hall ICB headquarter lease from September 2023 to run for a period of 10 years.

3.7 JSo stated that the Audit Committee on 24th June 2024 had reviewed the accounts, the Going Concern assessment Statement and had confirmed that this was in order and the reports from external audit and the recommendations, many of which were being worked on which had been very reassuring.

3.8 The internal audit opinion had also been very positive with moderate assurance overall. The internal auditors mentioned that they had recently issued a POD report on the dental aspects which had substantial across both design and effectiveness which was good. Other points would be covered at the Chair's update at the next formal Board meeting.

3.9 The Chair noted that the financial position was tighter than usual and also commended colleagues throughout every organisation in the system, all of whom had contributed to bringing the ICB to this position. The last year had felt very challenging and so to be in this position now demonstrated the incredible achievement in working together.

Resolution: The Board approved the NHS Gloucestershire ICB annual accounts and the signing of the Letter of Representation.

4. NHS Gloucestershire ICB Annual Report 2023/2024

4.1 MH said that the NHS Gloucestershire (ICB) Annual Report 2023/2024 was being presented today to the ICB Board for approval.

The Report highlighted many of the achievements delivered by the ICB and system partners during the year, set out under the three ICS strategic priority pillars:

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

It also reflected the challenges, opportunities and risks facing the ICB, the wider health and care community (ICS) and progress made to address those.

4.2 The ICB's objective was to produce a best practice Report and a public summary (Annual Review) to accompany it. The structure and much of the statutory report content for the full Report is determined by requirements set out in the Department of Health and Social Care Group Accounting Manual (GAM) 2023/2024, the NHS England ICB Annual Report Template 2023/24 and the NHS England - ICB Annual Report - Working with People and Communities Guidance.

4.3 As part of this, it was expected that the report should also describe how the ICB were delivering against eight specific duties as part of the annual ICB assurance process:

1. The duty to improve quality
2. The duty to reduce inequalities
3. The duty to take appropriate advice
4. The duty to have regard for the effect of decisions
5. The duty to use and promote research
6. The duty to involve patients and the public
7. The financial duties
8. The duty to support local strategies and priorities.

4.4 A short summary had been produced at the front of the Annual Report and after submission to the auditors and NHSE, who had given some brief comments and these had been incorporated into the document brought today. There will be a distribution plan for the Report to ensure it is accessible.

4.5 The Health Inequalities Information Review Statement had been circulated yesterday to Board members and this referenced the health inequalities section on Page 57 and gave a comprehensive overview of the work that had been conducted and approved by the systemwide Executive and amended accordingly.

4.6 DB mentioned that in preparation for a system leadership meeting tomorrow, some small alterations had been done around wording which was not deemed problematic by the Board. JCu had noticed that wording referring to Nurse Associates which should be Nursing Associates otherwise the Report was very good.

4.7 The Chair commended colleagues who had produced such a good quality and interesting document which demonstrated some good examples of the work having been undertaken

by the ICB. The Chair requested that MH thanked staff for the work and time taken to produce the Annual Report.

***Resolution*: The Board approved the NHS Gloucestershire ICB Annual Report 2023/2024 as an accurate representation of what the ICB had done and were happy to take this to the next stage.**

5. Any Other Business

5.1 There were no items of Any Other Business to discuss.

The meeting concluded at 1.50pm

Time and date of next meeting

The next ICB Public Board meeting will be held on Wednesday 31st July 2023 from 2.00 to 4.30pm

Withdrawal of the press and public

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

(Commercial in confidence discussions)

Gloucestershire Integrated Care Public Board Meeting

To be held 2.00pm to 4.00pm on Wednesday 29th May 2024

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

Members Present:		
Dame Gill Morgan	GM	Chair, NHS Gloucestershire ICB
Ellen Rule	ER	Deputy CEO & Director of Strategy and Transformation, NHS Gloucestershire ICB
Ayesha Janjua	AJa	Non-Executive Director, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Douglas Blair	DB	Chief Executive Officer, Gloucestershire Health & Care NHSFT
Dr Jo Bayley	JB	Chief Executive, GDOC Ltd.
Siobhan Farmer	SF	Director of Public Health, Gloucestershire County Council
Prof Jo Coast	JCo	Non-Executive Director, NHS Gloucestershire ICB
Prof Jane Cummings	JCu	Non-Executive Director, NHS Gloucestershire ICB
Julie Soutter	JS	Non-Executive Director, NHS Gloucestershire ICB
Karen Clements	KC	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MCr	Chief Nursing Officer, NHS Gloucestershire ICB
Tracey Cox	TC	Director of People, Culture & Engagement, NHS Gloucestershire ICB
Participants Present:		
Benedict Leigh	BL	Director of Integration, NHS Gloucestershire ICB and Gloucestershire County Council
Carole Alloway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council and Chair of Health & Wellbeing Partnership Board
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHSFT
Graham Russell	GR	Chair, Gloucestershire Health & Care NHS Foundation Trust
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Mark Cooke	MC	Director of Strategy and Transformation, NHS England
Dr Olesya Atkinson	OA	GP Fellow, Deputy Clinical Director Cheltenham Primary Care Network
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
In Attendance:		
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Christina Worle (*item 7)*	CW	Dental Strategy Clinical Lead, NHS Gloucestershire ICB
Becky Parish (*Item 6 & 7)*	BP	Associate Director Engagement & Experience, NHS Gloucestershire ICB
Lucy White (*Item 6 & 7)*	LW	Manager for Healthwatch, Gloucestershire
Sian Williams *(Item 7)*	SW	GP Clinical Pharmacist, NHS Gloucestershire ICB
Megan Terrett *(Item 7)*	MT	Service Improvement Manager, Eye Health Clinical Programme Group, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 The Chair welcomed members to the meeting. Apologies were received from Mary Hutton (MH), Ann James (AJ), Christina Gradowski (CG), Mark Walkingshaw (MW), Sarah Scott (SS), Kevin McNamara (KM), Pete Bungard (PB) and Martin Holloway (Mho). It was noted that Martin Holloway was currently acting as interim Chair for the South Western

Ambulance Service (SWAST). His contribution to the Board was positively noted by the Chair.

1.2 There were three members of public present at the meeting, who were welcomed to the meeting by the Chair.

1.3 The Chair welcomed GR and congratulated him on his new role as Chair of Gloucestershire Health and Care NHS Foundation Trust (GHC) and thanking him for his continued support to the Board.

The Chair also congratulated OA on her recent appointment as Deputy Medical Director at Gloucestershire Health and Care NHS Foundation Trust (GHC) who would further strengthening the line of sight from Primary Care to communities and localities across the collective system.

1.4 The Chair drew the Board's attention to the requirements which would be placed on public bodies in the run up to the General Election in July 2024. Adherence to election guidance, which would also be available to colleagues, would be vital, and the Chair advised those present become familiar with the rules during this time.

1.5 The Chair spoke about the recent public inquiry report into the Infected Blood Scandal whereby contaminated blood and contaminated blood products were given to men, women and children treated by the NHS in the United Kingdom. The report had been an extremely difficult and upsetting read for those who had been in the NHS for a long time, including the Chair who felt that it was something that needed to be discussed at a future Board meeting. **Action: Contaminated Blood Inquiry Report to be placed on a future Board agenda.** **CG/RB**

1.6 The Chair also suggested that the Countess of Chester case should be discussed at a future Board meeting, enabling reflection on some of the implications of the national findings and how these might be relevant in future. **Action: Countess of Chester case to be placed on a future Board agenda.** **CG/RB**

2. Declarations of Interests

2.1 The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)

There were no new Declarations of Interest for this meeting.

3. Minutes of the Public Board meeting held on 27th March 2024

3.1 The minutes from the Public Board meeting held on the 27th March 2024 were approved as an accurate record.

4. Matters Arising and Action Log

4.1 There were no matters arising. The Chair informed members that there were a number of actions on the Action Log which had been timetabled into future agendas, but these were to remain open until there had been satisfactory discussion and closure.

4.2 DE stated that the Chair's visit to the End-of-Life team had taken place six months ago and noted that this was going to the System Quality Committee. DE recommended that this item was not closed as an action at this point. JCu informed the meeting that the item was

to be discussed on the System Quality Committee which would be held on 5th June and reported in the minutes. **Action: The Dying Matters Report would be discussed by the System Quality Committee and the outcome reported to the Board.** **CG/RB**

5. Questions from members of the public

5.1 Three questions from members of the public were read out together with full responses from the ICB Board. These are included in a log on the ICB public website as below and responses would be sent directly to those who asked the questions: https://www.nhsglos.nhs.uk/about-us/how-we-work/theicb-board/

Any actions arising from the questions would be brought back to the Board as Matters Arising.

6. Patient Story – Community Pharmacy

6.1 LW introduced herself as the Manager of Healthwatch Gloucestershire. She explained that some of the recent changes in pharmacy arrangements had resulted in problems arising for members of the public, which were read out by LW and responded to by AR.

6.2 LW read out four issues which had arisen following a recent Healthwatch project on community pharmacies. AR confirmed that the feedback received from some of the Gloucestershire residents was echoed in the many messages received by the ICB's Patient Advice and Liaison Service (PALs) team.

6.3 The four key issues included:

1. *A breakdown in processes between GPs and Pharmacies leading to prescriptions being delayed.*
   - Patients coming in to collect prescriptions had sometimes found that these had not been issued to the pharmacy by GP surgeries. This often happened where more than one item was requested.
   - Some surgeries could take up to 5 days to authorise a prescription request that came in through the pharmacy service. A previously great service had, over the past 6 months, deteriorated and often texts were not received to inform patients that medications were ready for collection.
   - Electronic prescription arrangements at pharmacies was a long drawn put process. It was felt that it would be far more useful for the NHS App to be adapted to show the varying stages of the prescription's journey and ultimately when collection was ready.

6.3.1 ***ICB Response read by AR:***

Feedback from some Gloucestershire residents, as represented in these individuals' stories, was echoed by a number of people who had contacted the ICB PALS team for advice and support. This also aligned with the important themes shared in the national report published recently by Healthwatch England - Healthwatch Pharmacy: what people want.

The ICB welcomed the opportunity to work with Healthwatch Gloucestershire to increase the use of NHS App and raise awareness of the services available at our local community pharmacies over the next 12 months. Many pharmacies did send texts to patients and the ICB had established the NHS App Group, which was working to increase the use of the NHS App. The NHS App Team had attended the Countywide Patient Participation Groups meeting facilitated by the ICB and had received feedback from people and communities about the range of digital solutions. For those that were keen and able to use the NHS App

digital solution, this would create capacity for a tailored approach, offering a more bespoke solution.

6.4 *2. Shortages of medication were a concern.*

- Healthwatch had heard through public engagement that people were increasingly being told that medications were not in stock or not available for varying reasons. Over the past six months medication had often been late or incomplete; sometimes prescriptions had been lost. One person had changed his pharmacy only to find that the service they offered was no improvement.
- Delays in pharmacies caused by a lack of deliveries from preferred suppliers meant that patients had to wait for extended times to receive their medications and so suffered in the meantime.

6.4.1 ***ICB Response read by AR:***

Medication shortages remains a global issue. Pharmacy teams are increasingly spending significant amounts of time each day, trying to access medicines that patients required.

Specialist Pharmacy Services (SPS) had a national supply tool that could offer advice on those items recognised as being in short supply. The Medicines Optimisation team would be sharing information via the weekly ICB Primary Care Bulletin with general practices and pharmacies about the supply tool and items in short supply. The ICB would continue to explore the best solutions for keeping clinicians and patients informed.

6.5 *3. Confusion about extended roles and responsibilities of Pharmacists.*

- One patient had related his recent experience of having an ear infection and being directed to different pharmacists who had given varying advice, before being able to finally make an appointment with his GP practice to have the problem resolved.

6.5.1 ***ICB Response read by AR:***

The NHS Long Term Plan (LTP) is committed to the 'greater use of community pharmacists' skills and opportunities to engage patients'; in recognition of this commitment the ICB launched the Pharmacy First service on 31st January 2024. This new service offers patients further opportunities to access assessment, advice and if appropriate, treatments, such as antibiotics without the need for a GP appointment or a prescription.

Pharmacy First aims to encourage people to visit their pharmacy as the first port of call for the seven clinical pathway conditions and provide same day access to assessment and care before conditions worsen. Pharmacy First came with a national and local communications campaign that aimed to show people the skills and capabilities of pharmacists and their teams. There were very robust pathways of care for the seven common conditions. At this early stage there were no plans to extend beyond the seven clinical pathways, but this would be reviewed nationally going forwards.

The community pharmacists are highly trained experts in medicines and low acuity conditions. Further digital enhancements were due shortly with the aim to increase local communications and media campaigns to raise awareness around better utilisation of the community pharmacists and their teams, as an alternative to the traditional GP-led approach.

The ICB would shortly be working on a joint local project with Healthwatch Gloucestershire and the Local Medical Committee (LMC) to produce information focussed on how patients could obtain the best use of their GP practices; this would include information about extended and additional roles across Primary Care, including community pharmacies.

6.6 *4. Difficulty in accessing pharmacies.*

- One couple had reported that the pharmacy did not answer their calls and it was clear to them that there were now fewer staff present.
- One patient told Healthwatch about her difficulties in accessing her pharmacy as she was old, disabled and lived alone. There were no buses to the pharmacy and the lady therefore had to rely on lifts for which she would pay. Due to pharmacy deliveries only being available during weekdays, there would be a delay in starting any necessary medication over a weekend.

6.6.1 ***ICB Response read by AR:***

Sadly, Gloucestershire had experienced a small number of community pharmacy closures in the past year, with a resultant increase in the workload of nearby pharmacies. This along with a growing number of prescriptions supplied, medication and workforce shortages, in addition to funding challenges, was making it more difficult for people to access pharmacy services. The measures described above such as NHS App, collaborative working, increasing the registered pharmacy workforce and capitalising on digital and automation opportunities, was aimed to help the pharmacy services available to patients.

The ICB welcomed the opportunity to work with Healthwatch Gloucestershire to increase the use of NHS App and raise awareness of the services available at local community pharmacies over the next 12 months.

6.7 The Chair asked how the Board could get a view of performance in General Practice at a strategic level and asked how data was collected to reflect which pharmacies might be experiencing problems. HG responded that Healthwatch data will be used to feed into their planning, as they already collected rich and useful data provided to the ICB. HG explained that quality indicators would be examined across Pharmacy, Optometry and Dental (POD) to understand more about the provision of services and any gaps. The Chair stated that it was important not to have too great a bias towards activity, at the risk of losing the quality aspect.

6.8 OA commented that Cheltenham had very good communications with community pharmacies, but there was more that could be done in the future around promoting the hypertension monitoring service. There was still some work to be undertaken around addressing the processes for Pharmacy First for both patients and the pharmacists going forward. However, OA felt that as things progressed, some of the initial problems encountered would ease, and it would become clearer what pharmacists could offer under the contract to members of the public.

6.9 AJ informed the meeting that there had been discussions at the previous Primary Care and Direct Commissioning (PC&DC) Committee about the Community Pharmacy Assurance Framework, driven by the South West Commissioning Hub. The Committee had asked for the results of a survey on pharmacies and the quality of their services. Data was still inconsistent and the Committee would be trying to examine the outcomes and metrics across the wider Primary Care, including pharmacy that could be monitored and measured. Patient experience and customer satisfaction was important and the work undertaken by Healthwatch would be invaluable.

6.10 JB commented that there were some teething problems with Pharmacy First which were inevitable but did not want to minimise the intense frustration and inconvenience caused to patients. There was optimism that things would improve as people became more familiar with the system. JB commented that she would be interested to know numbers of prescriptions managed by GPs, pharmacies and their practices.

6.11 The Chair raised the issue that the shortage of certain drugs could be due to people buying them on the web. She stated that she would like to see any trend data on this to understand if this was a problem and the implications for health, particularly related to any financial costs.

6.12 LW confirmed that Healthwatch's priority this year would be Pharmacy and asked that Healthwatch be involved with some of the many groups and discussions on this subject. She felt that this would be very beneficial and assured the Board that Healthwatch would continue to provide the ICB with useful information and data. The Chair thanked LW for her contribution in the Board meeting today.

Resolution: The Board noted the content of the Patient Story from Healthwatch.

7. <u>Community Pharmacy, Optometry and Dental Services in Gloucestershire</u>

7.1 HG was pleased to report that the ICB had been working effectively with NHSE colleagues in the Commissioning Hub. There were still some challenges around capacity to support the ICB, but both sides felt that the relationship was productive and was working well.

7.2 POD Services were delegated to ICBs on 1st April 2023 from NHS England (NHSE) South-West. Managing these services locally had given the ICB the opportunity to ensure that services were designed in a way to ensure they met the needs of the local population. The purpose of the presentation was to give an overview of the progress made since 2023 and highlight the core set of priorities in place to deliver these services.

7.3 The ICB had worked closely with Gloucestershire County Council (GCC) who had a statutory duty for oral health. HS informed the Board that:

- The Supervised Toothbrushing Service had been taken up by the majority of the Core20PLUS5 schools in Gloucestershire and Health Visitors had been giving out dental packs to promote good oral hygiene.
- A new Oral Health Promotion Service was being developed to enable care home residents to access dental care when needed.
- Work was being undertaken to bring in more high street dental services, enabling better access to NHS dentists.
- The ICB was working with under-performing dental practices to transfer some of their activity into practices that could deliver this, starting with the larger providers. Meetings, which HG would be attending, were already established.
- The Units of Dental Activity (UDA) price had risen to £30 with the focus being on the Core20PLUS5 population.
- It was hoped that during this summer a 40,000 UDA Dental Centre of Excellence for Gloucester City would be procured, in collaboration with system partners to enable this Core20PLUS5 population to access dental services. The intention was to make this a training Centre of Excellence for dentists and those with affiliated specialties.
- West Cheltenham and the Forest of Dean were also Core20PLUS5 areas. There was an intention for 10,000 additional UDAs in West Cheltenham and the ICB was scoping the possibility of some further dental access in the new Forest of Dean Community Hospital.
- More urgent (a fivefold increase since last year) and stabilisation appointments were being offered via NHS 111.
- Some of the GHFT waiting list patients for the Minor Oral Surgery service had been transferred to GHC, who had been able to take on that capacity and it was hoped to increase capacity also in the community and primary care sectors enabling patients to be in the right place for the right procedure.

7.4 CW spoke about the workforce initiatives and explained that one of her key tasks was to write a Workforce Strategy which would incorporate the training and retention for all the dental roles. The majority of this would draw on the existing expertise of partners which would be utilised, without involving duplication. Dental schools had recently been told that they needed to expand training places and to do this via Outreach. It was hoped therefore that the ICB could capitalise on this with early conversations around the training of dental professionals within Gloucestershire.

7.5 Initiatives being examined were :

- An incentive for post foundation dentists who had completed their one year post graduation to encourage them to work in Gloucestershire for at least 3 years.
- Growing training practices by incentivising dentists to become trainers.
- Supporting the Golden Hello scheme mandated by the National Dental Recovery Plan, and potentially work this into an offer that would incentivise dentists who were further on in their career and focus on areas of health inequality.

7.6 ER informed the meeting that she had chaired the NHS111 meeting earlier and the latest data this month showed that the number one reason for people contacting NHS111 in Gloucestershire (8.5%) was for dental pain. ER was encouraged by the plan around Urgent Care. The second highest reason for calling (6.9%) was for repeat prescriptions, which demonstrated that quite a high percentage of the NHS111 urgent care capacity was being used for dental and pharmacy queries. The opportunity for improving those services was therefore important around the current access challenges for NHS111.

7.7 JCo asked what was being done for the people who were not in the Core20PLUS5 areas as the level of service was also very low for them.

7.8 HG confirmed that the focus needed to be on the whole population and the contract review process would help with this by be moving quite sizeable UDAs and contract values around. Following this, Expressions of Interest would go out across the county to dentists enabling some to provide more UDAs as quickly as possible and it would encourage greater access across the whole county.

7.9 SF spoke about prevention and recognised the Primary Care team's continued support of oral health and promotion saying that the prevention activity was hugely important and good oral health and access to dentistry services was a key source of inequality.

- The Supervised Toothbrushing Service would be rolled out to 60% of the most deprived schools in the area.
- The First Dental Steps (FDS) programme will maximise the role of health professionals involved in early years care to improve oral health and increase uptake of dental services.

The Chair recognised the wide breath of work being undertaken, which centred around the Three Pillars and incorporated long term improvements along the transformational journey and considered this report one of the strongest papers focusing on the three pillars she had seen.

Action: HG to update the Board at a future meeting to evidence ongoing progress around dental access. **CG/RB HG**

7.10 AR spoke about the role of Local Community Pharmacies in Health Promotion.

- Last year +14 million prescription items were dispensed in Gloucestershire.
- Over 80% of patients lived within a 20-minute walk of their pharmacy and crucially, access was greater in areas of higher deprivation.

- Pharmacy First, from April 2024 to the end of the year, is predicated to be around 17,420 contacts. The predicated numbers for hypertension at the end of the year would be 15,608 contacts. The Pharmacy Contraception Service had also recently been endorsed by Community Pharmacy England.
- There was an increased focus for the clinical pharmacy teams working with practice teams to increase referrals, support behavioural changes which would make a real difference.
- Gloucestershire values the skills and capabilities of Community Pharmacist Independent Prescribers (IPs). Community Pharmacist IPs were being increased by supporting study at university and learning in a prescribing environment. Half of the trainees were currently working in pharmacies in areas with high health inequalities.
- The expansion of Pharmacy Technician roles was emerging with national changes planned to further enable transformation to support recruitment and retention.
- Continuing automation and digital enhancement processes would continue to support the pharmacy workforce across the county.

7.11 JB was concerned about pharmacists having to undertake more work with the same resources by having to work smarter. When people were already very busy introducing new ways of work was not conducive and would recommend that the work plan looked at methods of working.

7.12 BP commented that there had been exemplary examples of pharmacists who had gone above and beyond with their support of some very challenging patients to access medication. **BP**

Action: BP to send a short summary of how pharmacists had recently helped patients to Board members.

7.13 MT spoke about Optometry services in Gloucestershire.

- Ophthalmology was the largest outpatient specialty in the NHS and referrals into secondary care ophthalmology were increasing by 2.92% per annum due to the ageing population.
- The roll out of Community Ophthalmic Link (COL) had seen a statistically significant reduction in Ophthalmology e-referrals and a corresponding reduction in the number of people waiting for a first outpatient appointment, which will help with the rate of avoidable sight loss.
- Workforce and infrastructure in community optometry remained strong in Gloucestershire with 68 practices across the county, equating to 1.16 practices available per 10,000 population, the highest in the South-West. Gloucestershire also has more practices in areas of deprivation compared to the other counties in the South West.
- Community optometrists historically had a good working relationship with the local Optical Committee and Eye Health Clinical Programme Group (CPG) and had always been keen to take on additional enhanced services within their practices.
- The ICB will continue with this good collaborative working, to enhance and transform the management of people with stable eye conditions through the investment of technology, whilst helping to reduce the burden of growth on ophthalmology services across Gloucestershire.

7.14 The Chair and ER praised the continuing innovative work across POD services. Visibility across the pathway was enabling optometrists to make referral decisions and further

support had been offered by NHSE to build the programme, for which the ICB was very grateful.

7.15 MC complimented the team on the approach that had been adopted and the amount of work that had gone into all the delegated areas, with good progress having been made by ICB. Data and information were available through the BSA and the Model of Health System dashboards available from NHS England. MC stated that he had some good links and contacts, should these be helpful. MC also commended and thanked the ICB for the good work having been undertaken so far on addressing health inequalities for the population.

7.16 The Chair recognised the importance of sifting out the useful data from the volume that was produced. Some of the data was too detailed and did not necessarily contain the quality metrics that were important to clinicians. The Chair felt this could be a useful piece of work that the Centre could potentially examine.

7.17 ***Resolution: The Board noted the presentation and information on Community Pharmacy, Optometry and Dental Services in Gloucestershire.***

8. Chief Executive Officer Report

8.1 ER highlighted some key items in the CEO Report:

- Sharing the Power: Research Engagement Network (REN) had a focus on increasing diversity in research in Gloucestershire. Details of the work undertaken within the last six months were contained in the Report.
- Get Involved in Gloucestershire (GIG) had added two new projects and feedback would be collected from the population on cancer, as well as the work being undertaken via the Partnership Boards.
- The One Gloucestershire Information Bus had been very busy over the last few months and had supported many activities, detailed in the Report.
- Cancer Care Programme – This featured the importance of early diagnosis in the improvement of outcomes and throughput of services.
- A new Maternity and Neonatal Independent Senior Advocate role pilot had been launched and Joanna Garrett was now leading on this. This will ensure that the voices of families who have experienced an adverse outcome were listened to, heard, and acted upon by their maternity and neonatal care providers.
- Dying Matters Week - Gloucestershire had now launched a new digital resource to help families, carers and those facing End of Life Care. Work continued in the ICB to focus on End of Life care.
- The following announcements were made prior to the pre-election period and were in the public domain:
    - An integrated Urgent and Emergency Care services contract was awarded to Gloucestershire Health and Care NHS Foundation Trust following a 12-month procurement process.
    - Some changes in the Community Wellbeing Service were being worked through with organisations and these were around building the Community Wellbeing Service offer around capacity (rather than sign posting) to deliver services to people in local communities.
- System Operational Planning 2024-2025. The Operational Plan had been submitted on 2nd May 2024 and covered performance, finance and workforce. This had evolved since then and a meeting with the National team had been very positive, with the focus on our ambition of being able to deliver a balanced plan.

8.2 DE asked for an update on delivering the No Criteria To Reside (NCTR) trajectory in the Operational Plan for 2024-2025 as she felt it is the defining constraint in terms of flow through GHFT and outcomes for patients. The target was to get down to 80 by the end of this year. It was noted that currently the number was 150 from 250 a couple of years ago, but that we are currently 'off trajectory' in terms of the plan.

8.3 DE asked whether there could be more of a focus on this trajectory within the integrated performance report and wondered whether this could be built in, every month with an action plan detailing contribution. The different organisations would need to do different things and would need to be monitored on the implementation of those actions. The Chair responded that she saw this in real time on a daily basis so is aware that reporting is in place. ER responded that this work had been undertaken around the Operational Requirements document, which quantified what and who needed to deliver to achieve all of the operational plan commitments (not just NCTR). This would be captured in one document and then a letter would be sent to the Chairs and Chief Executives to set out requirements, which it is expected will be monitored through organisational governance, each respective organisations could then agree on which sentinel metrics needed to be included at a system level.

8.4 The Chair commented the Working as One/Newton Programme had also experienced challenges in terms of data integration and so it was important that the Board tackled this. One version of the truth was what was needed in terms of key metrics.

8.5 CAM stated that demand brought challenges not only during winter, but all year round. The work had been constant and significant, and data was challenging, so it was important that everyone continued to work hard on this and be insightful. A future Chairs visit would be taking place to which CAM would be invited in order not to duplicate conversations.
Action: Working as One/Newton Programme representatives to be invited to a future Board meeting with an update on what outstanding issues for system partners. **ER**

Resolution: The Board noted the contents of the Chief Executive Officer Report.

9. Board Assurance Framework (BAF)

9.1 The Chair acknowledged the hard work that had recently gone into the BAF and thanked the Governance Team for their work on this. TC stated that the quality of the narrative had improved dramatically, and the team had worked very hard with leads to ensure that definitions were understood and what was meant by controls.

9.2 The BAF presented today had already been scrutinised by other Committees and their risks reviewed. The changes (on pages 49 and 50 of the pack) had been summarised with three main issues to draw out. Notably, the Quality risk score had been increased following a re-appraisal, taking into consideration some of the key issues across the system by AR and MCr. This was also reflective of the work still in train around the Patient Safety Incident Response Framework (PSIRF).

The planned care recovery and productivity risk (BAF 7) had been increased, as while NHSE had been informed that a balanced plan would be delivered this year, there was still a huge amount of work required as a system to deliver against this, hence the adjusted

scoring. The BAF score for Primary Care remained the same and the recent ICB Board Development Session discussed some of the risks there.

9.2 The Workforce risk was rated at 20, despite the fact that improvements had been seen in the metrics going in the right direction. Given that workforce was such a critical enabler in everything else that the ICB wanted to achieve, there was nervousness about dropping that risk and so it was left at 20. This would maintain the critical focus on the workforce risk.

9.3 JS commented that the work had been pleasing and was going very well with good conversations having taken place with colleagues. There was beginning to be some consistency around the BAF, those quality risks contained in the BAF would be reported to the next the System Quality Committee meeting on 5th June 2024. Good discussions would enable things to move further forward. The Audit Committee would then be looking at the BAF at the meeting at the end of June 2024.

9.4 Positive improvements have also been made on the Corporate Risk Register (CRR) to ensure that this was more useful for colleagues and JS was also very pleased with how things were progressing with this.

9.5 JS was thanked for her leadership on the Board Assurance Framework and the Corporate Risk Register. Once the document had come to fruition, the Chair asked that an hour should be spent looking at our understanding of each of the risks. The Chair urged caution as some of the actions and mitigations around the risks needed to be thoughtfully understood and considered before being moving through the RAG matrix rating system.
Action: TC and JS to bring the Board Assurance Framework and Corporate Risk Register to a future Board Development session. **CG/RB TC/JS**

9.6 MC informed the Board that the new oversight framework that NHSE would be using was currently out for consultation, for a relatively short period of time. This would contain several areas and metrics where this would be used in terms of the NHSE's assessment of the assurance of the ICB's progress during the year. MC recommended that it may be useful to check the oversight framework against the BAF and the strategic risks identified to ensure that reporting was aligned. It would be good to see the good work that Gloucestershire had already accomplished and was progressing in that oversight framework this year.

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

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

10.1 **Performance**
ER highlighted that the Learning Disability (LD) and Serious Mental Illness (SMI) health checks had seen a big increase in uptake during the last quarter of 2023/2024 which was very positive. The system expected to meet target commitments in these areas in 2024/25, which will ensure patients in need of follow up intervention were supported to actively manage their health. The Out of Area placements had reduced following a focus on reducing Length of Stay and improving system flow.

With full year performance now available for cancer waiting times, the system has achieved the 28 day Fast Diagnosis Standard on average across 2023/24. Performance against the 31 day wait for treatment had also improved on the 2022/23 position. There were plans in place to support specialties currently not achieving the 62-day treatment target, with the system committed to exceed the recovery expectation for 2024/25 set nationally.

Funding had been agreed locally to support endoscopy (colonoscopy, gastroscopy and flexi sigmoidoscopy) and angiography (including pacemakers, angiograms, angioplasty) to clear the backlog of patients waiting across these areas. Work was ongoing to address demand and capacity challenges and develop a sustainable offer that would meet the system's needs for the future.

Primary Care was still seeing increased demand and national metrics needed to be understood and considered in the context of local data. Balancing access with continuity of care was of importance and was being examined by the Primary Care team.

Category 2 ambulance response times remained an area of focus for the system and region. There were some days where response times were better than others which was indicative of the efforts of front line staff, but improvement is not yet consistent.

There were plans in place to support specialties currently not achieving the 62 day treatment target for cancer, with the system committing to exceed nationally set recovery expectations for 2024/25. There were continued challenges in urology, lower gastrointestinal and gynaecology and the ICB would be working in partnership with GHFT to address those areas as quickly as possible.

10.2 **Workforce**

TC informed the Board members that the metrics up until March 2024 were included in the report and these were positive except for leavers rate. Vacancy rates across the ICS were at 11.7%, which was a combined position of 8.2% across GHFT and GHC and sitting at 15.2% for Adult and Children's Social Care. There was some work to be undertaken on staff retention and reducing the vacancy rate in terms of the Operational Plan.

10.3 Sickness rates had also improved across health and social care and the tracking was below the rate assumed within the Operational Plan for the year ahead. Further positive reductions had also been seen in agency usage and ambitions reductions around agency expenditure in the year ahead.

10.4 Staff representation in senior roles was also highlighted in the report which was examined at the last People Committee. Disappointingly the metrics showed no overall change in the proportion of BME staff in senior leadership roles at Band 8C and above. There was marginal improvements around being appointed from shortlisting and some improvement around the proportion of staff who were appointed with a disability in senior roles. These would be areas of focus in the year ahead.

10.5 The ICS-wide Apprenticeship Strategy was being developed via the Education and Training Steering Group and would be brought to the People Committee in due course. New funding arrangements were awaited around apprenticeships and support for backfill would make a critical difference in that space.

10.6 The Leadership Conference series was being developed with the first one planned on 28th June 2024 on Health Inequalities and with special thanks to CAM, DB and GM who would be supporting that event. Unfortunately it had been revealed that this Conference would coincide with industrial action by junior doctors, potentially impacting attendance – however, at this point there were 225 people who had signed up for the Conference across the ICS, which was very positive.

10.7 **Quality**

MCr informed members that the NHSE SW Commissioning Hub Monthly Information pack had been received containing Q3 POD quality information. This would be brought to monthly meetings the first one taking place later this week. Meetings had also been

planned with other Chief Nursing Officers in partner organisations so that comparisons could be made.

10.8 A Maternity Quality Improvement Group would be starting on 17th May 2024 to decide on the five priority areas that the Local Maternity and Neonatal Systems (LMNS) and System had agreed. Progress on the areas would be closely monitored and reported via a fortnightly group chaired by MCr. GHFT had put huge effort into establishing the Quality Improvement Group to address the areas of concern from the Care Quality Commission (CQC) on their last inspection in March 2024. There were many actions that were needed but priorities would be to focus on the most important top ten. A report was still awaited from the CQC.

10.9 **ICS Finance Report – Month 12**
The year end outturn was a £541k surplus in the system versus the plan, which was a very pleasing result. Within that the ICB had made a small surplus of £93k. Auditors were currently undertaking thorough audits in all three organisations. Savings delivery had included a number of non-recurrent savings schemes to help offset slippage in the delivery of recurrent schemes.

10.10 While the 2023/24 financial position overall had absorbed the under-delivery, this slippage in the recurrent efficiencies would result in an increased financial challenge in 2024/25. Pressures seen in 2023/24 from Prescribing, Continuing Health Care (CHC) and workforce would be built into the 2024/25 plan. Improvements in controls had seen positive outcomes, particularly around workforce in GHFT.

10.11 There had been an agreed overspend on the Capital Departmental Expenditure Limit (CDEL) with NHSE, which was being countered by underspend elsewhere in the South West. This had resulted in being able to deliver somewhat more than had been anticipated from the capital programme.

10.12 Agency costs in GHFT had reduced and a 3.7% target had been delivered on the agency spend by the end of the year, which was a positive outturn on that trajectory. Regarding payment of invoices, all organisations delivered more than 90% of payment within 30 days which was important for suppliers and was an indication of healthy cashflow.

10.13 JCu noted the work that MCr had undertaken around maternity and extended her thanks for this. JCu had seen that the dashboard was showing the excess of the under 75 mortality rate for adults with Severe Mental Illness, as Red and this had not been discussed in detail. Although AR was currently undertaking work on mortality, assurance was sought that this would be looked at and appropriately reported. AR affirmed that this was the case. **Action: AR to bring a Hospital Mortality Rates report to a future Board meeting.** **CG/RB AR**

10.14 KC mentioned the increase in the rates of stillbirths and asked whether this had any connections elsewhere in maternity or whether it was just around individual circumstances. DE responded that the Neonatal and Perinatal Report had been taken to the GHFT Quality Committee and discussed in detail, which included stillbirths. DE explained that there were two months that were showing red on the dashboard, but these may not be useful in terms of being able to draw conclusions as the numbers were so small. GHFT have taken advice both internally and externally around the regulatory requirements outstanding, and this is considered to be more about pace of delivery and the emphasis on this in the context of an improvement plan that sets out a requirement for GHFT to report to the CQC on over 400 actions, the clarity now given to focus on the top ten actions was very helpful.

10.15 MCr commented that there was a need to benchmark against other LMNS. It was noted that LMNS Arrangements were already in place, but it was about making those more formal and reporting quality metrics and risks into the LMNS so that people were working as one. The Chair responded there were difficulties around the reporting of small numbers and statistical distribution was always difficult for interpretation as to whether it was something that could be intervened in, or whether things occurred by chance. However the progress of the LMNS would be reported to a future board meeting.

The Board noted that Kevin McNamara (CEO) from GHFT had recently commissioned two external reviews, one on maternal deaths and one on neonatal deaths.

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

11. Primary Care and Direct Commissioning (PC&DC) Committee Terms of Reference

11.1 AJa explained that the Terms of Reference for the Primary Care and Direct Commissioning (PC&DC) Committee had been reviewed. The Committee had been reviewing how it had been operating and reflecting on what had been working well and what areas had added value to the way it worked so that it could be more effective and efficient.

11.2 AJa explained that the committee had sufficient space and capacity to focus on the long-term strategic plans for primary care and POD, including workforce and would receive and input into those developing strategies and plans.

11.3 The PC&DC Committee would be seeking to operate as all other sub-committees of the ICB Board by reporting its minutes to the Board held in public, and the Chair of the committee would provide a verbal update rather than the PC&DC committee meetings being held in public. This way of operating was in line with all the other ICB sub-committees of the Board ensuring transparency with members of the public. It was noted that there would be increased opportunities to conduct deep dives into particular areas.

11.4 The Associated Non-Executive role would be removed from the Terms of Reference as this no longer applied.

11.5 DB referenced the narrative around strategic issues where there was mention of Primary Care Network involvement. Caution would be needed around potential overlap issues in relation to those aspects of the strategy regarding the overarching narrative. AJa responded that various discussions would include the impacts, barriers and challenges – as part of the whole system issues that needed to come to the Committee. JCu commented that there was a link between the Integrated Neighbourhood Team and PC&DC via the Primary Care Team and the System Quality Committee and this would be co-ordinated and managed appropriately.

Resolution: The ICB Board members:

1. ***Noted and approved the changes to the Terms of Reference for the Primary Care and Direct Commissioning (PC&DC) Committee.***
2. ***Agreed the proposal to move the Primary Care and Direct Commissioning (PC&DC) Committee meeting to be held in private with the stipulation that the open minutes would come to the ICB Board so that they remained in the public domain.***

12. System Resources Committee Terms of Reference

12.1 JCo informed the Board that the Terms of Reference for the System Resources Committee had recently been reviewed and that there were no major changes, just some tidying up and clarification. The Values Statement had been built in and also the definition of the understanding of the NHSE's Oversight Framework.

12.2 The System Resources Committee meetings would now take place in two parts (the Partnership Section and the ICB Section) to make effective use of partners' time. It was noted that the that digital was within the remit of the Committee.

12.3 JS reflected that there had been a prior discussion about becoming a member of the System Resources Committee to provide financial input. This was not evidenced in the revised Terms of Reference. The only mention was of an attendee or participant and not a member. **Action: RB to alter the phrasing to reflect that JS would be a member of the System Resources Committee and that this would be as an ex-officio role in the revised Terms of Reference prior to the document being sent out to Board members.** **RB**

Resolution: The ICB Board members noted and approved the changes to the Terms of Reference for the System Resources Committee subject to the wording to be included around the ex-officio role for Julie Soutter.

13. Committee Updates

13.1 **Chair's verbal report from the Audit Briefing** held on 9th May 2024.

13.1.1 This meeting was an informal briefing on the draft accounts as they stood at that point. Details had been made available to the Board and there was nothing further to add.

13.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 4th April 2024 and approved minutes from 1st February 2024.

13.2.1 The items discussed had been tabled at the Board today and there was nothing further to add.

13.3 Chair's verbal report on the System Quality Committee meeting held on 3rd April 2024 and approved minutes from 15th February 2024.

13.3.1 JCu feedback there were two items to mention from the meeting on 3rd April 2024. The positive and moving Dementia Strategy presented by Steve Shelley-King had been very well received with unanimous support from the Committee. It had also been noted that the committee had reflected that the volume of papers and data brought to the committee can sometimes make it difficult to work out what was really important, and it was felt that provision of the right documentation and risks would enable better identification of where early actions may need to be taken as a system. MCr and other provider colleagues would be reflecting on the best way forward together to address this.

13.4 Chair's verbal report on the People Committee meeting held on 16th May 2024 and approved minutes from 8th February 2024.

13.4.1 KC reported that the 16th May 2024 meeting had been slightly delayed in order to ensure that all were happy with the Operational Plan working across the system. A helpful deep dive on retention had taken place and there was a paper which TC could circulate should anyone wish to see this. It had clarified that the spike seen in retention for people with under one year's service was due to one year contracts ending rather than any other reasons. Regretted attrition will be examined rather than expected attrition. The deep dive

had also enabled better sight on where there were issues of retention in the nursing population which revealed particular challenges in children's nursing and community nursing which sat against a general trend of nursing attrition getting better.

13.5 **Chair's verbal report on the Resources Committee** meeting held 2nd May 2024 and approved minutes from 7th March 2024.

13.5.1 The May meeting discussed and had a presentation around residual risks so that members were more aware of those risks. Benefits Realisation from Working as One was also discussed.

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

14. **Any Other Business**

14.1 There were no items of Any Other Business to discuss.
The meeting concluded at 16.00 hours.

Time and date of next meeting

An Extraordinary Board meeting will be held on Weds 26th June 2024 1.30-2.00pm.
The next ICB Public Board meeting will be held on Wednesday 31st July 2024 from 2.00-4.30pm

Withdrawal of the press and public

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

(Commercial in confidence discussions)

Agenda Item 4

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

Meeting Date Raised	Reference	Action	Due	Updates	Status
31/01/2024	**Min 8.18 P2 beds/EoL**	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	**July 2024**	**May 2024:** May 2024: A discussion has been included on June agenda for the System Quality Committee with regards to EOL. Report to be brought back to the Board. Action Open.	**Open**
31/01/2024	**Min 10.12 LMNS membership**	MCr to examine membership of LMNS.	**September 2024**	**July 2024:** Following the further unannounced inspection of maternity services in March 2024 the CNO has established a Quality improvement Group as part of the National Quality Board framework of surveillance. The group will focus on the top 5/10 priorities including CQC Must do actions and immediate concerns. The review of the LMNS is part of this process but has not yet been completed. The regional CNO is advising the ICB CNO on this. There is an update Maternity and LMNS in the CEO report. **Action Open.**	**Open**
31/01/2024	**Min 11.2.1 Migrant Health Report**	Primary Care Team to bring a detailed report on Migrant Health to a future Board meeting.	**September 2024**	**July 2024:** A detailed paper will be submitted to the September ICB Board on Migrant Health.	**Open**
27/03/2024	**Min 8.1 Social Prescribing, CEO report**	Creative Health Consortium to be placed on a future Agenda for discussion around a Patient Story.	**Autumn 2024**	**July 2024:** This topic is on the list of patient stories for the Autumn 2024	**Open**
27/03/2024	**Min 13.2 Interim Procurement Strategy**	A review will be undertaken of the Audit Committee ToR to see if changes need to be made to ensure that Procurement items including the Strategy can be reviewed by the Audit Committee prior to coming to the Board for approval	**September 2024**	**July 2024:** The ToR will be reviewed and any changes will be reported and agreed by the Audit Committee in September to submit if required to the ICB Board in September.	**Open**

29/05/2024	**Min 1.5 - Contaminated Blood Inquiry Report**	Contaminated Blood Inquiry Report to be placed on a future Board agenda.	**November**	**July 2024 update:** The Blood Inquiry Report will be discussed at the System Quality Meeting in August and partners to share lessons that have been learnt. A summary report will then be produced by the CNO for the October meeting and reported to the ICB Board in November via the SQC minutes	**Open**
29/05/2024	**Min 1.6 - Countess of Chester case**	Countess of Chester case to be placed on a future Board agenda.	**November**	**July 2024 update:** The Countess of Chester Case will discussed at the System Quality Meeting in August and partners to share lessons that have been learnt. A summary report will then be produced by the CNO for the October meeting and reported to the ICB Board in November via the SQC minutes	**Open**
29/05/2024	**Min 7.9 - Dental Access**	HG to update the Board at a future meeting to evidence ongoing progress around dental access.	**November**	**July 2024 update:** To be included in the CEO report for the November Board meeting when further progress has been made.	**Open**
29/05/2024	**Min 7.12 Pharmacy First engagement**	BP to send a short summary of how pharmacists had recently helped patients to Board members.	**July**	**July 2024 Update:** This document has been sent to Board members. Action to be closed.	**Action to be Closed.**
29/05/2024	**Min 8.5 - Newton Europe Group**	Newton Europe Group representative to be invited to a future Board meeting with an update on what outstanding issues may be for the different organisations and compare these with the ICB's view.	**TBC**	**July 2024 Update:** TBC confirmed if this will be a Development Session or a report to the Board	**Open**
29/05/2024	**Min 9.5 - BAF and CRR**	Action: TC and JS to bring the Board Assurance Framework and Corporate Risk Register to a future Board Development session.	**October**	**July 2024 update:** A one hour session is being scheduled as part of the Board Development session in October to review the strategic risks across the system and discuss the risk appetite framework. CGi is meeting with ICS partner Governance leads in September to shape the session.	**Open**
29/05/2024	**Min 10.13 - Hospital Mortality Rates report**	AR to bring a Hospital Mortality Rates report to a future Board meeting.	**September**	**July 2024 Update:** SHMI will discussed at the System Quality Meeting in August and their deliberations would be shared with the Board in September	**Open**

29/05/2024	**Min 12.5 - Resources Committee 29/05/2024Terms of Reference**	RB to alter the phrasing to reflect that JS would be a member of the System Resources Committee and that this would be as an ex-officio role in the revised Terms of Reference prior to the document being sent out to Board members.	**TBC**	**July 2024 Update:** July 2024: The TOR have been updated and have been uploaded to the ICB website for Board Members information.	**Action to be Closed.**

ICB Board Meeting (July 2024) Case Study – Community Diagnostic Centre

Abdullah

The Patient, who we will call Abdullah, is 48-year-old male, living in Gloucester City. He does not drive and is currently unable to work due to ongoing health condition. English is not his first language. He is at greater risk of experiencing health inequalities.

Abdullah has an ongoing heart condition which necessitates regular visits to both acute and primary care. He is also awaiting urology surgery.

Abdullah received an Echo Physiology appointment in Spring 2024 at the new Community Diagnostic Centre at Quayside House in Gloucester city centre.

When sharing his story, Abdullah noted the challenges he has had financially in attending previous appointments at Cheltenham General Hospital but was grateful for the 99 bus service to attend these.

He noted that attending the CDC was great as he had been able to walk to his appointment easily. He was pleased to attend the CDC as he knew where it was located as his GP surgery is in the same location. He did find the entrance a little tricky to locate but found the centre to be welcoming, bright and clean. He also found the environment to be calm and quieter than the main hospitals.

Abdullah was very pleased with the care and service he received at the CDC and he wants to have more of his appointments at this venue due to the fact he is able to walk there and that his appointment was received quickly after being requested.

Abdullah felt that by not having to catch a bus and pay for the fare he experiences less stress and anxiety, two factors he is trying to manage due to his health condition. He is very grateful for the CDC to be available close to him.

Additional Background Information to support the ICB response

Patient Engagement: Experience Based Design (EBD)

- NHS Elect and national CDC programme mandated the requirement to undertake a cycle of EBD to qualify for 2024/25 CDC funding.
- The cycle of EBD was planned and completed in March 24 with feedback provided to NHS Elect.
- The EBD cycle involved compiling responses from patients and staff using the NHS Elect pre-defined template.
- A review session was then completed in May 24 and report generated.
- The report will be shared to CDC programme implementation board.

EBD Approach

The aim of this approach is to understand how patients and staff ‘felt’ at each stage of their journey and delivery of the service, to identify areas for improvement, to enhance the patient experience.

Responses were collected in March 24. This is within one month of the CDC opened and not all services were live. The responses mainly related to imaging services.

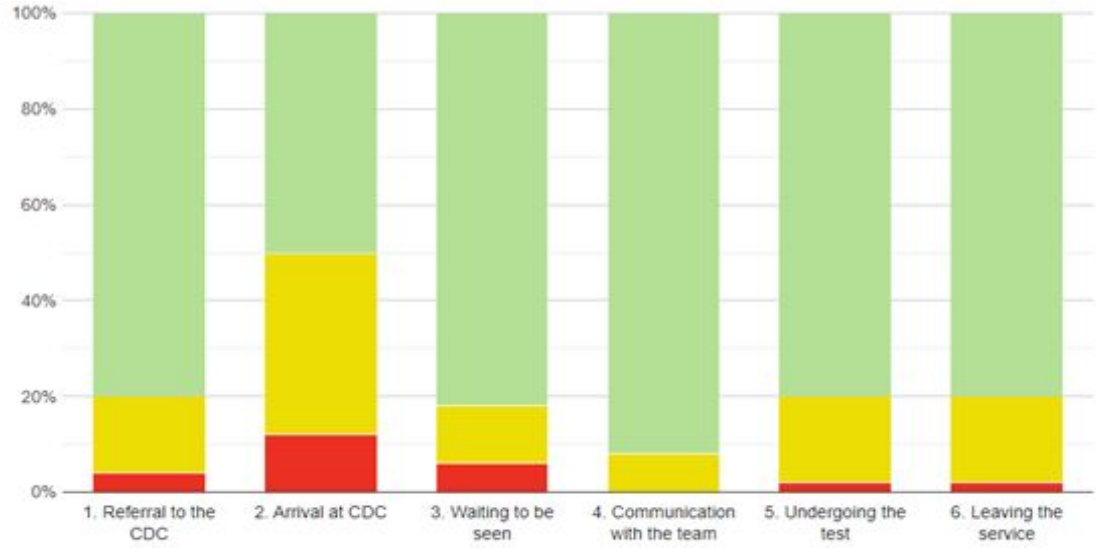
A total of 50 patient and 16 staff responses were gathered.

Themes from EBD feedback

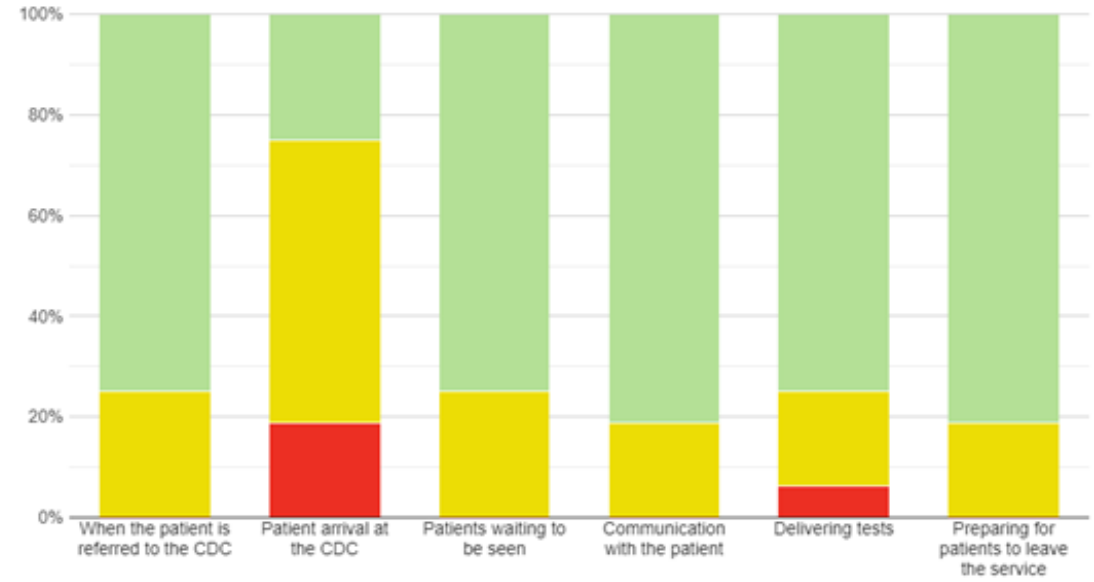
Patients- General interactions with staff while at the centre and during tests were very positive. Once patients find their way to the CDC they feel more relaxed and seem happy with the opportunity to attend a new facility.

Staff- Overall, the responses and staff comments on the pathway are very positive. Patients and staff rated the touchpoints similarly, and both picked up on several of the same areas in need of improvement.

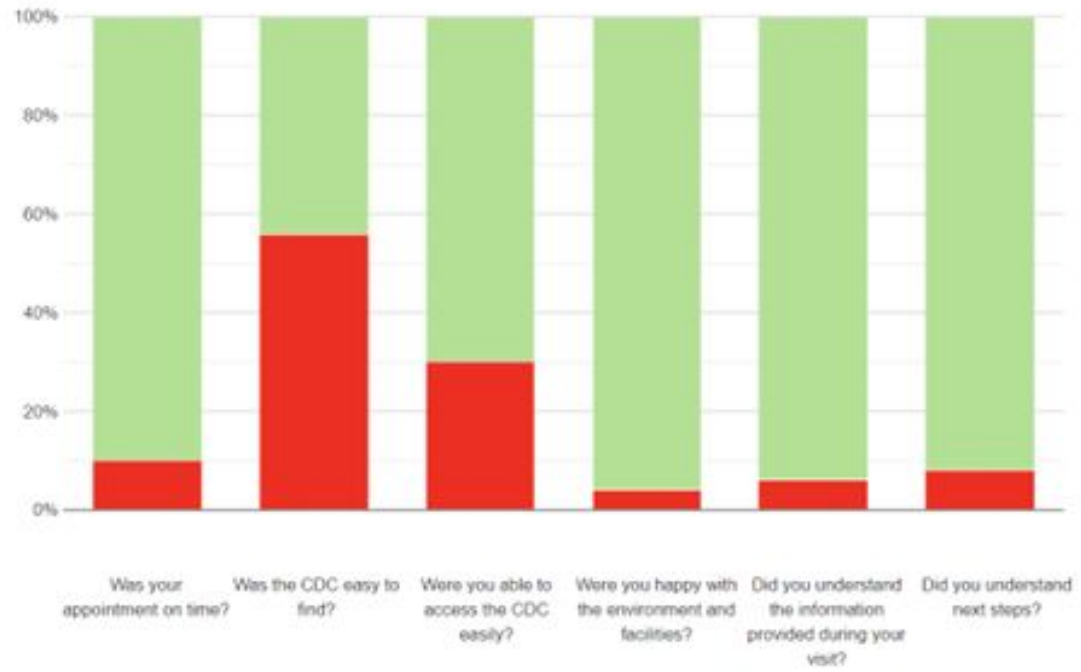
Emotional Responses (Patients)



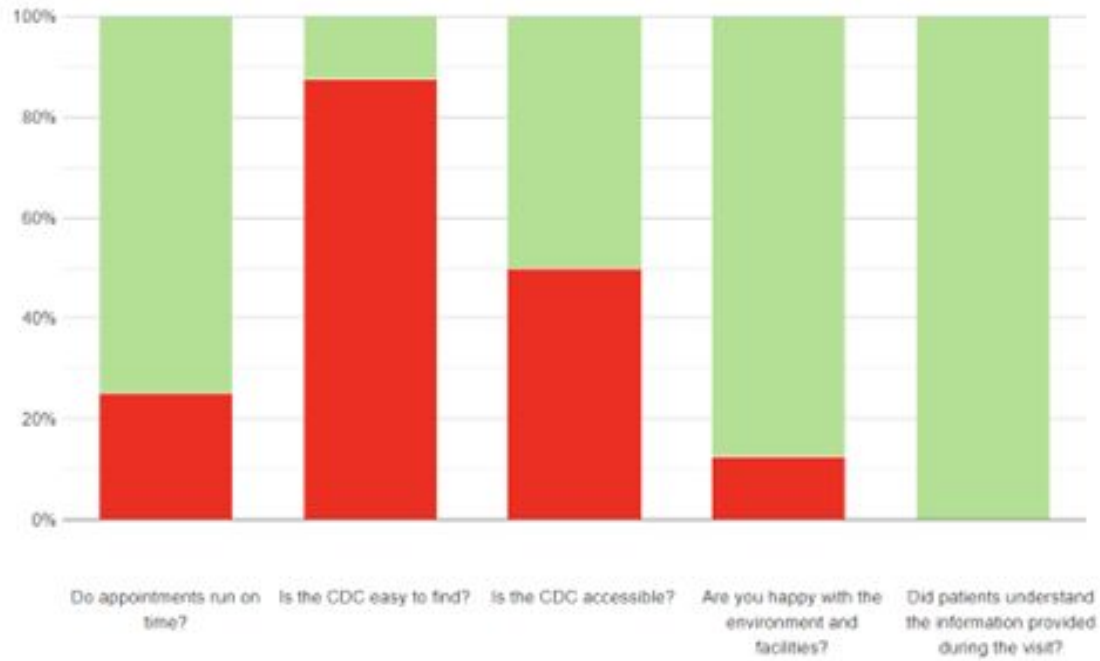
Emotional Responses (Staff)



Thumbs Up / Thumbs Down Responses (Patients)



Thumbs Up / Thumbs Down Responses (Patients)



Agenda Item 7

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**Spotlight on Elective Care Programme**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	A spotlight presentation on the elective recovery programme was requested by the ICB Board.					
Executive Summary	The presentation provides an overview of the elective care recovery programme following the pandemic, with details of what has worked well, latest performance, actions underway as well as the scale of the ongoing challenge and risks to delivery.					
Key Issues to note	While elective recovery has been good to date, the size of the challenge ahead is still considerable. There are many moving parts and specialty specific issues that need resolving while other factors such as industrial/group action are out of our control.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There is a risk that our plans will not deliver all of the required elective, diagnostic and cancer waiting time targets as well as our ERF value. Industrial action (junior doctors), GP group action and workforce availability and the main risks to delivery. Original risk rating (4x3) 12 Residual risk rating (4x2) 8					
Management of Conflicts of Interest	There were no conflicts of interests in relation to this report.					
Resource Impact (X)	**Financial**		**Information Management & Technology**			
	Human Resource		**Buildings**			
Financial Impact	Achievement of the elective plans are essential for the delivery of our ERF target and associated income. Overachievement of plans also provides an opportunity for additional income to help with the financial sustainability plan.					
Regulatory and Legal Issues (including NHS Constitution)	Delivery of the elective programme is required to achieve the national planning targets relating to elective care, diagnostic wait times and cancer performance.					
Impact on Health Inequalities	The projects and actions being taken within the elective recovery programme are all considered from a health inequalities perspective to ensure we help reduce them where possible or at the very least, we do not increase them.					
Impact on Equality and Diversity	N/A					

Impact on Sustainable Development	N/A		
Patient and Public Involvement	N/A		
Recommendation	**The Board is requested to:** • **Note the content of the presentation for information**		
Author	**Christian Hamilton**	**Role Title**	**Associate Director of Commissioning – Elective Care**
Sponsoring Director (if not author)	**Mark Walkingshaw, Director of Operational Planning and Performance**		

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

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Agenda Item

Elective Care

Christian Hamilton

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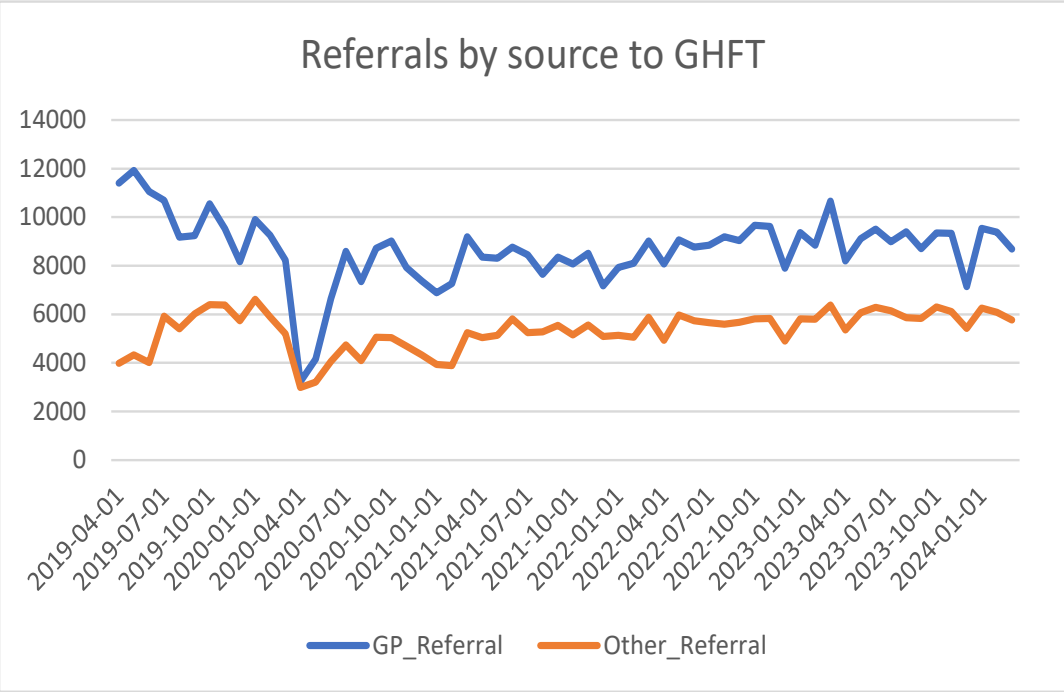
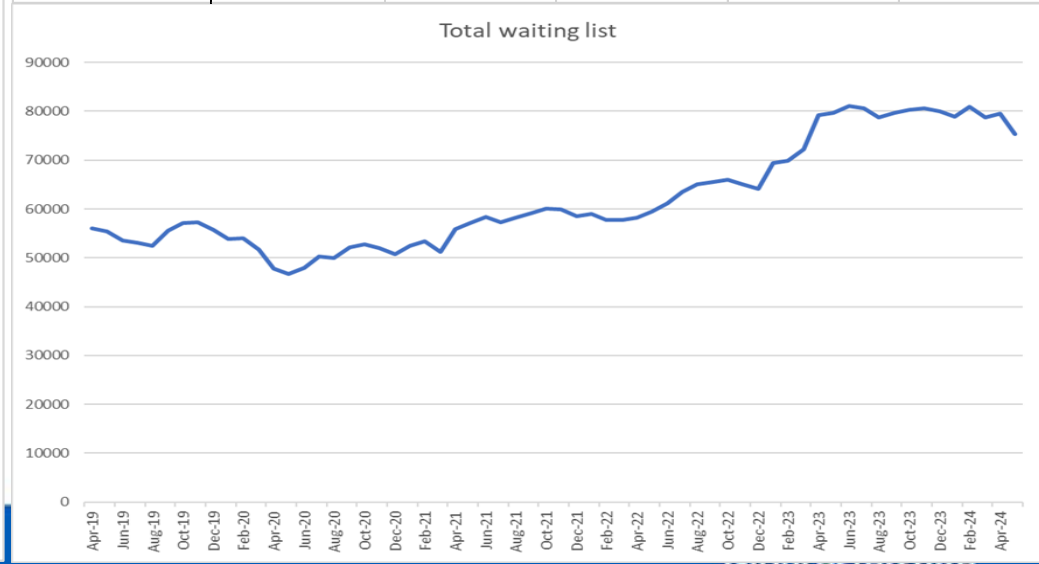
Part of the One Gloucestershire Integrated Care System (ICS)

Context

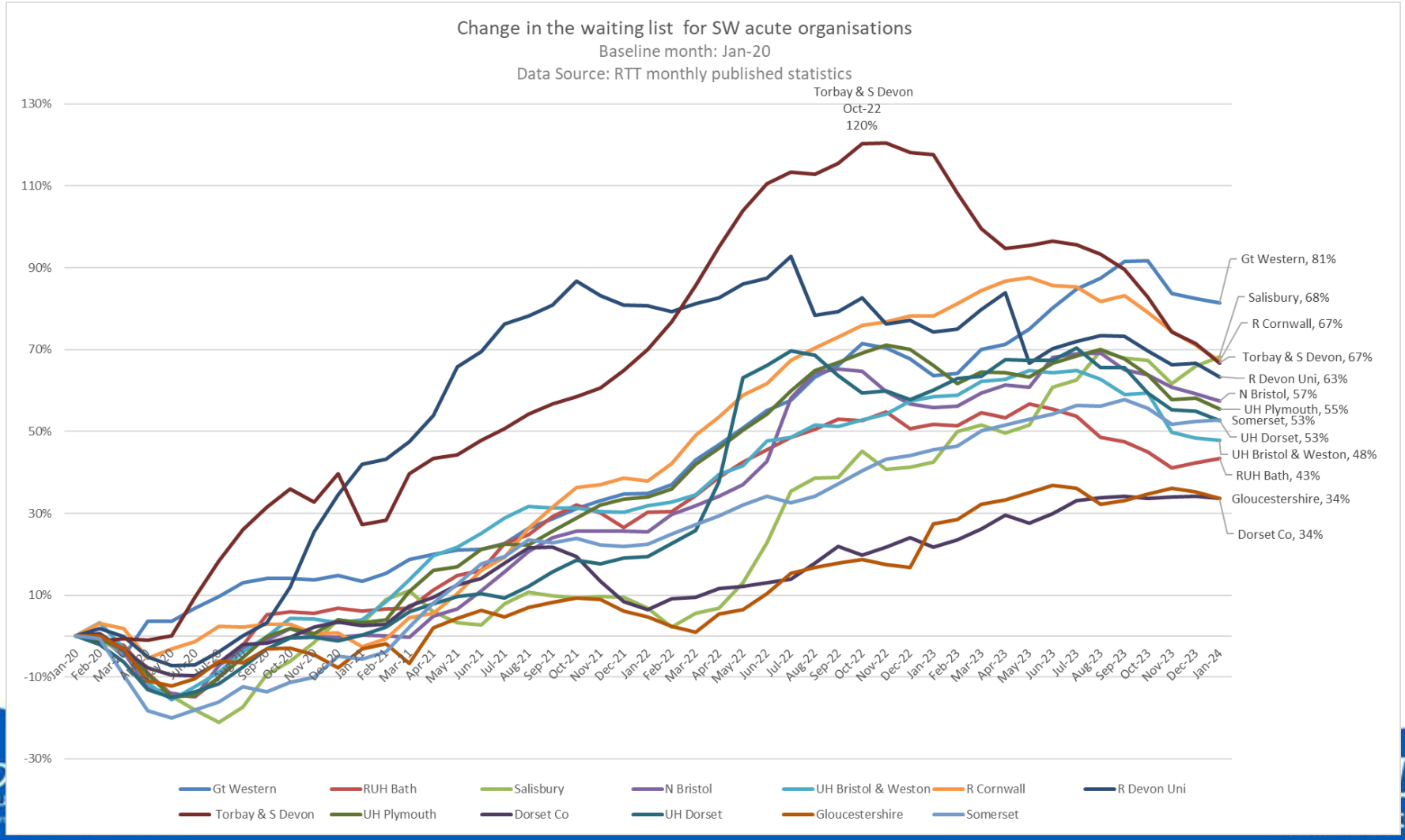
- The Covid pandemic had a profound impact on elective care with the vast majority of elective services closed during the initial lockdown period resulting in large backlogs of patients and very long waiting times. Actions taken (especially in the initial stages of Covid) has meant that recovery in Gloucestershire has been very good to date in comparison to other national and regional systems.
- However, elective recovery and performance remains a constant challenge with immediate issues to face (e.g. industrial action) while also building a sustainable and resilient service model for the future.



Date - Month	0-18 Weeks	> 18 Weeks	> 35 Weeks	> 52 Weeks	Total
Apr-19	45,054	10,919	2,056	87	55,973
Apr-24	53,517	26,080	10,416	2,869	79,597



Waiting list % growth comparison (Glos is brown line)



Recovery & performance

	104+		78w+		65w+		>53ww Cohort (Sep 2024 65ww)		52w+		Total List		<18ww performance	
Region	w-e 07 Jul 24 (un-published)													
SOUTH WEST	**1**	▼	**241**	▲	**5,019**	▼	**23,628**	▼	**26,303**	▼	**636,914**	▲	**60.3%**	▲
BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB	0	▶	5	▲	456	▲	3,235	▼	3,703	▲	106,415	▲	57.4%	▼
BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB	0	▶	34	▲	456	▼	3,540	▼	4,036	▼	106,453	▲	60.4%	▲
CORNWALL AND THE ISLES OF SCILLY ICB	1	▲	29	▼	348	▼	1,265	▼	1,403	▼	42,554	▼	67.1%	▲
DEVON ICB	0	▼	141	▲	1,786	▼	6,801	▼	7,482	▼	158,268	▼	57.7%	▲
DORSET ICB	0	▶	13	▲	918	▲	4,483	▼	4,958	▲	92,514	▲	58.4%	▼
GLOUCESTERSHIRE ICB	0	▶	1	▲	583	▲	2,564	▼	2,804	▼	73,432	▲	64.8%	▲
SOMERSET ICB	0	▶	18	▲	472	▼	1,740	▼	1,917	▲	57,278	▲	64.9%	▼

RTT performance (92%)	
Feb-20	83.25%
Jul-20	57.02%
Jul-21	76.32%

Diagnostic Performance (<5%)	
Feb-20	1.60%
May-20	47.70%
Mar-23	8.80%

65 week waiters	
Feb-20	-
Jun-21	1,212
Mar-23	250

ERF system achievement

- 2023/24 Value Weighted Activity (VWA) was 105.6% of 2019/20 vs target of 103%

24/25 M1

	VWA	Activity recovery	Perf to Activity plan
System	117.7%	125.8%	12.1%
GHFT		126.5%	15.5%
OOC		91.4%	-18.6%
IS		155.6%	5.3%

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Elective recovery - Better than others, but why?

Early decisions and supporting factors:

- Continued to accept GP referrals with Trustwide use of referral triage systems (CAS/RAS)
- Focused clinical time on validation and prioritisation
- Ring fenced elective beds (red/green sites) – bedded recovery
- Maintain urgent and cancer work as much as possible
- Rapid adoption of non-face to face alternatives
- Partnerships with independent sector providers e.g. Winfield
- Very advanced with GP advice and guidance
- Robust waiting list management already in place
- Excellent system working

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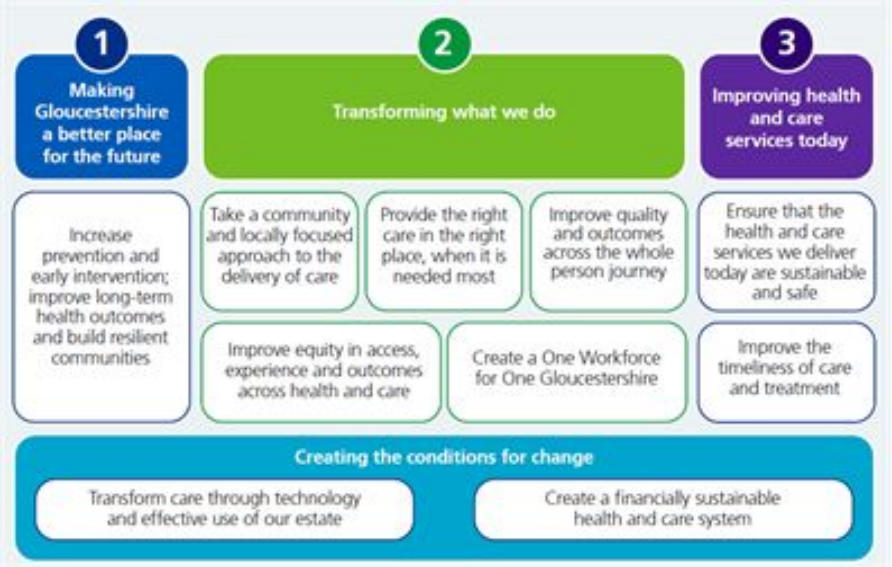
Joint Forward Plan – Long-term ambitions

- 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.
- Understanding the needs of our population, 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.



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Delivering our strategic objectives

1. Making Gloucestershire a better place for the future

- Provide timely access to diagnostics, elective and cancer treatments
- Reduce health inequalities in relation to elective care
- Continuously develop an efficient, productive and sustainable elective service model for the future
- Provide patients with the right information and tools to stay fit and well including greater digital options
- Be at the forefront of new technology and adoption of new treatments

2. Transforming what we do

Continuously redesign and improve patient pathways in line with best practice and the needs of our population

Transform Outpatients so that it is truly fit for the future

Strengthen the communication and interface between primary and secondary care, enabling patients to be treated in the most appropriate care setting

Explore the potential of AI and robotic automation

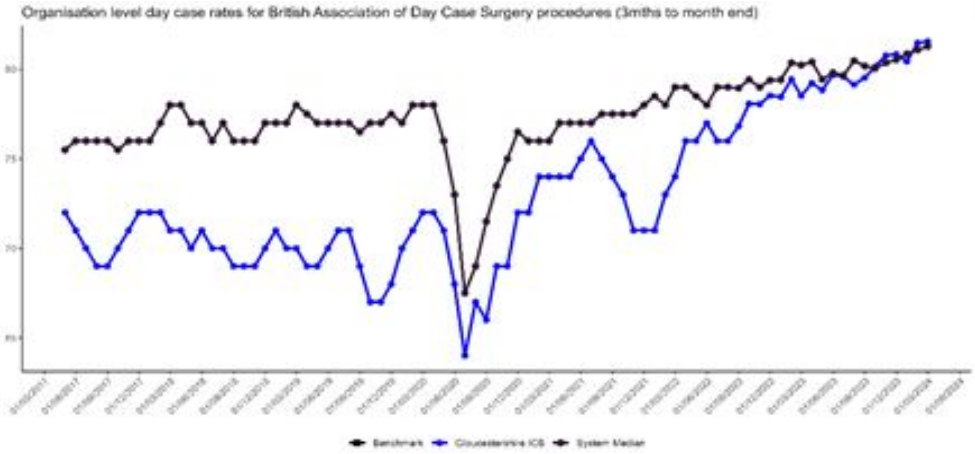
Provide care as close to patient's homes as possible, maximising the use of our community facilities

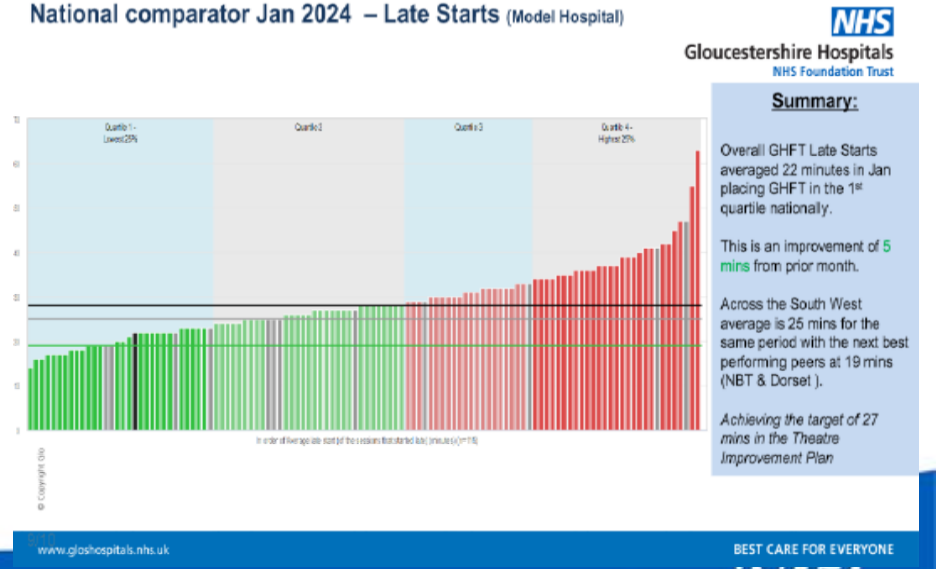
3. Improving health and care services today

- Create additional diagnostic and treatment capacity to reduce elective waiting times, including use of the Independent Sector
- Provide GPs with easy access to the information, advice and training needed to avoid unnecessary hospital appointments
- Clinical and administrative validation, analysis and prioritisation of waiting lists
- Enhanced bidirectional communication with patients via the patient portal and Elective Care Hub
- Specialty specific productivity and efficiency reviews (EVO)

Theatre transformation

- Improved theatre utilisation from 74% to 81%
- Daycase rate improved from 75% to 82% (graph)
- 6:4:2 booking process rolled out
- Theatre dashboard reviewed daily with look back at previous day
- Focus on avoiding late starts, early finishes, cancellations on the day, booking processes and procedure timings
- Embeding the new ambulatory hip and knee pathways to maximise the benefits of a new day surgery unit





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Referral optimisation & outpatient transformation

- 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
- Expand support to GPs by providing high-quality educational resources
- Elective Care Hub validation of waiting lists and proactive contact with patients
- Elective Care Hub validation of follow ups and consultant note reviews pilots
- Introduce a new patient portal to make it easier for patients to contact the hospital if they need to cancel or change appointments with 2-way messaging and link with NHS app
- Launch of GP expedite process that provides a single point of entry into Elective Care Hub.
- Clinic template reviews and develop clinic room utilisation reports
- Robotic automation of OP booking processes

Elective transformation examples from surgery

- Moving procedures down the "intensity gradient". Examples include conversion of mastectomy to 23hr, GA template biopsies into LATP high volume lists (greater productivity and LA vs GA), turning TURP into DC and introducing the daycase hip & knee pathways which has reduced LoS.

- Creating the capacity in OPD procedure rooms to pull work out of main theatres. Examples include being an early adopter of the Cytosponge pilot which pulled OGDs out of Endoscopy theatre into an OPD clinic, converting Gynae GA main theatre procedures into LA OPD procedure rooms. Creating minor op procedure rooms in Oral Surgery and ENT to pull work out of main theatres and offer LA rather than GA unless clinically indicated.

- Avoiding mixed lists where possible; cohorting types of procedures together to deliver "HIIT" lists that improve productivity and can quickly reduce waiting times for smaller, more routine patients (e.g. Circumcisions, complex hernias, simple teeth extracts).

- Early adoption of robotics. Our learning curve for Urology and Gynae-Oncology has been over a decade now meaning we are faster at completing major operations with fewer post-operative complications. Our early adoption of robotic Aquablation will put us ahead of the rest of the South West as we began treating patients in April 2024.

Challenges and risks

There are some significant risks and challenges to our recovery plans which include:

- Further junior doctor industrial action
- General practice group action
- Staff recruitment, retention and burnout
- Provider Selection Regime (PSR)

Appendix 1 - 2024/25 Targets/objectives

- 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.
- Identify and deliver additional efficiency schemes to support the MTFS

Appendix 2 Engagement Value Outcome - Impact

EVO was launched in GHFT during 2023

Ophthalmology has fully completed an EVO programme

Key outcomes:

- Theatre utilisation improved from a baseline of 56% to 77% so far in 24/25
- DNA rates have reduced from 7% to 5% over a 6-month period
- Waiting time for cataracts reduced from 13 months to 2.5 months
- Service understands their performance data
- Costs are under control (0% inflation-adjusted growth vs 19/20)
- Overall productivity: In 23/24 the service out-performed 22/23 by 5.4% and is only behind 19/20 productivity levels by 2.4% (at the start of EVO, the service was 7.4% below 19/20)

Other services currently in 'active' or 'paused' EVOs:

- Gastroenterology and endoscopy (paused to enable better activity visibility through improved internal datasets)
- Cardiology (paused to enable go-live of cath lab)
- Obstetrics
- TIA and Stroke about to commence (pre-meet happened 03.07.24)

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**Chief Executive Report**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.					
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer. There is a special focus this month on the Government's manifesto pledges for the NHS and social care.					
Key Issues to note	This report covers the following topics: • **NHS Oversight Framework** • **ICS Engagement Improvement Framework** • **CQC major review, Maternity s.31 assurances** • **Primary Care Industrial Action** • **Fit and Proper Person Test** • **Election implications for Health and Social Care based on the Labour Party Manifesto.**					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The report references a number of different services, schemes and initiatives with associated risks included on the project / implementation plans. The risk associated with not producing a CEO report that summarises key programmes is relatively small, as there would be other mechanisms to communicate with partners and stakeholders.					
Management of Conflicts of Interest	There are no conflicts of interests associated with the production of this report.					
Resource Impact (X)	**Financial**		**Information Management & Technology**			
	Human Resource		**Buildings**			
Financial Impact	The schemes and initiatives included in this report will have associated financial plans that have been approved through established groups and committees.					
Regulatory and Legal Issues (including NHS Constitution)	The ICB constitution includes specific requirements for the ICB to engage and involve its local communities in health services and has specific duties with regard to the public sector equality duty. s. 1.4.5(e) The public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35). s.1.4.7(f) section 14Z45 (public involvement and consultation).					
Impact on Health Inequalities	N/A					

Impact on Equality and Diversity	
Impact on Sustainable Development	N/A
Patient and Public Involvement (PPE)	See the article on ICS Engagement Improvement Framework
Recommendation	**The Board is requested to:** • **Note the contents of the CEO report.**
Sponsoring Director	**Mary Hutton, ICB Chief Executive Officer**

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
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Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Chief Executive Report

1. Introduction

1.1 This report summarises key achievements and significant updates by the Chief Executive Officer of NHS Gloucestershire to the Integrated Care Board. This report is provided on a bi-monthly basis to Board meetings held in public.

2. New Oversight and Assessment Framework

2.1 At the end of May NHS England published an updated Oversight and Assessment Framework for a three-month consultation running until 13th June.
Some of the key changes to the framework are as follows:

- All ICBs and Providers will be assigned a segment on a scale of 1-4 (with 1 consistently high performing to 4 multiple failures).
- Segmentation will continue to take account of performance on metrics; 'additional considerations' including aggregated system performance on national priorities (which in 24/25 will focus on UEC, Elective, Cancer, Financial Performance, Mental Health and Primary Care); capability of organisations to improve without support; improvement trajectory for organisations including the role it is playing in supporting system partners in meeting shared priorities:
- Quarterly self-certifications for providers and assessment for ICBs considering 'capability' and 'delivery'.
- Where the ICB rating is 'excelling' or 'achieving' NHSE will discharge their role for overseeing providers through the relevant ICB.
- NHSE will continue to seek views from the ICP and Health and Wellbeing Board on the role of the ICB in supporting the delivery of wider local health and care strategies.
- NHSE will publish ICB and Provider scores, segmentation and underlying metrics quarterly.

2.2 Metrics to assess organisations' contribution to NHS system objectives as set out in the NHS delivery metrics will be updated annually to reflect the latest priorities but currently comprise:

Objectives	Sub-Domain
Improve population health and health care	Urgent and emergency care
	Elective care
	Cancer care
	Diagnostics
	Mental health care
	Learning disabilities and autism care
	Primary and community care
	Children and young people
	Frailty
Tackle inequalities in outcomes, experience and access	Inequalities in access and outcomes
	Outcomes and prevention
Enhancing productivity and value for money	Finance
	People
Support social and economic development	Social value

2.3 Mark Walkingshaw represented Southwest systems in the review of this framework with the national team. A set of recommendations have been agreed to help inform the further development of this framework, in a way which 'adds value' and minimises the additional requirements this process generates. It is anticipated that the framework will be piloted in the Autumn.

3. ICS Engagement Improvement Framework

3.1 NHS Gloucestershire ICB has been selected as one of four prototype sites to test and support the development of the ICS Engagement Improvement Framework, having submitted an Expression of Interest. The framework is being developed collaboratively by

the CQC, the Point of Care Foundation and National Voices, to enable Integrated Care Systems (ICS) to measure how well they listen to, and act on, the experiences and needs of people and communities to reduce health inequalities in their area, and feedback how experiences have informed the work of the ICS.

3.2 **What is the purpose of this project?**

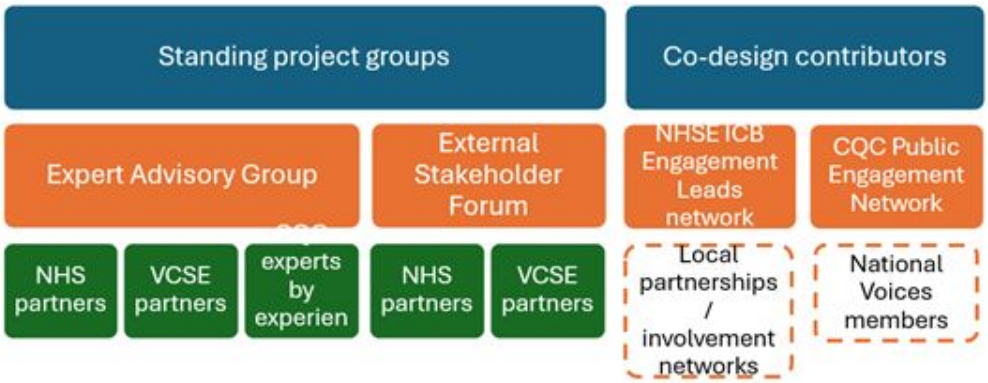
The project aims to support ICSs in achieving two of their core objectives: to improve outcomes in population health and healthcare; and to tackle inequalities in outcomes, experience, and access, by providing a consistent, rigorous, and scalable approach to assessing, reporting, and driving improvements in:

1. People's experiences of integrated care.
2. How ICSs are performing in relation to their Working with People and Communities strategies.
3. How ICSs are performing in acting on people's needs and experiences to reduce. Inequalities in health and care provision.

The framework will be a practical improvement tool, that adds value and compliments – rather than duplicates – existing frameworks, approaches, and strategies. ICSs will be able to use the framework to demonstrate to CQC assessment teams that they are self-assessing their own performance.

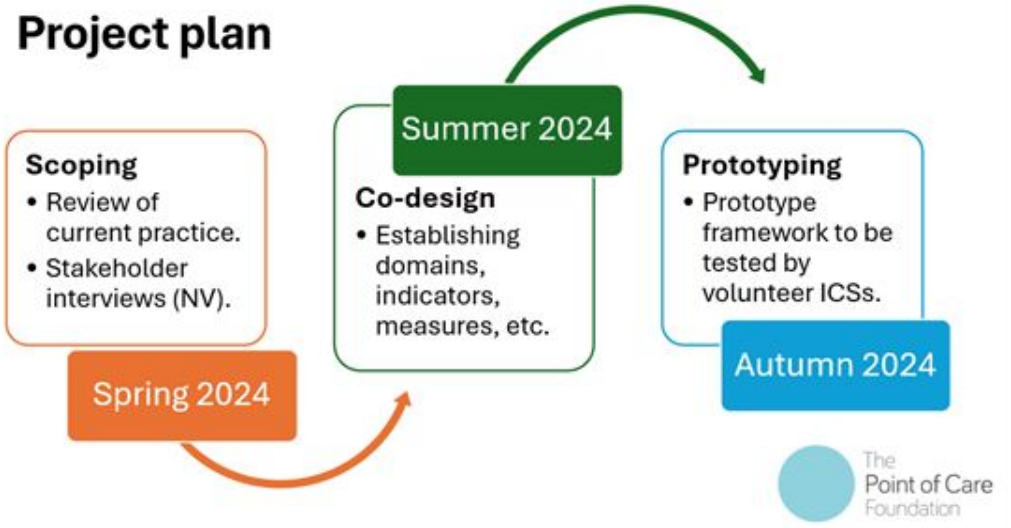
3.3 **Who is involved?**

A national Expert Advisory Group has been established to coproduce the framework and includes those from VCSE organisations representing key communities affected by health inequalities, as well as with people with lived experience. NHS Gloucestershire ICB is a member of the External Stakeholder Forum, which ensure that there is senior input into the project from a broader range of stakeholders with an interest in tackling health inequalities.



3.4 **What is the timeline?**

The timeline for the project is set out in the plan below; the testing phase is expected to commence in September 2024 and will run until the end of October 2024. The testing will be carried out in collaboration with relevant VCSE partners and lived experience partners. The CQC plan to launch the framework in February 2025.



The CQC will be sending out communications about this project in September, which will include announcing the test sites. NHS Gloucestershire ICB will coordinate local testing using local mechanisms.

4. **Maternity Services update**

4.1 The ICB has adopted a more formal surveillance, oversight and assurance role that had previously been held by NHS England Regional team in April 2024 through the Local Maternity and Neonatal system (LMNS); which is a subgroup of the ICB. Prior to this the LMNS worked in partnership with NHS England to identify, address and escalate issues. Earlier in the year the LMNS Board agreed that there were some areas of concern identified that needed extra focus to understand and resolve and at the end of March 2024, Gloucestershire Hospitals NHS Trust had an unannounced Care Quality Commission (CQC) inspection, which is the fourth inspection of maternity services in two years. Whilst initial feedback identified no immediate safety actions, a section 31 letter of intent was issued on May 1 outlining safety concerns and subsequently a section 31 enforcement notice was issued.

4.2 The concerns identified included five clinical safety concerns with an overall theme of;

- Stronger systems to provide an up to date and overarching view of quality and safety across the maternity service;

- Systems and processes to identify and action timely identification and learning from incidents across all teams in the department.

4.3 As a result, a Quality Improvement Group (QIG) was set up chaired by the Chief Nursing Officer in the ICB under the National Quality Board guidance to take these issues forward at pace. Membership of this group includes CQC, NHS England and Gloucestershire Hospitals Foundation Trust, including the CEO, CNO and CMO. Following on from this CQC notice, progress has been made in taking forward the issues raised by the CQC and those issues identified by the LMNS with clear actions, timescales and outcomes, which are being monitored through the Quality Improvement Group. Under the National Quality Board guidance, it has been agreed that the Trust maternity services are under enhanced surveillance.

4.4 In addition, an external review of the LMNS is underway with the intention of strengthening oversight including working more closely with Bath, Swindon and Wiltshire ICB to ensure cross system learning is embedded.

4.5 Furthermore an 'Insights Visit' led by the ICB, supported by NHS England Regional team, local and external Maternity and Neonatal voices took place on the 16th July with Maternity services. The focus of this visit was:

- Gaining assurance of safety and governance processes and how learning is shared across the Multi Disciplinary Teams;
- How learning from the Five Key Areas of the Section 31 is being embedded in practice.

Progress was seen in taking forward the recommendations of the section 31 notice and in implementing the recent Patient Safety Incident Response (PSIRF) framework. The findings from the visit will be fed back to the service to support improvements going forward.

5. GP Collective Action

5.1 There is significant concern across general practice because of the current 2024 to 2025 GP contract offer. In March the BMA held a referendum and 99.2% of BMA members voted against the 2024/25 GMS contract. The BMA is now in dispute with NHS England

.5.2 A ballot by the BMA of GP Partners to gain a mandate for taking collective action opened on 17 June and will close on 29 July. In the ballot partners are being asked if they are prepared to undertake one or more examples of collective action from a menu of 9 options. Co-ordinated national primary care industrial action would impact the whole Gloucestershire system and patient care and experience at a time when General Practice is facing unprecedented demand with GP surgeries across Gloucestershire delivering an

increase of 26.2% on pre-Covid levels. Primary Secondary Care interface work is a key component of the Primary Care Access.

5.3 Recovery Plan (PCARP) and will support general practice. However delivery of the primary secondary care interface requirements will need to be considered within the wider context of potential national General Practice Collective Action.

5.4 The Primary Care team have taken a paper to the ICB's Operational Executive and it is also going to the ICS Strategic Executive. Collective Action has been added to the Corporate Risk Register and referenced within the Board Assurance Framework as a significant risk to the system as a whole. The prospect of General Practice Collective Action has resulted in the Primary Care team putting in place mitigated actions including:

- Collective Action Task & Finish Group in place and we have engaged colleagues across the ICB including secondary and urgent care. The Group is undertaking impact assessments against the 9 potential areas across the system
- Primary Care Sustainability and Resilience Subgroup in place and monitoring risk of collective action
- Working closely with the LMC
- Working closely with Clinical Directors
- Secondary Care/Primary Care Interface Group established and Chaired by CMO.

5.5 We continue to work closely with other ICBs regionally and NHSE regional team. Regular updates will be provided to the ICB Board.

6. Fit and Proper Test – ICB Board Members

6.1 The Previous Government had commissioned the Kark Review in 2018 (under Regulation 5 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014). The purpose was to review the scope and process of the Fit and Proper Person Test (FPPT); an assurance process designed to prevent unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors.

6.2 Following the recommendations made by Tom Kark in his 2019 review of the FPPT (the Kark Review), NHS England developed a Fit and Proper Person Test (FPPT) Framework. This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

6.3 The FPPT Framework seeks to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The Framework introduces a means of retaining information relating to testing the

requirements of the FPPT for individual directors, a set of standard competencies for all board directors, including a new way of completing references with additional content whenever a director leaves an NHS board, and an extension of the applicability to some other organisations, including NHS England and the CQC.

6.4 The Framework was effective from 30 September 2023, at which time ICB board members were notified of the FPPT process and the information that would be collected for each board member, which was essential for assurance purposes. The ICB commissioned the South Central and West Commissioning Support (SCW) HR Team to undertake the FPPT process, overseen by the Associate Director of Corporate Affairs and Director of People, Culture and Engagement.

6.5 A FPPT report was produced for board members covering Non-Executive Directors and Executive Directors. In addition each NED / executive was required to complete a Self-Attestation Form counter-signed by the ICB Chair. Partners organisations were required to verify the arrangements they had in place to ensure that their senior executives were fit and proper board members. Health organisations confirmed that the same framework and process had been followed and confirmed that partner members had satisfactorily completed the FPPT process. Gloucestershire County Council are not required to follow the FPPT process council board members have completed Self Attestation Forms and sent them to the ICB HR Team.

6.6 The Chair of the ICB was taken through the process and documentation, and confirmed that she was assured that the Non-Executive Directors, Executives and Partner members were fit and proper board members. The Vice-Chair of the ICB was also taken through the process and documentation pertaining to the Chair of the ICB and confirmed that the Chair was a fit and proper person to hold the position of Chair of the ICB Board.

6.7 Thereafter the NHS England's Annual Assurance statement was completed and submitted to NHSE by 30th June 2024.

6.8 It should be noted that this is an annual assurance exercise and will need to be completed at the same time next year. This process is in place for new members of the ICB board and senior managers promoted into a director's role

7. General election implications

7.1.1 We have welcomed all the newly elected MPs representing Gloucestershire and continue to be committed to working closely with all elected representatives within the county. As part of the welcome to MPs a letter went from myself and the Chair, along with an accompanying briefing pack, to help newly elected MPs understand our system.

7.1.2 It will take time for the new government to fully develop their plans for the NHS in England, but the King's Fund summary of the key Labour party election pledges provides a useful starting point (summary of main pledges below).

7.1.3 The Board will recognise that many of these are already existing areas of focus for the ICB. However we are anticipating national announcements during the next few months which will provide additional detail. It is important to recognise that the key quality and performance commitments remain, alongside the central importance of strong financial discipline.

7.2.1 **Labour Government election pledges:**

7.2.2 **Prevention:**

- Ensure the next generation can never legally buy cigarettes.
- Ensure all hospitals integrate 'opt-out' smoking cessation interventions into routine care.
- Ban vapes from being branded and advertised to appeal to children.
- Ban sale of high-caffeine energy drinks to under-16s.
- Ban on junk food ads on television before 9pm.
- Introduce a supervised tooth-brushing scheme for three to five-year-olds, targeting the areas of highest need.
- Halve the gap in healthy life expectancy between the richest and poorest regions in England.
- Commission a new HIV action plan in England, in pursuit of ending HIV cases by 2030.

7.2.3 **Social Care Reform:**

- Undertake a programme of reform to create a National Care Service.
- New national standards for adult social care to ensure consistency of care across England, with a principle of 'home first'.
- Develop local partnership working between the NHS and social care sector on hospital discharge.
- Task regulators with addressing the role social care workers can play in basic health treatment and monitoring.

7.2.3 **Access to hospital care:**

- £1 billion pledged to provide 40,000 more appointments, operations and scans every week.
- Return to meeting NHS performance standards, for example, the 18-week referral-to-treatment waiting time standard.

- Use spare capacity in the independent health care sector to bring down waiting lists.

7.2.4 **Access to primary and community care:**

- Train thousands more GPs and guarantee a face-to-face appointment for everyone that wants one.
- Deliver a modern appointment-booking system.
- Bring back 'the family doctor' by incentivising GPs to ensure people always see the same GP.
- Create a 'community pharmacist prescribing service', granting more pharmacists independent prescribing rights where appropriate.
- Allow other professionals, such as opticians, to make direct referrals to specialist services or tests, and expand self-referral routes where appropriate.
- Trial 'neighbourhood health centres', bringing together existing community services such as family doctors, district nurses, care workers, physiotherapists, palliative care specialists and mental health specialists under one roof.
- Move to a 'neighbourhood health service' with more care delivered in local communities, shifting resources to primary care and community services over time.

7.2.5 **Access to Dentistry**

- Reform the dental contract, with a shift to focusing on preventive care, and the retention of NHS dentists.
- £125 million funding for a dentistry package that includes 700,000 urgent appointments every year, of which 100,000 would be for children

7.2.6 **Additional NHS funding commitments**

- £1 billion to fund 40,000 more operations, scans and appointments every week.
- £125 million dentistry package including 700,000 urgent appointments every year.
- £410 million to recruit 8,500 new mental health staff

7.2.7 **Capital investment in NHS buildings and equipment**

- £250 million pledged for a 'fit for the future' fund to double the number of NHS CT and MRI scanners.
- Deliver the new hospitals programme.

7.2.8 **Workforce:**

- Recruit 8,500 new staff for mental health services.
- Deliver the NHS Long Term Workforce Plan.
- Ensure the publication of regular, independent workforce planning across health and social care.

- Establish a 'fair pay agreement' in social care – a collective agreement with the sector to set fair pay, terms and conditions.

7.2.9 **Relations with NHS staff:**

- Reset relations with NHS staff and move away from the current approach on strikes.
- Implement professional standards and regulation for NHS managers.
- Establish a royal college of clinical leadership to 'champion the voice of clinicians'.

8. Recommendation

8.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**Board Assurance Framework**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	Risks are sent to lead directorates and executives each month.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	ICB Operational Executive	02/07/2024	Strategic Executive	18/07/2024			
Executive Summary	The BAF was refreshed in October and November to align with the three pillars, updated strategic objectives and the key priorities. A number of key changes were made following board members feedback at the ICB Board in November, January and most recently in May and early July. Feedback has been obtained from system partners at the Audit Committee meeting in March and Quality Committee in April as well as the Primary Care & Direct Commissioning Committee in April. The Audit Committee reviewed the BAF at its meeting on 24th June 2024 and the feedback from the Committee was given to risk leads and directors.						
Key Issues to note	**Key issues to note** As significant work was undertaken on the BAF ahead of the May ICB Board, in line with feedback from the March ICB Board and key board sub-committees, there is less to update the Strategic Executive on updates / changes to be made to the BAF risks this month. There has been some tangible changes to certain key risks see below, and all risks have bene reviewed by a Director, but there has been no change in risk score or risk appetite related to the 12 BAF risks. Some of the changes to note: • **BAF1** Health Inequalities risk has been reviewed with significant updates to the controls, assurances and actions and Director's review. There is no change in the risk score since the March report**.** • **BAF 3a** People and Culture risk, has been reviewed, the controls, gaps in controls and assurances have been updated. The actions have also been updated and correspond with the Director's update. The next review takes place at the People Committee on 18 July 2024. • **BAF 3b** Equality, Diversity and Inclusion has been reviewed, the controls, gaps in controls and assurances have been updated. The actions have also been updated and correspond with the Director's update. The next review takes place at the People Committee on 18 July 2024. • **BAF 7** Recovery / productivity risk has been reappraised following the Audit Committee & Quality Committee feedback and there has been an increase in the score from 12 to 16 and in the risk appetite from Zero/minimal to Cautious which was reported to the May ICB Board. For the July report significant updates have been made to the controls, assurances and action plan. The Director's report has been updated.						

Key Risks: Original Risk (CxL) Residual Risk (CxL)	The risk associated with not reporting risks is that key issues may not be identified and/or discussed at committee and board level. (4x3) 12 (4x2) 8			
Management of Conflicts of Interest	There have been no conflicts of interest in producing this report. If there are conflicts of interest identified, they should be managed in line with the Standards of Business Conduct Policy.			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	Risk around finance have been included within this report.			
Regulatory and Legal Issues (including NHS Constitution)	The ICB Constitution requires the ICB to have appropriate arrangements for the management of risk.			
Impact on Health Inequalities	There is a risk pertaining to health inequalities within the BAF see BAF 1.			
Impact on Equality and Diversity	An Equality Impact Assessment is included in the Risk Management Framework and Strategy			
Impact on Sustainable Development	No specific risks relating to sustainable development included in the BAF			
Patient and Public Involvement	There are no risks included in the BAF on Patient and Public Involvement			
Recommendation	The Board is asked to; • discuss the system wide strategic risks contained in the BAF and review the changes made to the quality risk and recovery risk as well as the new primary care risk. • note the report.			
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**	
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**			

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

Strategic Risks – Refreshed Board Assurance Framework

Summary July 2024

Pillar	Risk ID	Strategic Risk	Date of Entry	Last updated	Lead	Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Committee
Pillar 1	**Strategic objective 1: Increase prevention and tackle the wider determinants of health and care Strategic Objective 3: Achieve equity in outcomes, experience, and access**								
Making Gloucestershire a better place for the future	BAF 1	The failure to promote and embed initiatives on health inequalities and prevention.	13/11/23	05/07/2024	Dir Operational Planning & Perf	**4x3=12**	**4x3=12** ***(unchanged)***	**4x2=8**	ICP Resources Committee Quality Committee
Pillar 2	**Strategic Objective 2: Take a community and locality focused approach to the delivery of care**								
Transforming what we do	BAF 2	The risk is that our delivery structures are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change.	14/11/23	16/07/2024	Director of Primary Care & Place	**4x3=12**	**4x3=12** ***(unchanged)***	**4x1=4**	Quality Committee
	Strategic Objective 4: Create a One Workforce for One Gloucestershire								
	BAF 3a	Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan	01/11/22	28/06/2024 ***(next review at People Committee 18/07/24***	Dir of People, Culture & Engagement	**4x4=16**	**5x4=20** ***(unchanged)***	**5x1=5**	People Committee

	BAF 3b	Equality, Diversity and Inclusion: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse and engaging culture for staff we employ	15/02/24	28/06/2024 ***(next review at People Committee 18/07/24***	Dir of People, Culture & Engagement	**4x3 = 12**	**4x3=12** ***(unchanged)***	**4x1=4**	People Committee
	Strategic Objective 5: Improve quality and outcomes across the whole person journey								
	BAF 4	The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients.	07/11/23	17/07/24	CNO & CMO	**5x3 = 15**	**4x4 =16** ***(increase and reappraised risk)***	**4x1=4**	Quality Committee
Pillar 3	**Strategic Objective 6: Address the current challenges we face today in the delivery of health and care**								
Improving health and care services today	BAF 5	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.	13/11/23	11/07/24	Deputy CEO / Dir Strategy & Transformation	**5x4=20**	**4x3=12** ***(unchanged)***	**4x2=8**	Resources Committee
	Strategic Objective 6: Address the current challenges we face today in the delivery of health and care								
	BAF 6	Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures.	15/11/23	16/07/2024	Director of Primary Care & Place	**4x4=16**	**5x4=20** ***(unchanged)***	**5x1=5**	Primary Care & Direct Commissioning Committee
	BAF 7	Failing to deliver increased productivity requirements to meet both backlogs and growing demand	01/11/22	05/07/2024	Director of Operational Planning & Perf	**4x4=12**	**4x4=16** ***(increased)***	**4x1=4**	Quality Committee / Resources Committee
	BAF 8	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes	01/11/22	16/07/2024	Director of Integration	**4x3=12**	**4x3=12** ***(unchanged)***	**4x1=4**	People Committee
	BAF 9	Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver	01/11/22	08/07/2024	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16** ***(unchanged)***	**4x2=8**	Audit Committee / Resources Committee

		improvements in value for money and productivity							
	BAF 10	The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high-quality care	30/01/23	08/07/2024	Chief Finance Officer (CFO)	**4x4=16**	**4x4=16** ***(unchanged)***	**4x2=8**	Audit Committee / Resources Committee Audit Committee
	BAF 11	EPRR - Failure to meet the minimum occupational standards for EPRR and Business Continuity.	01/11/22	17/07/2024	Chief Nursing Officer (CNO)	**4x3=12**	**4x4=16** ***(unchanged)***	**4x1=4**	Quality Committee Audit Committee (IA report)
	BAF 12	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.	15/02/204	12/07/2024	Chief Clinical Information Officer	**5x4=20**	**5x4=20** ***(unchanged)***	**5x2=10**	Audit Committee

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

Key changes since March 2024 report

- **BAF1** Health Inequalities risk **has been reviewed with significant updates to the controls, assurances and actions and Director's review. There is no change in the risk score since the March report.**
- **BAF2** community and locality transformation has been re-aligned with the Director of Primary Care & Place. **The Director of Primary Care and Place along with the Primary Care Team reviewed this risk and there are no updated to be made. There is no change in the risk scoring since the March report.**
- **BAF 3a** People and Culture risk, **has been reviewed, the controls, gaps in controls and assurances have been updated. The actions have also been updated and correspond with the Director's update. The next review takes place at the People Committee on 18 July 2024.**
- **BAF 3b** Equality, Diversity and Inclusion **has been reviewed, the controls, gaps in controls and assurances have been updated. The actions have also been updated and correspond with the Director's update. The next review takes place at the People Committee on 18 July 2024.**
- **BAF 4** Quality Risk has been reappraised by the Chief Nursing Officer. **The controls, gaps in controls as wells as actions have been updated. There is a comprehensive Directors report.**
- **BAF 5.** Urgent and Emergency Care risk, has been **reviewed with updated controls and actions as well as an updated Director's report.**
- **BAF 6.** Primary Care risk had been rearticulated and updated with an increased risk rating from 16 to 20, this followed on from a PCDC Committee meeting held on 1st February. **This risk has been reviewed and there are no changes to be made to this risk.**

- **BAF 7** Recovery / productivity risk **has been reappraised following the Audit Committee & Quality Committee feedback and there has been an increase in the score from 12 to 16 and in the risk appetite from Zero/minimal to Cautious which was reported to the May ICB Board. For the July report significant updates to the controls, assurances and action plan have been made. The Director's report has been updated.**
- **BAF 8** Mental Health services **This risk has been reviewed by the Mental Health Team and there are no changes to be made to the May report.**
- **BAF 9** Financial Sustainability risk; **this has been reviewed and the actions and Director's report has been updated. The risk scoring remains unchanged since the March report.**
- **BAF10** Estates Infrastructure risk **this has been reviewed and the actions and Director's report has been updated. The risk scoring remains unchanged since the March report.**
- **BAF 11** EPRR is included as the ICB is a Category 1 Responder. **This risk has been reviewed and a comprehensive Director's update included. There is no change to the risk score.**
- **BAF 12** Cyber Security risk **has been reviewed. It is noted that GHFT did reduce their BAF score with regard to Cyber, however they have also just completed a significant penetration test of the network and there is a need to review the findings before reappraising this risk.**

NB. Target risks aligned to current risk impact.

Strategic Risks

Pillar 1: Making Gloucestershire a better place for the future					
Strategic Objective1: Increase prevention and tackle the wider determinants of health and care **Strategic Objective 3: Achieve equity in outcomes, experience, and access**					
2023-24 key priorities: Continue to increase the focus on prevention for health and care – for people of all ages; Work with wider partners and communities to enable people to take an active role in their own health and care. **23-24 key priorities: Reduce unfair and avoidable differences in health and care – including improving outcomes for specific groups of our population**					
Risk Ref: BAF1 **Strategic Risk** ***(previous BAF 3 integrated into this risk)***	**The failure to promote and embed a health inequalities and prevention approach.** **Due to:** long-term, entrenched and multi-faceted social, economic and racial inequalities which have profoundly impacted racially minoritized and socially marginalised communities; as well as insufficient resources and capacity to effectively tackle long term entrenched health inequalities arising from the wider determinants of health. **Impact:** Can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions and ultimately higher mortality - all associated with greater cost to the individual, society and the health and social care system.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**4x2=8**	⟷ ***unchanged since March report***
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				
Aligned to other system partners risks (include ref no.)	**GHC Risk ID 2** There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities (Red 16)				
Aligned to current ICB Risks	No relevant risks in the CRR				
Committee	**ICP/ Resources Committee / Quality Committee**	**Last Review and Updated:**	**5th July 2024**		
Current Controls (*what do we have in place to mitigate the risk?*)	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

		(how do we know the controls are working?)	
• Prevention Delivery Group and EAC-I oversight. • Health inequalities embedded in transformation programmes. This includes activity in Gloucester City ("Core20"), race relations ("PLUS") and 5 nationally identified clinical areas. • Health inequalities is a standing item at the Planned Care Delivery Board. • Integrated Locality Partnerships take a place-based approach to identify priorities for addressing the root cause of health inequalities. • System representation at Regional Inequalities Group and links with local and regional networks. • Consideration of health inequalities as part of service development and change through application of Equality and Engagement Impact Assessments. • Health Inequalities annual statement – reviewing the status of specified metrics as defined by NHSE • Organisational level self-assessment and peer review tool. • ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery. • Commitment to patient participation in all workstreams. •	• Some gaps remain in data quality and data sharing between ICS organisations. • Lack of a social value policy to guide proportionate universalism in funding allocations. • No routine or consistent collection of evidence or reporting of how successfully interventions are addressing health inequalities. • Health Inequalities annual statement does not cover all programme areas and inequalities and requires development to provide review of progress in reducing health inequalities. • Equality and Engagement Impact Assessments are not completed routinely in all parts of the system.	• Health inequalities measures built into strategic outcomes framework with Board-level assurance. • Regular reporting to System Resources Committee & Strategic Executive. • Quarterly activity reporting to NHSE. • Oversight by SROs. • Children's' CPG to have oversight of the data for the Core20PLUS5 for CYP	• Coordinated reporting on both longitudinal health inequalities and medium-term control impact (e.g. Core20Plus5). • Public reporting of health inequalities now in place but requires iterative development. • Monitoring effectiveness and impact of interventions. • Governance and accountability structures in development for the prevention and health inequalities agendas.

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
1. Prevention Delivery Group and Health Inequalities Improvement Manager stocktake of work to be refreshed; to include measurable impact. 2. Review of referral process and elective waiting list has commenced with clinical input from the PHM Clinical lead for Health Inequalities (Dr Charlie Sharp). 3. Work with information teams to collate and analyse data related to the Core20PLUS5 for adults and children and young people to inform targeting of resources. 4. Further develop Statement on Inequalities to reflect progress in reducing inequalities over time, and widen the metrics and populations covered by the review. 5. Project to increase and improve engagement with underserved communities continuing with evaluation and report currently being written. 6. EAC-I has been re-established and will provide governance and oversight of work taking place across the system to tackle health inequalities. 7. NHS Gloucestershire ICB is a test site for the development of the ICS Engagement Improvement Framework, which will enable systems to measure how well they listen to, and act on, the experiences and needs of people and communities to reduce health inequalities. The framework will be launched in February 2025.	**Q1 24/25** 1. System Leadership Development session was held on 28th June with senior leaders and practitioners from across the system to promote our strategic approach to addressing health inequalities in Gloucestershire and embed it into business as usual. 2. The Health Inequalities Framework for the ICS has been developed and was adopted by members of the ICB Board in February. This will be used as a mechanism for programmes to report on their contribution to addressing health inequalities and was presented at the system leadership event of the 28th June. 3. Reporting template to enable partners to report the work that they are doing in relation to the framework, allowing us to track outcomes and guide priorities has been finalised and ready to be rolled out. 4. National guidance on reporting system position on health inequalities has been published. The One Gloucestershire report in line with these requirements has been published alongside the annual report. 5. Development of an ICS Health Inequalities Intelligence Group to work collaboratively to build the intelligence around health inequalities across the system and ensure a coordinated approach to health inequalities analysis. 6. Roll out of the Gloucestershire Prevention and Health Inequalities Hub; an online compendium of information, resources, and tools designed to help the workforce better understand and take action to improve health equity in their areas of work. 7. Elective workstream has identified potential for work with patients on multiple waiting lists, this has commenced through the referral optimisation group, and a project is being carried out by an intern from the "10,000 Black Interns" Programme to identify priority areas of focus that align with the national major conditions strategy. 8. Specific focus on Gloucester Inner City in underway as Targeted Lung Health checks are rolled out – this will include support for patients with incidental findings in addition to those identified as having suspected cancer. 9. Operational plan for 24/25 has been submitted with Health Inequalities a focus throughout.
Relevant Key Performance Indicators: • Health inequalities narrative and system outcome measures to be included in bi-monthly integrated performance report. • Performance against NHS constitutional targets (e.g. RTT, Cancer Wait times, Diagnostic access, UEC waiting and response times)	

	• Joint Forward Plan metrics. • NHSE Statement on Inequalities – system annual reporting.

Strategic Objectives: Take a community and locality focused approach to the delivery of care					
23-24 key priorities: Continue to support improvements in outcomes for people at every stage of life – delivering care that is closer to home and person-centred.					
Risk Ref: BAF2 Strategic Risk	The risk is that our delivery structures are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change. **Due to: Multiple and competing demands to transform services, couple with i**ncreased demand for services and challenges in recruitment and retention. Delivery requires prioritisation across GHC and primary care as well as GCC teams to ensure progress is delivered in 24/25. **Impact:** waiting times and service delivery across primary and community care. The ability for the community providers to meet increasing demand and the ability to deliver transformation is diluted.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score**
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**4x1=4**	⟷ ***unchanged since March report***
Strategic Risk Owner (Director)	**Helen Goodey, Director of Primary Care & Place**				
Aligned to other system partners risks (include ref no.)	There are no correlating risks.				
Aligned to current ICB Risks	Risk of instability and resilience in general practice.				
Committee	**Quality Committee**	**Last Review & Updated:**	**16th July 2024**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Neighbourhood Transformation Steering Group in place to oversee the transformation of care at neighbourhood level, integration of health & care workforce and the introduction of new models of care • UEC prevention workstream adopting a population health approach to support	• Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. • Sufficient change management resource to deliver sustainable change across the ICS in the timeframe required.	• Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG) • Reporting through the UEC prevention programme. • Ongoing monitoring	• Further development of the performance and benefits realisation trajectories required.

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

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

	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Ill health prevention Outcomes data (November 2023 IPR Report) and Ageing well KPIs

Pillar 2: Transforming what we do					
Strategic Objective Create a One Workforce for One Gloucestershire					
24-25 key priorities: Increase staff retention, provide good training and development opportunities of our One Gloucestershire workforce and build an inclusive and compassionate culture.					
Risk Ref: BAF3 **Strategic Risk**	**People & Culture**: Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan **Due to:** High levels of vacancies across key staffing groups **Impact**: Increased pressure on existing staff, impacting staff morale and wellbeing, and impacting on bank and agency targets for 2024-25.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Cautious**	**4x4=16**	**5X4=20**	**3x2=6**	***unchanged since March report***
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	**GHFT SR16** Inability to attract and recruit a compassionate, skilful and sustainable workforce (risk rating 20, May 24) **GHC ID3** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives (Red 12) **GHC ID12** There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target (risk rating 9, May 24)				
Aligned to current ICB Risks	**PCE 1:** Risk of further industrial action: There is a risk that industrial action will be taken impacting delivery of services. (Residual score 4x5=20). **U&EC 3**: Risk of insufficient expansion of UEC workforce. (risk score 4x4=16)				
Committee	**People Committee**	**Last Review and Updated:**	**28/06/2024**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**

• Utilisation of all available resources from NHSE monies for Continuing Professional Development and leadership development to support staff training & development • Some leadership learning and development programmes in place • People Promise Leads in both Trusts focusing on all aspects of People Promise elements and best practice • System level delivery plans focusing on agreed priority areas for action in 24/25 for each Steering Group. • Robust organisational plans in place for EDI, retention and temporary staffing spend reduction. • Colleague Communications & Engagement • System-wide careers and engagement team (2 year FTC) focused on promoting careers in health and care	Lack of an adequately defined and resourced system-wide and medium-term plan for staff relating to leadership development (Mapping of current leadership development approaches and offers completed the ICS, options for future being developed)	• Reporting to the People Board, People Committee, and the Board of the ICB • On-going monitoring of progress on key workforce metrics through Integrated Performance Report (see below)	• Implementation details relating to supporting delivery of NHS Workforce Plan. • Reduced funding for workforce transformation and remaining uncertainty relating to 2024/25 funding (e.g CPD funding) and mechanisms to sustain targeted work.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
The system continues to develop and embed targeted initiatives: 1. People Promise Leads and work programmes in both GHFT and GHC. 2. System wide EDI actions focusing on 3 areas, data, anti-discrimination & recruitment/career progression 3. Collective focus on agency and temporary staffing spend in response to revised 3.2% target for 2024/25, zero off-framework usage from July 2024 and no revenue non-clinical agency usage from April 2024 4. On-going recruitment activities at organisational level and roll out of system wide recruitment promotion campaign "Be in Gloucestershire" 5. Draft health and wellbeing strategy developed and key initiatives for staff including proposed staff housing hub 6. Continued focus on System Leadership with a programme of conferences and events for leaders across the system.		1. Peoples Promise Managers appointed within GHC and Gloucestershire Hospitals NHS Foundation Trust (GHFT). Retention focus (deep dive) undertaken at the May People Committee noting the actions being taken by system partners to tackle retention 2. ICS workforce analyst supporting re-presentation of EDI, aim for completion by the end of July. System engagement in regional workshop on "Too Hot to Handle Report" on 10/7/24 3. ICS Temporary staffing group in place to bring shared system oversight and sharing of initiatives and best practice. M2 position showing spend as 2.7% of total pay budget 4. Recruitment: We Want You project team has transitioned into a new service arrangement with the commencement of two system careers engagement officers. 5. HWB strategy drafted and out for review by system wide leads, pilot new starter induction was undertaken in May and conclusion to incorporate concepts in induction processes. Regional conversations to establish	

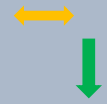
	housing hub ongoing and seeking approval to recruit Housing Officer role, Homeshare element continues to be provided (by Age UK). 6. System wide leadership conference held on 28/06/24 focusing on health inequalities circa 160 leaders across the system attended the event. Discussion with Strategic Executive on 18/7/24 on Leadership development and alignment with system objectives.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Staff Engagement Score (Annual) • Sickness Absence rates, Staff Turnover % & Vacancy Rates • Bank and Agency Usage • Apprenticeship levy spend and placement numbers

Pillar 2: Transforming what we do					
Strategic Objective Create a One Workforce for One Gloucestershire					
23-24 key priorities: Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.					
Risk Ref: BAF3b **Strategic Risk ED&I**	**Equality, Diversity and Inclusion**: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse and engaging culture for staff we employ. **Due to:** insufficient strategic focus and actions that make a real difference to improving diversity and representation of staff across the pay grades including senior positions (clinical and non-clinical); and improves staff experience in the workplace ensuring compassionate leadership and a compassionate culture is in place. **Impact**:. The system does not benefit from cognitive diversity and fails to enhance opportunities to reduce the negative impacts on recruitment, retention and poor staff workplace experience	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**4x3=12**	**4x3=12**	**3x2=6**	***unchanged since March report*** ↔
Strategic Risk Owner (Director)	**Tracey Cox, Director of People, Culture and Engagement**				
Aligned to other system partners risks (include ref no.)	**GHFT SR17** Inability to attract a skilful, compassionate workforce that is representative of the communities we serve, (Culture & Retention (risk rating 20, May 24) **GHC ID4** There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment (risk rating 9, May 24)				
Aligned to current ICB Risks	**ODSG Risk ID 20** There are a plethora of national EDI reporting requirements, making it difficult to be clear on priorities with overlapping plans and reporting requirements and additional effort in maintaining reporting requirements (risk score Amber 12)				
Committee	**People Committee**	**Last Review and Updated:**	**28/06/24**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances**	**Gaps in Assurance**		

		(how do we know the controls are working?)	
• Reporting through the ICS People Governance Groups • Monitoring from the Equality and Human Rights Commission on the Public Sector Equality Duties • Annual reporting against Workforce Race Equality Standards, Workforce Disability Standards & gender pay gap with corresponding action plans • EDI task and finish group	Lack of system wide improvement targets for • Recruitment • Movement between pay bands • Insufficient frequency in metrics related to engagement and staff experience • Significant volume of data but more granular analysis required to support improvement plans	• Reporting to the People Board, People Committee & relevant Committees of providers • Reporting to the ICB Board • Audits undertaken by Internal Auditors	People Committee requested further system wide focus and commitment to discuss improvement trajectories.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
1. One Glos People Strategy priority and commitment to ED&I 2. All NHS partners engaged in Equality Delivery System framework 3. Action planning in response to 6 high impact actions in national EDI Improvement Plan 4. System wide commitment to support agenda prioritising: o Data collation and presentation, o anti-discrimination policy and practice & o recruitment/career progression		1.Clear and tangible actions being developed as part of 2024 work programme based on national EDI improvement plan and WRES/WDES analysis. – to be shared with July People Committee. 2. ED&I sub-group continues to meet sharing learning and actions. Some partners are organising bespoke staff surveys related to WRES and WDES outcomes to help produce more effective actions to tackle discrimination in the workplace. Projects and schemes being shared with partners. 2. EDS2 discussions relating to preparatory work for 2024-25 requirements initiated. 3. Individual organisational level action plans progressing focusing on anti-discrimination approaches and reporting of incidents. 4. The BI workforce analyst is working on standardising the reporting of WRES, WDES and GPA for system partners to be completed by end July 2024	
	Relevant Key Performance Indicators: Annual reports • Workforce Race Equality Standard report (metrics on % of BME staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WRES metrics) • Workforce Disability Equality Standard report (metrics on % of Disabled staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WDES metrics) • Gender Pay Audit – gender pay gap includes data on pay gap (mean and median hourly rates) • Racial Disparity Ratios and Staff Survey results for each organization.		

<table>
<tr><td colspan="6">Pillar 2: Transforming what we do</td></tr>
<tr><td colspan="6">Strategic Objective: Improve quality and outcomes across the whole person journey</td></tr>
<tr><td colspan="6">23-24 key priorities: Increase support for people living with major health conditions – shifting to a more preventative approach and earlier diagnosis.</td></tr>
<tr><td>Risk Ref: BAF4
Strategic Risk</td><td>The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients.

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

Impact: Patients and citizens will be potentially put at risk of harm or suboptimal outcomes and have a poor experience if providers are unable to deliver high quality care.</td><td>Original Score (I x L)</td><td>Current Score (I x L)</td><td>Target score (I x L)</td><td>Movement in score
  </td></tr>
<tr><td>Risk Appetite (include colour)</td><td>Zero/Minimal</td><td rowspan="3">5x3=15</td><td rowspan="3">4x4=16</td><td rowspan="3">4x1=4</td><td rowspan="3">Increase in score from last reporting period (March 24) from 5x2 =10 to current score 16 (see director’s update)
  </td></tr>
<tr><td>Strategic Risk Owner (Director)</td><td>Chief Nursing Officer
Chief Medical Officer</td></tr>
<tr><td>Aligned to other system partners risks (include ref no.)</td><td>GHFT SR2 Failure to implement the quality governance framework (risk rating 16)

GHFT SR 5 Failure to implement effective improvement approaches as a core part of change management (risk rating 16)
GHFT SR1 Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System (risk rating 25)

GHC ID 1 There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support; (ii) address variability across quality standards; (iii) embed learning when things go wrong; (iv) ensure continuous learning and improvement, (v) ensure the appropriate timings of interventions (risk rating 12)</td></tr>
<tr><td>Aligned to current ICB Risks</td><td colspan="5">Integration 15 Maternity services recent inspection March 2024 - GHFT issued with a Section 31 letter of intent related to safety and learning including Women unable to access first trimester antenatal screening or growth scans; Massive obstetric haemorrhage; 3rd and 4th degree tears – significantly outside of national parameters.
S&T 2 A risk that our system partners cannot support or drive transformation programmes and projects due to operational and workforce pressures.
U&EC 6: Risk of failure to meet core UEC performance metrics</td></tr>
</table>

Committee	Quality Committee	Last Review & Update Date:	17th July 2024

Current Controls (*what do we have in place to mitigate the risk?)*	Gaps in Controls	Current Assurances *(how do we know the controls are working?)*	Gaps in Assurance
• ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput. • Reporting from and attendance at Provider Quality Committee. • Learning from Case Reviews • System Quality Group • System Effectiveness Group • System IPC Group • System Mortality Group • Rapid Review and Quality Improvement Groups where appropriate for specific service areas challenged • Weekly safety huddle within ICB now routinely in place •	• New PSIRF will turn on the previously mentioned Patient Safety System Group. • Colleagues leading the work on the System Safety, Effectiveness and Experience groups will be meeting to ensure new groups are aligned. • Until groups are in place and functional existing control methods will continue as a risk mitigation. • Triangulation of data across the system through quality dashboards not in place currently	• Reporting to Quality Committee • Quality Assurance discussions • Intelligence gathering through data relating to all aspects of quality • Contract Management Boards • Regulatory reviews	• There are gaps in some of the controls as stated and while there is a sound governance system in place for oversight, we will not have full assurances until we assess if the controls around PSIRF and alignment of groups (System Safety, Effectiveness and Experience groups) are working. •

Actions to mitigate risk & implementation dates	Director's update on actions to date (quarterly update)
1. NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. 2. System Safety and Learning Group to be instigate by 31st December. 3. PSIRF to be ratified by Quality Committee in February 2024 Continued focus on personalised care training across the system 4. Established Quality and clinical gov internal ICB group – first meeting 30th May 2024. TOR to triangulate data drafted.	1. PSIRF now in place although early days of new approach. Some enhanced measures and reporting in place, beyond PSIRF oversight, with maternity services owing to the level of surveillance and concerns 2. Internal ICB Quality and Clinical Gov group to more formally bring together triangulated data across the system to promote learning and ensure focus support on challenged areas. First meeting has taken place and TOR drafted. 3. System Mortality: The national ONS/NHSE data tool, shows SHMI to be 'Higher than Expected'. This figure is different from the figures based on Healthcare evaluation data (HED). There are questions raised about the accuracy of data

		including coding which is a risk. This is being reviewed by the CMO at the system mortality group working with the acute trust and further discussions will be held to collectively explore the trends and issues and to implement required actions. 4. Quality Improvement Group (QIG) remain in place for maternity services and currently subject to enhanced surveillance owing to Section 31 notice. 5. Significant challenges within UEC and GHFT risk rated at 25.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Summary Hospital-Level Mortality Indicator (SHMI) • NHS staff survey safety culture theme score • Percentage of patients describing their overall experience of making a GP appointment as good • National Patient Safety Alerts not declared complete by deadline • Consistency of reporting patient safety incidents.	

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Support improvements in the delivery of urgent and emergency care					
Risk Ref: BAF5 Strategic Risk	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care. **Due to:** Insufficient improvement capacity and / or capability, insufficient staff engagement, or prioritisation of available resource on operational flow pressures. **Impact:** Continued pressure on our staff, performance commitments and system finance plan. Risk patients will have a poor experience of urgent and emergency care services.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ⬇ ⬆
Risk Appetite (include colour)	**ZERO/Minimal**	**5x4=20**	**4x3=12**	**4x2=8**	⟷ *Unchanged from March report where risk was scored as 4x3=12*
Strategic Risk Owner (Director)	**Deputy CEO / Director of Strategy and Transformation**				
Aligned to other system partners risks (include ref no.)	**GHFT SR1** Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System. **GHFT SR5** Failure to implement effective improvement approaches as a core part of change management.				
Aligned to current ICB Risks	**U&EC 1**: Risk of insufficient access to alternative pathways to ED **U&EC 2:** Transformational change across U&EC **U&EC 6**: Risk of failure to meet core UEC performance metrics. Risk of failure to meet National Ambulance Response times, Risk of non-delivery of reduction in hospital length of stay & Risk of failure to meet National targets for UEC waits: Emergency Department (ED) and Ambulance Handovers [UEC ED Flow]) **U&C 4:** Risk of insufficient system Resilience				
Committee	**Resources Committee**	**Last Reviewed and Updated:**	**11/07/2024**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		

• Strong system wide governance for system operational issues (daily and weekly rhythm including Exec oversight), supported by System Control Centre. • Strong operational governance through system meetings (e.g. UEC CPG, Flow Friday) and contractual oversight (SWAST, PPG). • Transformation capacity and capability all in place since August 2023 including Board, Steering Group and workstreams in place including Benefits Oversight and Assurance Group. • Agreed reporting on priority improvements in place. • Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver improvements within UEC system flow. • Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme. • System wide operating plan to align with Transformation priorities for 2023/24. • Agreed UEC Transformation Programme in place including Working as One across all system partners. • Annual Winter Plan to be developed and in place to communicate to patients about where to access services during winter.	• Enhanced outcome and performance reporting across governance structure (to be enabled by digital platform). • Agree funding for improvements as part of the 24/25 operating and financial planning process.	• Ongoing monitoring of system wide priorities including operational planning targets via TEG/SEG. • Reporting to the Board of the ICB on key metrics via Integrated Performance Report. • NHSEI Reporting. • Benefits Realisation for Working as One Programme in place.	• Further development of the performance and benefits realisation trajectories required for some measures, with a focus on quality and outcome measures. • Impact of operational demand on the ability to continue at pace with the Working as One Transformation Programme.
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• 1. Transformation Workstreams continue to deliver priority trials at pace to agreed schedule, all workstreams to have completed a trial by December 2023, with further iterations of trials through first half of 2024 dependant on learning (Action adapted to account for PDSA / Trial methodology).		• 1. All workstreams have a trial mobilised or are in further iterations of trials (as at July 2024) Hospital Flow workstream is progressing into sustain phase with LOS reductions seen,	

• 3. Benefits realisation being developed, Programme metrics to be finalised by December 2023. • 4. Communication and Engagement plan developed, core narrative and supporting materials to be shared in November 2023 (action to remain open) • 5. Improvement trials targeted to areas where performance improvements are needed (ongoing action with regular review at UEC CPG).		whilst continuing to consider where further improvement cycles could support. • 3. Programme metrics for Working as One are in place. Workstream measures have been developed. Action remains open whilst quality and outcome measures are refined, alongside automated reporting. Automated reporting has been developed, under review prior to roll out across the system. • 4. In line with the target date of November 2023 Working as One communications and engagement plan in place and core narrative shared and regular bulletins are distributed across the system. Action remains open whilst we continue to explore the impact of comms material and how we can increase reach. • 5a. Integrated Hub went live on 19th February (4-week trial) to improve hospital flow and reduce no criteria to reside. Options Appraisal for continuation to be considered at August Exec Programme Board. • 5b. Audit of Ward 6A completed in GHFT to understand ambulance handover delays to create an improvement plan. Plan on Page agreed by system and shared with regional NHSE, SWASFT and ICB colleagues as part of SWASFT contract arrangements. • 5c. Implemented schemes through winter support resilience and reduce reliance on beds.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) IPR Reporting for Acute, Winter monitoring and Ambulance metrics.	

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Support a resilient and accessible primary care for the public and increasing workforce recruitment and retention.					
Risk Ref: BAF6 Strategic Risk	Risk of instability and resilience in general practice due to increasing costs and financial risk to delivery and capacity of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures. **Due:** Practices are facing new financial challenges due to the increase in costs associated with staffing, energy, goods and supplies as well as a significant increase in patient demand due to the changing nature of general practice, therefore impacting increasing workloads. Practices are increasingly unable to afford to replace staff and are having to consider ways to reduce costs at a time when they are holding more risk due to extended wait times for secondary care. There is also a general concern regarding workforce resilience and retention across all roles within primary care and estates constraints to delivery. This will be further compounded by potential primary care national industrial action during 2024/25, following BMA Letter (18th April 2024) to all ICBs. LMC advising potential timings will be Q2 onwards. **Impact:** These challenges could result in practices facing serious financial hardship with potential contract hand backs and foreclosure of loans on premises. If GPs are made bankrupt they are unable to hold a medical services contract, therefore the local population could have no contract holder for medical services or premises to operate from, leading to significant instability. This is also impacting on delivery of services with waiting times increasing for patients to see primary care professionals, poor morale and hence higher turnover of staff. There is also a wider risk to the system of increased demand on other services if primary care are unable to deliver core services due to complete saturation or through taking steps to manage down capacity.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↑
Risk Appetite (include colour)	**Cautious**	**4x4=16**	**5x4=20**	**4x1=4**	⟷
Strategic Risk Owner (Director)	**Helen Goodey, Director of Primary Care and Place**				

Aligned to other system partners risks (include ref no.)	**GHC ID8** There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities (risk rating 9)				***unchanged since March report where risk was scored 5x4=20***
Aligned to current ICB Risks	**PC&P 2** There is a general risk that the ICB's requirements of providing Primary Medical Services for practices that are facing resilience challenges (RED 15) **PC&P 9** Current and future GP Training Capacity will be reduced due to challenges with GP educators and estate (RED 16).				
Committee	**Primary Care & Direct Commissioning Committee**		**Review Date:**	**16th July 2024**	

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Primary Care Team continues to provide on-going support to practices, to identify mitigations and provide resilience funding where appropriate • Resilience and Sustainability of General Practice Sub Group (to the PC strategy group) established • A standard operating procedure (SOP) has been developed to ensure a fair and consistent approach with good governance. • An independent accountant working with the practices and ICB finance team to review the position and put in controls where appropriate • There is a monthly review of practices to assess the issues that have arisen and where additional support may be needed • Primary Care Workforce Strategy is in place and is being implemented with a vast array of projects and initiatives including supporting new roles ARRs, recruitment and retention schemes, open days and campaigns • Workforce data is analysed on a monthly basis to ascertain early any problems with	• Awaiting national DDRB (Independent review body on doctors' and dentists' remuneration Board) pay award decision on GP Contract • Details on when the primary care industrial action will be undertaken and level of industrial action to determine which areas of work/system this will impact	The Primary Care Operational Group receives regular reports on practice resilience and the schemes and initiatives to support practices including workforce reports. The Primary Care and Direct Commissioning Committee receives those reports from PCOG and provides oversight and scrutiny. The resilience and sustainability of General Practice sub group has been established to further develop the ICB response to struggling practices. The resilience and sustainability of General Practice Sub Group (which includes LMC representation) has been established and is monitoring the situation with regard to Industrial action.	• Volume of shared care and additional 'discretionary' activity, are both unknown with regard to potential industrial action.

staffing and support is provided to practices where required • Partners Survey to understand current position on retirements • Primary Care Audit undertaken to understand what is driving increased demand • ARR underspend process completed to enable PCNs to maximise recruitment. • Primary Care Strategy is in place with associated plans • ICB & LMC working with secondary care colleagues (GHFT) to brief them on potential national primary care industrial action and potential impact to their services • Secondary Care/Primary Care Interface Group (senior leads level) has been established and will be briefed and kept updated on potential industrial action as potential impact could heavily focus on the 4 key areas of the interface work			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Further Admin and Reception Staff Training Events - planned - conflict resolution and customer service • Primary Care Induction Sessions - supporting knowledge and training of those new to general practice. • Collaboration with the Wellbeing Line to support staff and retention within roles • Joint working with Gloucestershire Skills Hubs to support people returning to work. • Working with ICS 'We Want You' Programme to support promotion of Primary Care roles to secondary school age children. • Collaborating with Gloucestershire College on T-Level Placements & working on bespoke apprenticeship opportunities with practices		• Working closely with the LMC to understand the potential impact to general practice capacity, due to the sustainability challenges • Regularly surveying practices to understand impact to capacity, particularly urgent on the day care • Resilience and Sustainability sub group - focussed on understanding the impact on general practice and ensuring we are developing action plans to support mitigations • Financial Awareness Training is being developed for all partners and practice managers	

• Primary Care Resilience and Sustainability Subgroup are working with the Primary and Secondary Care Interface Group to ensure a shared understanding of the potential impact of industrial action.		
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) • Reporting on Access to Primary Care and Quarterly surveys and data relating to primary care.	

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities improve access to care – reducing backlogs for people waiting for assessment as well as hospital treatment.					
Risk Ref: BAF7 Strategic Risk	Failing to deliver increased productivity requirements to meet both backlogs and growing demand. **Due to**: Waiting list backlogs generated through Covid as elective services were stood down for long periods of time. On-going impact of staff sickness/absence and general workforce shortages in both medical and nursing posts affecting smaller specialties such as haematology, rheumatology and Cardiology. UEC pressures on elective bed availability continue to be an issue although some elective ring fencing has been possible with new ward reconfigurations. There has also been a growth in 2ww referrals across a number of big cancer specialties such as Lower GI which has diverted all elective capacity towards seeing and treating them at the expense of routine patients. **Impact**: Most elective specialties have a level of long waiters >52 weeks and the total waiting list size is double what it was pre-covid. Clearance of non-admitted patients generates additional admitted patients, and the shape of the waiting list curve is such that waves of long waits come through at different times making PTL management difficult and seasonal. The increase in cancer work for specialties such as Lower GI and Urology has made it difficult to maintain routine elective activity and so these patients continue to wait longer than we would want. Prioritisation of waiting lists for cancer and urgent P1-2 categories often pushes the P4 routine waits further and further back. Follow up patients are also often very delayed for the appointments and largely go unnoticed as they are not reported in any national waiting time target but pose a significant risk of harm especially in specialties such as Ophthalmology or cancer follow ups.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** 
Risk Appetite (include colour)	**Cautious**	**3x4=12**	**4x4=16**	**4x1=4**	 ***Increase of this risk from***
Strategic Risk Owner (Director)	**Mark Walkingshaw, Director of Operational Planning and Performance**				

Aligned to other system partners risks (include ref no.)	GHC 3 There is a risk of demand for services beyond planned and commissioned capacity				***3x4=12 since March report***
Aligned to current ICB Risks	OP&P 5: Risk of failure to comply fully with NHS Constitution standards for planned care waiting times OP&P 7: Risk of services not delivering to commissioned standards or provider failure				
Committee	**Quality Committee / Resources Committee**		**Last Review & Update Date:**	**5th July 2024**	
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**		**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**	
• Clinical validation and prioritisation of system waiting lists plus regular contact with patients to notify them of delays and what to do if clinical condition changes. Elective waiting list prioritised with P codes. • Weekly check and challenge meetings in place at GHFT to focus on longest waits by specialty and instigate immediate remedial actions. • Elective care hub undertaking patient level contact, validation and link to social prescribers as well as escalation of any patients with a worsening condition to the relevant specialty. • Additional elective activity commissioned with Independent Sector providers both for new referrals and transfer of long waiters from GHFT where required. • Additional capacity commissioned with GHFT in key long waiting specialties as part of annual planning process using ERF funding stream. • Work continues with primary care through the Referral Optimisation Group to manage referral demand into secondary care. Increase in A&G services and access to Cinapsis as well as progress with "Advice First" approach and RAS role out. Expanded GP education programme and G-Care pathway content.	• Stratification of waiting list based on other health and socioeconomic factors under development. • Specific plans for improving C&YP access to elective services in development. • Elective recovery plans for Gloucestershire patients treated at out of county NHS providers subject to further development.		• Performance Reporting to the Planned Care Delivery Board, System Resources Committee and the ICB. • Elective recovery planning and oversight provided by the Planned Care Delivery Board (PCDB) with escalation via Programme Delivery Group and ICS Execs as required. • Reporting to NHSE/I on waiting times. Any elective cancellations reported to NHSE/I. System waiting times monitored through the WLMDS tableau report. Regular Elective Recovery COO and Performance Directors meetings with NHSE for the region. • Regular contract and performance management governance structures in place to review performance and associated recovery plans with all independent sector providers.	• Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.	

• Regular analysis of waiting lists in place to ensure equity of access, waiting times and outcomes for our most deprived populations and ethnic minority groups. Weekly check and challenge meetings at GHFT to micromanage long waiters in place. • Clinical harm reviews undertaken for all long waits. • Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.			
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
1) Commitments made in the 24/25 Operational plan monitored through Planned Care Delivery Board (ICS level meeting with GHFT represented). 2) Additional capacity investments via ERF are being agreed through system prioritisation process. 3) Additional elective activity planned for 2024/25 (e.g. endoscopy, WLI GLANSO lists as well as insourcing and outsourcing). 4) Additional pathways continuing to be rolled out at the CDC to fully utilise available estate. 5) Additional activity to be commissioned from ISPs as part of 24/25 operational planning. 6) 3rd Cath Lab being commissioned for 24/25 – go live date currently planned for November 2024. 7) New FoD community hospital being commissioned with endoscopy facility due to open Sept 24 8) Patient Engagement Portal phased implementation underway 9) Renewed OP transformation programme underway at GHFT including roll out of patient portal and Going Further Faster GIRFT initiative		1) Operational plan now submitted. ERF to continue through 2024/25 with system aiming to achieve significantly higher recovery than the 2023/24 position (which was impacted by industrial action) in addition to 5% productivity increase. 2) All ERF and High Risk investments are being assessed through NHSE triple lock process to assure financial value for money and achievement. Business cases for all key investments have been worked up for system support. 3) Additional 2x daycase theatre capacity at CGH now operational. 4) GHFT theatre utilisation improvement project has seen good progress with decreases in time lost to early finishes and late starts, and overall improvement in % utilisation. 5) Community Diagnostic centre open, creating significant additional capacity with additional pathways coming online in 24/25 (e.g. Complex Breathlessness service and Liver Disease "One-Stop" clinic). 6) ISP contract and activity confirmed for 2024/25 with potential new providers being available through the PSR process. 7) Working assumption to start using new endoscopy facility for 2 days a week from July 24. Funding implications still to be finalised and prioritised alongside other elective investments. 8) Patient Engagement Portal (PEP) gone live with phase one 9) Going Further Faster GIRFT initiative to be undertaken in 19 outpatient specialties. Handbooks and self-assessment checklist have been shared and programme being developed.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)		

	• Elective recovery as a % of 2019/20. • ERF achievement. • Long waiters' performance. • % of diagnostic tests completed within 6 weeks. • Early diagnosis rates for cancer. • Faster Diagnosis Standard (% patients receiving diagnosis or all clear within 28 days of referral). • % of patients with cancer receiving first definitive treatment within 31 and 62 days.

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 Key priorities: Improve mental health support across health and care services.					
Risk Ref: BAF 8 Strategic Risk	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes **Due to:** Number of vacancies across CAMHS and adult mental health services and difficulties in recruiting to vacant posts. **Impact:** Waiting list for treatment remains high for children and adults Urgent referral to treatment times have improved and routine waits have reduced but there are a number of people waiting over a year.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↑
Risk Appetite (include colour)	**Cautious**	**4x3=12**	**4x3=12**	**4x1=4**	***Unchanged risk score since March report***
Strategic Risk Owner (Director)	**Benedict Leigh, Director of Integration**				
Aligned to other system partners risks (include ref no.)	**GHC ID3** There is a risk of demand for services beyond planned and commissioned capacity, which cannot be managed through usual mechanisms, resulting in services not meeting the expectations of our community (risk rating 16) **GHC ID4** There is a risk that we fail to recruit, retain and plan for a sustainable workforce to deliver services in line with our strategic objectives (risk rating 16) **GHC ID9** There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs (risk rating 6)				
Aligned to current ICB Risks	ID 25 -Increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals PC & E 1Lack of workforce in key services across the ICS				
Committee	**People Committee**	**Last Review & Updated:**	**16th July 2024**		

Current Controls (*what do we have in place to mitigate the risk?)*	Gaps in Controls	Current Assurances *(how do we know the controls are working?)*	Gaps in Assurance
• Eating Disorder Programme including system wide prevention through to crisis workstreams established. • •CAMHS recovery plan including within service provision and system wide to support improvements. • •Neurodevelopmental business case and plan in place. Project team established to oversee recommissioning of ADHD/ASC pathway • Adult Community Mental Health Transformational programme: Transformation programme has officially finished as of end of Q4 23/24. The process of transferring to BAU is in progress. Service specification has been drafted for key transformational changes. 6 month extension to programme management agreed. ICB PM resources released to support UEC MH programme/Right Care Right Person.	No significant gaps identified as a monthly system-wide multi-agency meeting is well established and any and all matters of programme management around and performance against the trajectories within the action plan for eating disorders are progressed. If the programme is of trajectory, then the matter is escalated. •No significant gaps identified as a monthly meeting is in place with CAMHs and s system wide multiagency meeting monitors progress bi monthly. No significant gaps in the Adult Mental Health Transformational programme ICB PM resource that supported CMHT will now be used to support UEC mental health programme which was previously reported as a gap. Shared care arrangements for ADHD prescribing between primary/secondary care.	• Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput. • • Waiting times for urgent and non-urgent referrals are reducing for eating disorders • There is in place a significant recruitment and retention plan to tackle issues around capacity • Robust governance arrangements in place for community mental health with experts by experience included. • Neurodevelopment Project Team established between GHC/ICB to oversee development of new pathways including working on shared care issues between primary/secondary care.	No gaps in assurance

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• Ongoing monitoring of the mitigations and engagement with service review around increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals.	The significant work on SEND and across services for children has started to show results, with improving services and greater impact. We are continuing to focus on waiting lists and on appropriate provision. Partnerships with the VCS and with education are delivering excellent results.

	• •Proposal to commence 3 year contract for both TIC+ and Young Gloucestershire to enable security and retention of staff and ensure business continuity. • •Regular reporting to the Children's Mental Health Board and Adult Mental Health Board • •SEND inspection complete and ICB SEND programme board established. • Work is progressing in this area.	Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy. Embedding the community transformation for adult mental health remains a challenge, particularly in the context of significant national policy changes in relation to system partners. Work with police colleagues on a local RCRP implementation model is developing well but remains a work in progress. Data and intelligence challenges remain, particularly in the area of understanding demand changes and modelling future impact.
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Improving Access to Psychological Therapies Eating Disorder Access Perinatal mental health -% seen within 2 weeks CYP access CMHT Access APHC for SMI	

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Creating a financially sustainable health and care system.					
Risk Ref: BAF 9 **Strategic Risk**	**Financial Sustainability** Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity. **Due to:** – increasing demand for services, increased inflation, ongoing impact of the covid pandemic on a wide range of services and staff and new service requirements – Lack of delivery of recurrent savings and productivity schemes – Recruitment & retention challenges leading to high-cost temporary staffing – Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost – Decrease in productivity within the system – Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding **Impact**: – underlying deficit position within the system as a whole revenue and the system is unable to achieve breakeven recurrent position – Increased requirement to make savings leading to inability to make progress against ICS strategic objectives – Capital costs growth meaning that the system is unable to remain within its capital resource limit	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔ ↑
Risk Appetite (include colour)	**Open**	**4x4=16**	**4x4=16**	**4x2=8**	↔ ***Unchanged since March report***
Strategic Risk Owner (Director)	**Chief Finance Officer**				

Aligned to other system partners risks (include ref no.)	GHC: 8 There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care GHC 9 Funding - National Economic Issues There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs (risk rating 6) GHFT: SR9 - Failure to deliver recurrent financial sustainability (risk rating 25)				
Aligned to current ICB Risks	F & BI 9 - The ICB does not meet its breakeven control total in 2024/25 (noted that these risks are to be updated on ICB risk management system) F&BI 10- The ICS does not meet its breakeven financial duty in 2024/25 (noted that these risks are to be updated on ICB risk management system)				
Committee	**Audit Committee / Resources Committee**		**Last Review & Updated:**	**08 July 2024**	
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**		**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**	
• Governance in place in each organisation and System-wide Financial Framework in place • Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC • Financial plan aligned to commissioning strategy • ICS single savings plan in place managed by PMOs & BI teams across the system forming part of the monthly finance review process • Contract monitoring in place • Robust cash monitoring with early warnings • System Plan in place and further development in progress • Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to	• Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. • Methodology on realisation of productivity benefits not in place • Capacity of teams through the system to deliver programmes of work required to transform system is limited particularly in times of ongoing urgent care escalation • Monitoring of workforce numbers is incomplete currently across the system		• Reporting into Board of the ICB and relevant Committee for each organisation. • Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position. • Capital monitoring is produced monthly and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system.	• Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk	

inflation and wider risks within the system resulting from a slower capital programme		• Annual internal audit reviews on key financial controls	
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• GHFT internal financial improvement plan progressing and plans for new financial year being included, control review is ongoing. Reporting through to the GHFT Finance Committee. • System savings plan for new year and longer term in development, monitoring of progress and delivery by individual organisation and at system level each month to Executives.		• Work underway within GHFT on changes in productivity since 2019/2020 key areas of focus identified and programmes in outpatients and theatres progressing, impact being brought into elective recovery programme • Actions to identify non recurrent and other measures to help close the financial gap in the plan for 24/25 progressing, PMO support in place. • Workforce monitoring for budgeted and worked WTE progressing with monthly reporting and monitoring within organisations and to the system in development, initial reporting at M3 planned.	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Delivery of Full year efficiency target Achievement of Elective Services Recovery Fund Target Delivery of in-year breakeven financial position		

Pillar 3: Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
23-24 key priorities: Creating a financially sustainable health and care system.					
Risk Ref: BAF 10 **Strategic Risk**	**Financial Sustainability** The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high quality care **Due to:** – increasing inflation on capital costs – Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost – Decrease in productivity within the system – Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding – High level of backlog maintenance within GHFT (c£72m) **Impact**: – Capital allocation "buys less" as a result of increasing inflation and System may be unable to live within its capital resource limit – Inability to reduce the level of high-risk backlog maintenance, to replace equipment when due or to refurbish facilities across the system in a timely manner leading to down time for unplanned maintenance and reduced productivity across the system –	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ⟷ ↑
Risk Appetite (include colour)	**Open**	**4x4=16**	**4x4=16**	**4x2=8**	⟷
Strategic Risk Owner (Director)	**Chief Finance Officer**				

Aligned to other system partners risks (include ref no.)	GHFT: SR10: Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in (current risk score 16)				***Unchanged since March report***
Aligned to current ICB Risks	**F&BI 11** - The ICS does not achieve a breakeven position against its Capital Resource Limit **Dig 1** – ICS Digital Strategy				
Committee	**Audit Committee / Resources Committee**		**Last Review & Updated:**	**08 July 2024**	

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Governance in place in each organisation • Monthly review of whole-system financial position by Directors of Finance with reporting into relevant Committee for ICB, GHFT, GHC • Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme • Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed, • EPRR in place, to support any critical infrastructure failures within provider organisations • Mature Provider estates planning forums to manage risk and capital planning oversight • This risk will form part of the ICB infrastructure plan.	• Longer term strategic plan which delivers sustainably for the system.	• Reporting into Board of the ICB and relevant Committee for each organisation. • Monthly capital monitoring is produced and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system.	• Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk

Actions to mitigate risk & implementation dates	**Director's update on actions to date (quarterly update)**
• ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS • . 5-year capital plan in development as part of the MTFP, draft to be brought to Boards in July • Disposals across the system identified and included in the capital plan • Developing 'library' of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes	• Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed, • ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS, deadline end of July 24 for completion

• 24/25 capital programme agreed including additional capital available for 24/25 with focus on mitigating highest risks		
	Relevant Key Performance Indicators: (taken from the Integrated Performance report) Delivery of in-year breakeven capital financial position	

Pillar 3 Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB					
Emergency Preparedness, Resilience and Response (EPRR) BAF 11	**EPRR:** - Failure to meet the minimum occupational standards for EPRR and Business Continuity. **Due to:** Lack of oversight and resource in the ICB's emergency planning and business continuity team to fulfil the functions and responsibilities of a Category 1 responder. **Impact:** Unable to fulfil our responsibilities as a Category One responder, and effectively lead a robust, effective and coordinated system response to a major incident.	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↑
Risk Appetite (include colour)	**Zero/Minimal**	**4x3=12**	**4x4=16**	**4x1=4**	↔ ***Unchanged since last report March 24***
Strategic Risk Owner (Director)	**Chief Nursing Officer**				
Aligned to other system partners risks (include ref no.)	**GHFT SR12** Failure to detect and control risks to cyber security (score Red 20) **GHC 8** Cyber There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc (score Red 20)				
Aligned to current ICB Risks	EPRR 2 – EPRR Resourcing				
Committee	**Quality Committee**	**Last Review & Update Date:**	**17th July 2024**		
Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**		
• EPRR On-call manager training • EPRR exercises • Oversight of EPRR through the Local Health Resilience Partnership.	• Insufficient internal debriefs have been performed for exercises that the ICB has participated in or that	• Reporting to Quality Committee • NHS England system assurance review and provider assurance process against national standards • BDO Internal Audit Report (November 2023) moderate	• BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium		

	lessons learned have not been embedded, • Lack of progress on the implementation of the cyber security exercise action plan points relating to the joint working and processes required with the cyber and EPRR teams. • Insufficient resources within the EPRR team (the team are currently reviewing capacity and benchmarking against other ICBs)	assurance for design and effectiveness	recommendations (November 2023). • NHS System Assurance all but one of the Partners has achieved a standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. One organisation (E-MED PTS) has been assessed regionally as "non-Compliant". ICB itself has seen its overall rating fall from that obtained in 2022 (substantially assured) to a rating in 2023 of "partially assured".
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• We have now updated our On-Call rota system matching skills where possible to compliment those on-call. We have also brought titles in line with EPPR frameworks, with Manager and Senior on call being replaced with Tactical and Strategic leads. • A full programme of training has been set up, with a dedicated EPPR training manager in place. • There is a plan to review the resources of the team initially with some dedicated administrative support and secure some permanent funding for the training post if appropriate. • There are some further long-term discussions to be had with system partners about revisiting the work undertaken that proposed a system wide EPRR Function.		All on call managers and senior managers have access to a clearly defined work programme which enables all of these staff to achieve and maintain minimum National Occupational Standards. More work needs to be undertaken to ensure all staff take up training opportunities. The ICB, as part of the EPRR work plan for business continuity, is currently undertaking a three-month programme ensuring departments review and update their departmental Business Continuity Management (BCM) plans /Business impact analysis with local departmental walkthrough /discussion of what they would do for a loss or partial loss of service. Review if all areas of previous partial compliance against core standards taking place to ensure compliance this year or identify any gaps. Band 4 admin/ERPP assistant now being recruited to support team Exec briefing session planned to reiterate cat 1 responder duties and responsibilities and update	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)		

Pillar 3 Improving health and care services today					
Strategic Objective: Address the current challenges we face today in the delivery of health and care					
There is no exact correlation with the strategic objectives 2022-23 but this is a key priority for the ICB					
Cyber Security BAF 12	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS **Cause:** Cyber-attacks from organised groups targeting NHS • Malware attacks • Phishing attacks via emails to staff • Password access through data breaches • Inadequate firewall protection and security updates **Impact:** Whole loss of systems and downtime – with inability to recover quickly • Demands for money to recover data (ransomware attacks) • Access to patient records (CHC Trakcare and Liquid Logic and personal data that could be published)	**Original Score (I x L)**	**Current Score (I x L)**	**Target score (I x L)**	**Movement in score** ↓ ↔
Risk Appetite (include colour)	**ZERO/Minimal**	**5x4=20**	**5x4=20**	**5x2**	↔ ***Unchanged from March report***
Strategic Risk Owner (Director)	**Chief Clinical Information Officer**				
Aligned to other system partners risks (include ref no.)	**GHFT SR12** Failure to detect and control risks to cyber security (score Red 20) **GHFT SR13** Inability to maximise digital systems functionality (Score Amber 12) **GHC 8 Cyber** There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc (score Red 20)				
Aligned to current ICB Risks	Dig 2 Cyber Attacks (score Amber 12)				
Committee	**Audit Committee**	**Last Review & Update Date:**	**12 July 2024**		

Current Controls (*what do we have in place to mitigate the risk?)*	**Gaps in Controls**	**Current Assurances *(how do we know the controls are working?)***	**Gaps in Assurance**
• Cyber Security action plan in place, reviewed annually and gaps in security and investment identified • Monitoring systems in place and dedicated cyber security team at GHFT • Backup systems and disaster recovery in place and regularly updated • Cyber security delivery workstreams – monitoring safety and access • Investment in cyber tools and software • Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches • Monitoring and reporting via ICS Digital Executives and the ICB Audit Committee; ICS Cyber Operational Group • NHS national monitoring (alerts) and NCSC alerts • Communications and engagement with users on prevention	• Insufficient in-house expertise in cyber security team • Inability to recruit specialist cyber staff because of cost (market forces) • Disaster recovery planning around support systems (out of IT control) not consistently in place • Operating model of cyber-technical & cyber-governance currently not optimal • Volume of cyber-security issues requiring resolution • ICS-wide incident response processes not fully operational	• External audit recently completed by BDO identified no new/unknown risks or issues • External penetration testing conducted annually by GHC and ICB and findings managed • ICB board cyber development session took place in December followed by invitation to complete online training. • Facilitated session with audit committee and digital leads scheduled for 7th March • Annual cyber incident response exercise scheduled for 12th March	• GHFT/CITS penetration test to be scheduled • Action log and schedule arising the external audit report to be published and progress monitored
Actions to mitigate risk & implementation dates		**Director's update on actions to date (quarterly update)**	
• Board level awareness of risk and issues • Rationalisation of detection and prevention tooling. • Introduction of targeted monitoring and alerting across key systems and entry points. - Contract monitoring third party suppliers to ensure that there is sufficiently robust data security and protection software and safeguards in place as well as reporting. - Removal of all end-of-life software and hardware.		• The ICB Board Cyber development session in December was positively received. • The annual cyber incident response exercise was on 12th March and was well attended. This gave chance to review improvements from last year's exercise and the SWASFT cyber incident. • The focus of effort continues on the two red rated risks - risk management and IT asset management	
	Relevant Key Performance Indicators: (taken from the Integrated Performance report)		

5x5 Risk Matrix

Green: Low; Yellow: Moderate; Amber: Significant; Red: High

Likelihood \ Consequence	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

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

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

Agenda Item 10

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**Integrated Performance Report**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting	N/A					
	ICB Internal	**Date**	**System Partner**	**Date**		
			Strategic Executive	18/07/24		
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for July 2024. The report brings information together from the following four areas: • Performance (supporting metrics report can be found here) • Workforce (supporting metrics report can be found here) • Finance (ICS and ICB M03 reports) • Quality The report includes assurance pages from each of the relevant ICB Committees relating to their part of the IPR, a headline summary from each of the areas above and a more detailed breakdown of progress within the remainder of the document. There is a supporting metrics document that lists performance on the individual metrics that can be found here.					
Key Issues to note	Areas of key exceptions have been included at the front of the Integrated Performance Report.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The Integrated Performance Report (IPR) provides an overall summary of the current position of health and social care in Gloucestershire. Issues in delivery will have an impact on our ability to deliver against the priorities for the health and care system that we have committed to. Our performance also feeds into the NHS Oversight Framework and influences segmentation decisions made by NHS England. There is a close link between the risks within the BAF and delivery of our objectives through the Integrated Performance Report.					
Management of Conflicts of Interest	None					

Resource Impact (X)	**Financial**	X	**Information Management & Technology**	X
	Human Resource	X	**Buildings**	X
Financial Impact	See financial section of the report.			
Regulatory and Legal Issues (including NHS Constitution)	The ICB has a statutory duty not to exceed the revenue resource limit set by NHS England. The Integrated Performance Report will be used to inform regional discussions as part of the NHS Oversight Framework.			
Impact on Health Inequalities	See Performance section of the report.			
Impact on Equality and Diversity	See Performance section of the report.			
Impact on Sustainable Development	None			
Patient and Public Involvement	The Integrated Performance Report (Quality section) currently provides information on patient and public feedback.			
Recommendation	The Integrated Care Board are asked to: **Discuss the key highlights from the Integrated Performance Report** identifying any further actions or development points that may be required.			
Author	**Performance:** **Kat Doherty** **Workforce:** **Tracey Cox** **Finance:** **Chris Buttery** **Shofiqur Rahman** **Quality:** **Rob Mauler** **PMO:** **Jess Yeates** **Mark Golledge**	**Role Title**	Senior Performance Management Lead Director for People, Culture & Engagement Finance Programme Manager Deputy CFO (Interim) Senior Manager, Quality & Commissioning ICS PMO Coordinator Programme Director – PMO & ICS Development	

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

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

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Integrated Performance Report

July 2024

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Integrated Performance Report Contents

Transforming Care, Transforming Communities

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Feedback from Committees

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	4 July 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Performance	**LIMITED**	Stable performance across most indicators. Good progress noted against planned commitments for 23/24 as well as full achievement of full achievement of 23/24 for ERF. Areas of focus include Urgent and Emergency Care; continued recovery of cancer targets and diagnostics, specifically endoscopy.	Endoscopy recovery programme – demand and capacity analysis has been completed and new workforce capacity has been recruited for imminent starts (fixed-term). NHS England review for endoscopy services planned for July.	August 2024
Finance	**LIMITED**	System overall position at M2 2024/25 is a breakeven position although GHFT are reporting a year to date shortfall of £898k relating to staffing overspends. System work is continuing on mitigating schemes to reduce the financial risk – including £15m risk across the system as well as pressure within GHFT.	Actions are continuing to deliver against the single savings plan for 2024/25. This includes reducing the system financial pressure by mitigating schemes that are high risk to delivery.	End of July 2024
Benefits	**LIMITED**	Review / deep dive into the risk around delivery of benefits realisation. This included work being undertaken by the Evaluation Review Group. Update provided to the Committee on the work being undertaken specifically on the WaO benefits and evaluation approach.	Development of a pipeline of evaluations (previous investments) for the evaluation review group to assess in 24/25. Continued work underway on the approach to realisation of benefits for the WaO programme.	August 2024
Productivity (GHFT)	**SIGNIFICANT**	Presentation provided GHFT on the approach being used to monitor productivity within the Trust. This includes work on the Engagement Value Outcome (EVO) Programme and associated work to increase theatre productivity and reduce DNA rates.	Other services being considered for EVO includes TIA & Stroke and Obstetrics.	Ongoing

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

Issues referred to another committee

Topic	Committee
None	None

People Committee

Accountable Non-Executive Director	Karen Clements
Meeting Date	18 July 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Impact of financial recovery plan on meeting Long Term Workforce Planning trajectory assumptions	**LIMITED**	Committee identified risks to delivery of both Apprenticeships and Advanced Care Practice staffing numbers with a reduction in both Apprenticeship starts (down from 403 in 22/23 to 328 in 24/25). There has also been a fall in ACP roles. This is due to a loss of flexibility in budgets reducing ability for service leads to consider new and varied roles.	Risk flagged to Regional team as part of Operational Plan Delivery performance review process. Apprenticeship Strategy approved at People Committee on 18th July 2024 with associated actions to improve position. Business case under development for ACP lead role to maintain momentum around ACP strategic approach when non-recurrent funding ends in Dec 24.	Review in 3-4 months

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

Issues referred to another committee

Topic	Committee
None	None

Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	5 June 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Maternity & Neonatal	**LIMITED**	Maternity was discussed in detail. There had been over 400 actions from the CQC and Maternity Advisors. Following the last Section 31 notice, it was decided to reprioritise and focus on the top 7 actions: • Massive Obstetric Haemorrhage/ Post partum haemorrhage • Maternity early warning scores • Interpretation and escalation of CTG • VTE risk assessment • Governance processes. • Agency staff • Trust data dashboard The Trust has recently commissioned an external review of Maternal Mortality, Morbidity and Neonatal Deaths	• A Quality Improvement Group has commenced to progress at pace those areas where traction and resolution were required. • Oversight now devolved to LMNS. • Work is underway to improve data quality • Improvements to an Assurance and Surveillance dashboard • The ICB has commissioned a review of the LMNS which is underway and will report back late August /Sept.	Ongoing
PSIRF & LFPSE	**SIGNIFICANT**	PSIRF and LFPSE now in place across the county. New PSIRF tools (after action reviews, swarm huddles and Patient Safety Investigations) appear to be working well, but the new framework reduces traditional reporting to the ICB, which leaves some concerns about system oversight. PSIRF is a massive change in culture and will take time to embed.	• Approval of a 'system investigation' policy (under development) • Continued updating to system plans • Ongoing adaption as the new way of working is embedded • Review due in September	September

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

Issues referred to another committee

Topic	Committee
None	None

6

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

Our Performance

Key Achievements

- NHS111 performance in June 2024 has recovered following some challenges over the holiday periods in May with 3.9% of calls to the service abandoned in June 2024 (against a 3% target).
- Elective Recovery Performance has met the national target for 2023/24 (103% of 19/20 value weighted activity) - at M12 Gloucestershire ICB commissioned Value Weighted Activity (VWA) is 105.6% of 2019/20 including pathways avoided (*note: this remains a draft position while we await the finalised baseline from NHSE*). 2024/25 performance to date has continued to be strong, with the system position increasing VWA to 113.7% (provisional performance as at May 2024).
- Primary care activity continues to be above capacity, showing significant increases from the pre-COVID baseline position. The potential impact of 'collective action' remains a concern. However, performance against the measure for appointment booking within 2 weeks has improved in May 2024. The national GP survey results have been published, with Gloucestershire practices again achieving above average rating in the majority of measures – in particular, overall experience, and experience of contacting the practice.

Areas of Focus

- Ambulance handover times and Category 2 response times have remained stable in 2024/25 (with average handover time around 75 minutes and Category 2 response time at around 40 minutes) but have improvement trajectories outlined to achieve by March 2025 (40-minute handover time, and 30-minute Category 2 response time). The Working as One transformation programme has been working to identify opportunities to support performance improvement and a series of actions across all system partners have been identified.
- Cervical screening uptake in primary care has seen a drop (also reflected across the region), particularly in younger women eligible for screening. There has also been an increase in symptomatic/high risk patients identified through screening. Outreach work is ongoing, particularly to ensure communities less likely to take up screening invitations have access to information and support (for example, provision of engagement events with interpretation. Most recently, in June, the cancer CPG carried out an engagement event with Afghan refugees with a Farsi interpreter).
- There has been an increase in long waits on the RTT patient list, despite an overall reduction in the total waiting list in May 2024. Specialties with the highest number of long waits continue to be Oral Surgery, ENT and T&O. There are additional clinics and theatre lists planned to support reductions of long waits in these specialties.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Funding Opportunities

- Arts, Health and Wellbeing Centre invited Expressions of Interest for small grants to support research and evaluation projects across the ICS, over 40 grant applications were received with 12 approved for funding. The projects include proposals from across the ICS including VSCE partner organisations. A further round of funding will be issued later in the year.

Strategy & Planning

- Completion of revised final numerical workforce ops plan submission completed 2nd May
- All Steering Group Plans on a page approved
- ICS Apprenticeship strategy and ICS Advanced Practice High Level Strategic Ambitions agreed and approved by Steering Group and People Board (virtually) – going for ratification at July's People Committee

System-wide Development Programmes

- Systems Thinking masterclass cohort 5 completed
- ICS Leadership conference took place on 28th June – very well attended with constructive engagement at the event and positive feedback following it.

Programme Delivery

- Q1 reports collated and submitted.

Areas of Focus

Strategy & Planning

- Development of ops planning monitoring process with finance colleagues.
- Health & Wellbeing strategy being finalised and submission to People Committee for ratification

System-wide Development Programmes

- Exploring (internal) options for further cohort delivery of system thinking masterclasses.

International Recruitment

- Further focused promotion of international recruitment of care workers for eligible providers following slow update of initial offer.
- Continue the pastoral care support arrangements.

People team

- Recruitment process to replace Principal analyst role commenced.

Quality – Safety, Experience and Effectiveness

Quality

Please note: The Quality report is updated bimonthly.

Key Achievements

- Research Engagement Network members have participated in two workshops i) Reward and Recognition for involvement, independently facilitated workshop attended by ICS colleagues (NHS GCC, VCSE, Community Members) ii) Communications – sharing research opportunities and outputs across the county
- Insight Outreach Work: The ICS Information Bus has made several visits to The Willows Traveller site in Gloucester over the past few months. Visits have focussed on dementia awareness, respiratory, blood pressure, mental health and oral health – promoting supervised tooth brushing and distributing brushes and toothpaste.
- System partners have worked together to develop a 'System Investigation' policy to support PSIRF.

Areas of Focus

- The ICB has commissioned a review of the LMNS which is underway and will report back late August /Sept.
- A Maternity Quality Improvement Group (QIG) has commenced to progress, at pace, those areas where traction and resolution are required. The Trust has seven workstreams which are overseen by the QIG.
- We have started to work with other systems to discuss and develop oversight arrangements for POD alongside the quality reports flowing form the NHSE Southwest Quality Hub.
- The recent translation and interpretation procurement was undertaken in partnership with Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust and Gloucestershire County Council. Over the coming weeks we will be working with the successful provider Word360 to ensure the smooth implementation of the new contract including bespoke training for staff working in GP practices across the county.

Finance and Use of Resources

Finance

Key Messages: Month 03

- The system financial plan includes a significant amount of financial risk, in particular delivering savings plans including the stretch plans to achieve breakeven. Mitigations are in varying stages of development, however, this remains work in progress and the associated risk to delivering the breakeven plan remains high.
- The year to date income and expenditure position compared to the plan is a £2.2m deficit. Within this position, GHFT have a £1.9m deficit due to June industrial action costs (£0.5m), pay overspends slippage in the delivery of the financial sustainability plan (£1.4m). GHC are reporting a small shortfall against their planned surplus due to the timing of delivery of specific efficiency savings but this is expected to recover in month 4.
- The system and all organisations are forecasting a breakeven out-turn position. There is currently a small positive variance reported for GHC which is likely to reduce to breakeven at month 4.
- Year to date savings are £1.9m, or 10%, behind plan. Work is being escalated within organisations and the system to accelerate existing savings and also develop mitigations to recover the position.
- Annual efficiency savings are forecast to be delivered in full against plan. There are ongoing initiatives to mitigate the significant values of high risk and unidentified schemes within the delivery plan.
- Year to date capital expenditure is £4.1m below the capital plan due to slippage in some schemes. The full year forecast is for expenditure to be in line with planned underspend of £2m. There is a risk to the plan relating to disposals, mitigations are being developed to ensure that the outturn remains as per the plan.
- Agency expenditure is reducing in both GHFT and GHC and remains below 3.2% national cap.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

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Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

ICP Dashboard

	Significantly better than the national average		Significantly better than the county average
	No significant difference to the national average		No significant difference to the county average
	Significantly worse than the national average		Significantly worse than the county average

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Overarching	0.1	Life Expectancy	Life expectancy at birth (male)	79.5	80.9	79.7	77.8	80.6	80.6	79.8
	0.2	Life Expectancy	Life expectancy at birth (female)	83.6	84.7	83.5	81.7	83.8	84.5	83.6
	0.3	Premature mortality	Under 75 mortality rate from all causes rate per 100k	326.0	266.1	315.1	406.1	281.7	296.4	315.5
	0.4	Infant mortality	Infant mortality rate, 2020-2022	3.4	1.4	3.2	4.0	4.7	3.8	3.5
Pillar 1: Health and Wellbeing Board	1.1*	Physical Activity	% of physically inactive adults	16.3	15.2	23.9	19.0	14.8	23.6	18.5
	1.2	ACEs	% of Children reporting that they 'have someone to help with personal issues'	83.7	85.9	84.1	82.2	85.5	84.0	84.0
	1.3*	Mental Wellbeing	Emergency hospital admissions for intentional self-harm RATE per 100k	120.2	131.1	80.9	126.5	135.0	107.3	114.5
	1.4	Social Isolation & loneliness	% of adults who feel lonely often/always or some of the time	24.5	18.9	18.3	19.8	17.9	22.8	20.4
	1.5	Healthy Weight	% Year 6: Prevalence of obesity, 22-23	17.9	15.7	20.1	26.2	18.4	20.2	20.3
	1.6	Early Years and Best Start in Life	Infant mortality rate, 2020-2022	3.4	1.4	3.2	4.0	4.7	3.8	3.5
	1.7	Housing	% of households which are overcrowded in terms of bedrooms	1.9	1.2	1.8	3.5	1.6	1.4	2.0

Updated metrics indicated with *

Improving Services & Delivering Outcomes

ICP Dashboard

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Updated metrics indicated with *

Improving Services & Delivering Outcomes

ICP Dashboard

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	No significant difference to the national average		No significant difference to the county average
	Significantly worse than the national average		Significantly worse than the county average

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 3: Improving Health and Care Services Today	3.1	Improve access/ reduce backlogs	Numbers/breakdown of waiting lists by locality – rate per 1000	102.3	104.8	122.5	110.0	101.5	101.8	106.5
	3.3	Improve mental health support	% SMI register health check uptake	82.6	74.3	81.1	76.5	84.2	80.1	79.8
	3.7	Improve access to care: Cancer	% of cancers diagnosed at Stage 1 and 2, 2020	54.0	53.7	54.1	52.6	46.8	54.2	52.4

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

Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
0.1	Life Expectancy	Life expectancy at birth (male)	2020-2022
0.2	Life Expectancy	Life expectancy at birth (female)	2020-2022
0.3	Premature mortality	Under 75 mortality rate from all causes	2020-2022
0.4	Infant mortality	Infant mortality rate	2020-2022
1.1	Physical Activity	Percentage of physically inactive adults	2022/2023
1.2	Adverse Childhood Experiences	Percentage of Children and Young People reporting that they 'have someone to help with personal issues', 2022	2022
1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm (Directly Standardised Rate)	2022/2023
1.4	Social Isolation & loneliness	Percentage of adults who feel lonely often/always or some of the time	2019/2020
1.5	Healthy Weight	Year 6: Prevalence of obesity	2022-23
1.6	Early Years and Best Start in Life	Infant mortality rate	2020-2022
1.7	Housing	Percentage of households which are overcrowded in terms of bedrooms	2021
2.1	Health equity	Inequality in life expectancy at birth (male), 2018-2020	2018-2020
2.2	Health equity	Inequality in life expectancy at birth (female), 2018-2020	2018-2020
2.3	Health equity	Excess under 75 mortality rate in adults with severe mental illness	2018-2020
2.4	Health equity	School Readiness: percentage of children achieving a good level of development at the end of Reception,	2022/2023
2.5	Employment exemplar theme	Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2022/2023
2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage	2023
2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+)	2022
2.8	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations	2022
2.9	Blood pressure exemplar theme	Percentage of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	To December 2023
2.10	Blood pressure exemplar theme	Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	To December 2023

Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
3.1	Improve access to care and reduce backlogs	Numbers/breakdown of waiting lists. WLMDS – *to be replaced with rate*	April 2024
3.2	Improve access to care – primary care	Primary care: GP headcount per 100k population (General Practice Workforce - NHSD) – *note quality concerns have been raised with this metric – exploring with BI and primary care*	February 2024
3.3	Improve mental health support	SMI physical health check uptake	March 2024
3.4	Support Improvements in delivery of Urgent and Emergency Care	A&E attendances - Rate per 1000 population	March 2024
3.5	Support Improvements in delivery of Urgent and Emergency Care	Emergency admissions - Rate per 1000 population	January 2024
3.6	Support Improvements in delivery of Urgent and Emergency Care	Long lengths of hospital stay over 21 days	January 2024
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	2020

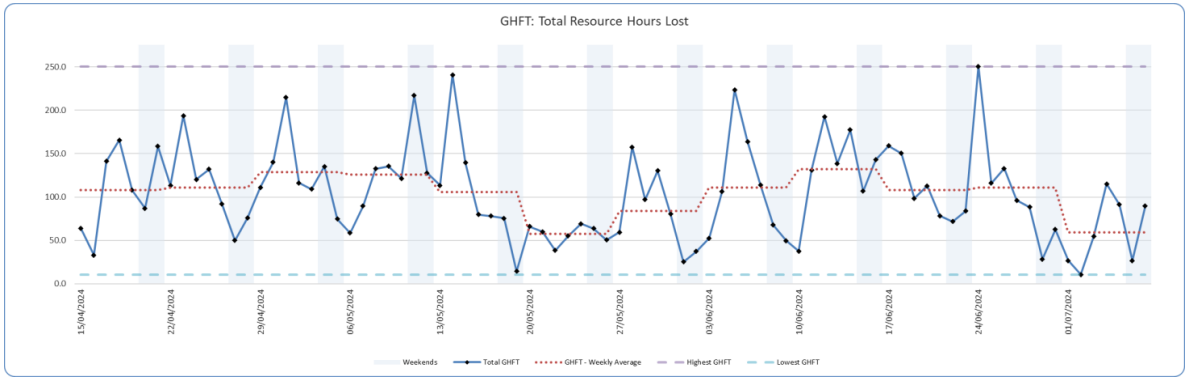
Improving Services & Delivering Outcomes

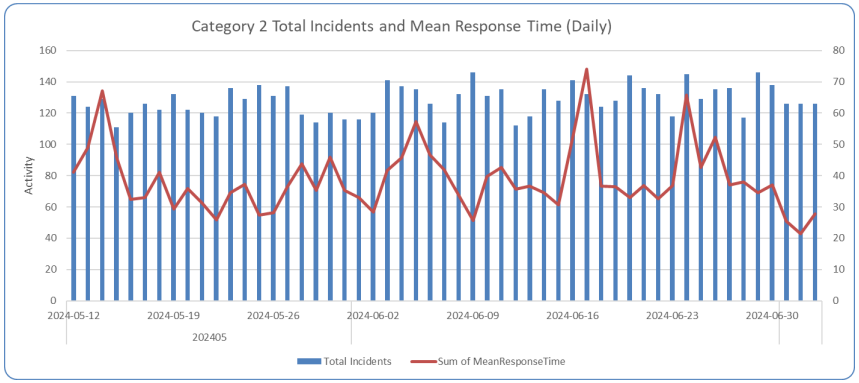
ICP Dashboard

- Our collective understanding of need in the local community is set out in our Joint Strategic Needs Assessment (JSNA) which is a strategic planning tool that brings together the latest information on the health and wellbeing of people who live in Gloucestershire. Health and Wellbeing | Inform Gloucestershire.
- An introduction to the Outcome Measures reporting was included in the March 2024 report and can be found here. While the measures on the outcome measures dashboard may be infrequently updated and cover the last 3 years, they have been selected to align to measures already identified as priorities for the system. Change over time will indicate that our programmes are delivering their objectives.
- There have been updates to two metrics in Pillar 1 this month (Percentage of physically inactive adults and Emergency hospital admissions for intentional self-harm), with both showing improvements in 2022/23 compared to the 2021/22 position on average:
    - Physical activity: Cheltenham improved significantly against the county average in terms of decreasing proportion of physically inactive adults, with decreases also seen in Gloucester and Stroud. While still lower than the county average, the Cotswold saw an increase in physically inactive adults, alongside the Forest of Dean and Tewkesbury. This may be aligned to population demographics (e.g. age) or access to support for physical inactivity, which may be targeted towards more urban areas.
    - Emergency hospital admissions for intentional self-harm: there has been a reduction in the rate of emergency hospital admissions for intentional self-harm across all areas except for Cotswold, which saw an increase. Notably, these improvements have led to the county average overall reducing significantly in comparison to the national position. Gloucester locality was previously the only locality to have a rate of admission significantly higher than the county average, and this has now reduced to be in line with the county and national average.
- There has been an update to the Pillar 2 metric - Gap in the employment rate between learning disability and overall employment rate. There has been a slight reduction in this gap for people receiving support for disability from the position in 2021/22 to 2022/23 for the county. District level data is not available for this metric. As it is not known what proportion of the population with a learning disability this captures and how this varies between areas it is not possible to know the impact of this on area level variation, so direct comparison should be carried out with caution.

Improving Services & Delivering Outcomes

Area of focus: Ambulance response times





Just under 50% of ambulance incidents are classified as Category 2, and this reflects urgent but not immediately life-threatening incidents requiring a response within 18 minutes. Improvement in this metric is a key focus for 2024/25 nationally (to 30 minutes). In Gloucestershire, Ambulance handover delays and Category 2 performance have remained stable on average across 2024/25 to date with daily handover hours lost fluctuating around 100 hours/ day, and the category 2 average response around 40 minutes across the county. Daily variation for both metrics tends to correlate, with resource hours lost a better predictor of increased Category 2 response times than activity demand. There are three key areas of focus to improve Ambulance Response Times, which are being driven though the system transformation programme (Working as One):

SWASFT Actions

- Development of SOPs to allow off-load to minors / conveyance to MIIU / direct to SDEC pathways
- Staff training and pathway development to support redirection of patients away from the ED
- Prioritise XCAD developments including roll out to SDEC and staff training
- Collaborate on 6A audits to support staff training and development
- Engagement in development of Clinical Advice and Assessment Service (CAS)

GHFT Actions

- Continued focus on delivery of clear Ambulance Offload Escalation sequence.
- Use XCAD as the primary administration and monitoring system.
- ED escalation Policy in place (including supporting ambulance offloads).
- Deliver Trust wide improvement programme focussed on improving discharge and flow, which includes Internal Professional Standards, Clinical Vision of Flow, Ward Improvement programme and focus on discharges.

System and Partner Actions

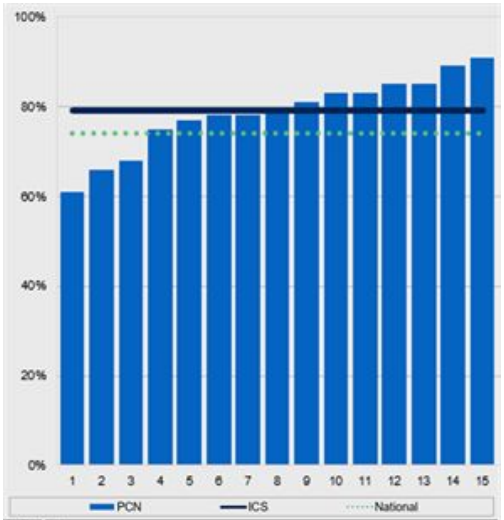
- Introduction of full IUCS service to include Clinical Advice and Assessment Service (CAS).
- Increase Rapid Response capacity through efficiency and inclusion criteria.
- Review of MIIU pathways.
- Agree future ED streaming offer
- Develop Integrated Flow hub
- Optimisation of Frailty pathway
- Continue to develop community alternatives such as CATU, Virtual wards etc.

Improving Services & Delivering Outcomes

Area of focus: GP experience

Overall, how would you describe your experience of your GP practice?

Gloucestershire		National	
Good	Poor	Good	Poor
79%	9%	74%	13%



PCN	Name
1	ROSEBANK PCN
2	GLOUCESTER INNER CITY PCN
3	ASPEN PCN
4	ST PAUL'S PCN
5	SOUTH COTSWOLDS PCN
6	CHELTENHAM PERIPHERAL PCN
7	NORTH & SOUTH GLOUCESTER (NSG) PCN
8	HADWEN QUEDGELEY PCN
9	FOREST OF DEAN PCN
10	SEVERN HEALTH PCN
11	TWNS PCN
12	BERKELEY VALE PCN
13	CHELTENHAM CENTRAL PCN
14	STROUD COTSWOLD PCN
15	NORTH COTSWOLDS PCN

Overall, how would you describe your experience of contacting your GP practice on this occasion?

Gloucestershire		National	
Good	Poor	Good	Poor
73%	14%	67%	19%

How do you feel about how long you waited for your appointment?

Gloucestershire		National	
About right	Too long	About right	Too long
63%	37%	66%	34%

The GP Patient Survey (GPPS) is an England-wide survey, providing data about patients' experiences of their GP practices. Results for 2024 were published in early July, with detailed data expected to be released in September 2024. Full details will be reported through the Primary Care Organisational Group – three highlighted areas are shown above.

79% of people in Gloucestershire responding to the 2024 survey reported that their overall experience of their GP practice was Very good or Fairly good. Overall experience of GP practices rated "Good" remains higher than the national average and compares well with systems across the South West.

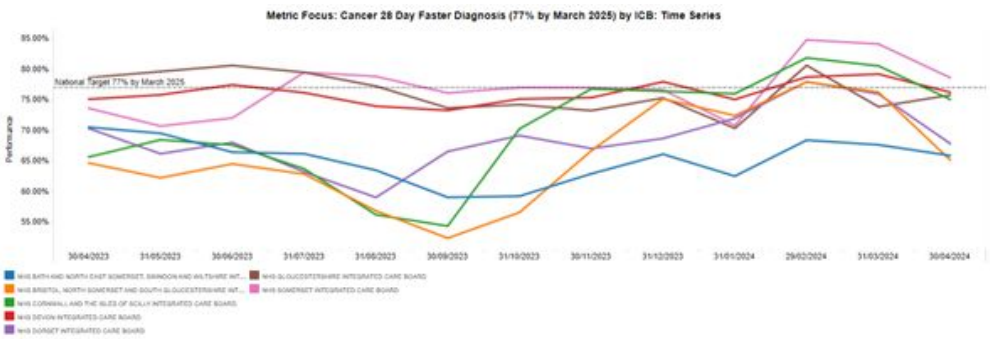
There is variation between PCNs across Gloucestershire, with three PCNs seeing the proportion of patients rating their overall experience as "Good" below the national average – Rosebank, Gloucester Inner City and Aspen. These PCNs are all in the Gloucester locality and have younger, more deprived and more ethnically diverse populations than the county average – these are all demographic groups which were more likely to respond negatively to the question: "During your last appointment, how good was the healthcare professional at treating you with care and concern?"

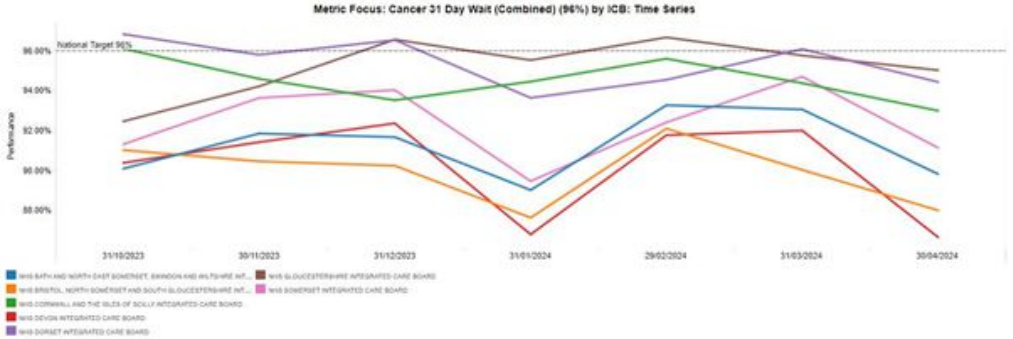
Gloucestershire had above the national average proportions of people rating their overall experience of contacting their practice as "Good" – with most people phoning the practice (71%), visiting in person (12%), or using an online option (12%). 3% of respondents used the NHS app.

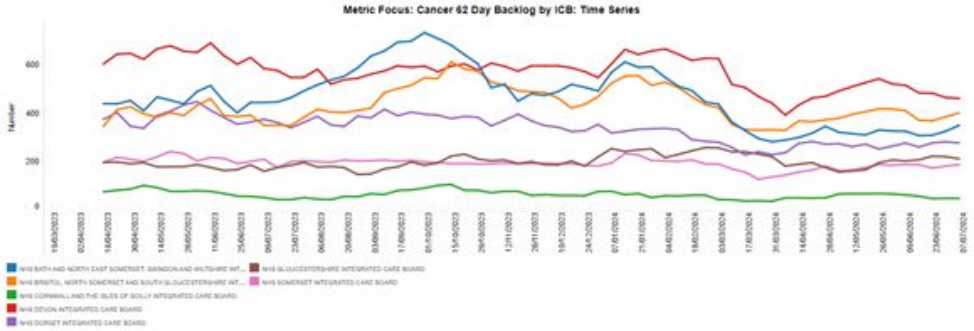
One area where Gloucestershire results were below the national average was people's feelings about how long they waited for an appointment, with 3% less people agreeing their appointment was within the right timescale than nationally. This question scored similarly to the overall experience of contacting the surgery nationally, but was 10% lower in Gloucestershire respondents.

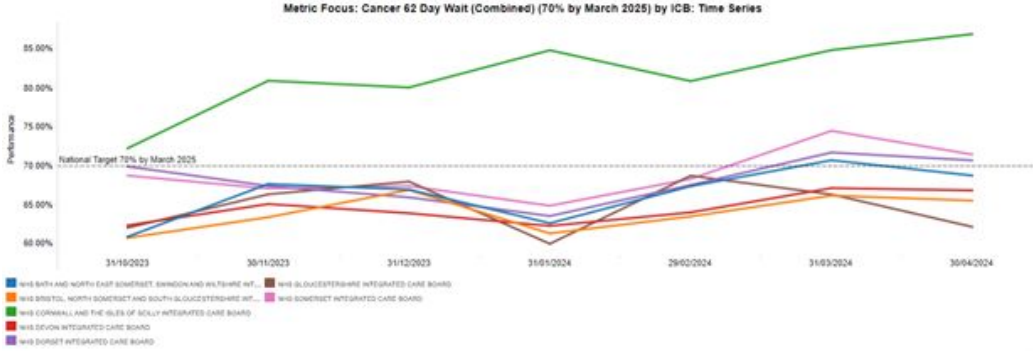
Improving Services & Delivering Outcomes

Area of focus: Cancer wait times performance benchmarking









Cancer performance has remained stable in Gloucestershire and benchmarks similarly to the wider South West region, with the exception of 31-day treatment, where performance is among the highest in the region. Industrial action that took place throughout the financial year initially did not impact cancer performance as cancer services were prioritised, however as repeated cycles of industrial action took place, the resilience of the system was affected. For example, once dates were announced, fewer cancer treatments were scheduled to avoid industrial action dates, leading to a steady increase in the backlog of patients waiting over 62 days throughout the second half of the year. This has been substantially reduced during March 2024, leading to the dip in performance seen against the 62-day standard at the end of the financial year. Performance against the 28-day Faster Diagnosis Standard has generally been good throughout 23/24 (meeting the overall 75% standard on average throughout the year) and the system is confident in meeting planned commitments to reach 77% against this standard in 2024/25.

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- UEC services have been under considerable pressure in June, with increases in outbreaks of infectious disease (both COVID-19 and norovirus) which has affected bed availability at times. A further period of industrial action necessitated the centralisation of ED at the Gloucester Royal Hospital site between Wednesday 26 June to and Monday 1 July. ED at Cheltenham General operated as an MIIU during this period to ensure safe staffing for patients. At times, the OPEL level reached level 4 across the system, however successful joint working and system focus on early discharge planning has supported a reduction in the OPEL level moving into July. Further development of NCTR reporting is also underway to support system visibility across all settings.
- June performance at GHFT: 58.6% of patients were see and treated and admitted/ discharged within 4 hours or less in a Type 1 setting. Gloucestershire system saw 74.3% of patients in all settings within 4 hours. Compared to last month, GHFT's & Gloucestershire ICB's performance improved Type 1 setting from 58.5% and improved for all settings from 73.9%. As a system (across Type 1 and Type 3), we are committed to delivering 78% against the 4-hour target by March 2025. Our trajectory recognises our current performance in March 2024, so sets our improvement from 74% in April, 76% by September and then 78% by March 25 across all ED/MIIU departments in the ICS.
- Ambulance average response time for Category 2 incidents was 40.8 minutes in June 2024. Handover performance has been stable month to month in 2024/25 to date, however day to variability has been high. In June, 3298 hours were lost to handover delay, with the average handover taking 79 minutes at GHFT. To support handover and response time performance, GHFT and SWAST have been carrying out audits as part of the Working as One transformation programme. This has identified that most patients conveyed arrived after 1400 and are frail, elderly patients. 50% were identified as requiring ongoing hospital support following their conveyance.
- Abandonment rates in the NHS111 call service improved to 3.9% of calls to the service abandoned (against a target of 3%) from more than 8% in May 2024. The new Integrated Urgent Care Services (IUCS) covering NHS111, a clinical assessment service and Out of Hours service is expected to mobilise at the end of November 2024 with joint work ongoing between the ICB and the new provider to ensure a smooth roll out.
- Virtual wards are now well established in supporting urgent care – with Frailty, Respiratory and Surgery tech enabled pathways in our Virtual Hospital. Acute Respiratory Infection and SDEC pathways into respiratory are now live with further development planned for 24/25 – including expansion of the frailty and surgical pathways, and additional support from pharmacy. Latest capacity and occupancy figures show that 216 beds are available, and 85% are in use (as of the 28th June 2024).
- A development plan is in progress for the Rapid Response service, working through recommendations from the Working as One programme to increase referrals, carry out demand and capacity modelling, improving data visibility, and simplify the triage process (ensuring a single point of access). The service is also working to widen the inclusion criteria. Latest performance for Rapid Response shows good compliance against the 2-hr response target, with the latest full month (June 2024) performance at 74.6% against a target of 70%, and with 453 total responses.

Improving Services & Delivering Outcomes

Elective Care

- The full year performance against the Elective Recovery Fund target for 2023/24 was 105.6% M12 freeze (*note: this remains a draft position as we are awaiting a finalised baseline from NHSE to reconcile the final position*). The target for the year had been reduced to 103% to account for the impact of industrial action.
- M2 2024/25 Flex is currently calculated based on the baseline used for the 23/24 calculation while the 24/25 baseline is finalised by NHSE therefore may be subject to change. Current performance is showing Value Weighted Activity at 113.7% of 2019/20 including pathways avoided to the end of M2 (this includes activity recovery overall of 113.2% at GHFT). This is likely to increase when finalised data is available.
- RTT performance was 65.5% in May (% of the waiting list under 18 weeks). The overall waiting list reduced in size by over 3000 patients, however long waits increased compared to the position in April: 52-week waits rose to 3,009, up from 2,869, 65-week waits rose to 550, up from 402 in April, and there were 13 over 78 week waits (3 at GHFT, 10 out of county). The reduction of long waits remains the focus for the system with additional activity commissioned in specialties with large volumes of long waiters. Specialties with the highest number of long waits continue to be Oral Surgery, ENT and T&O.
- Utilisation rate for pre-referral A&G in the third quartile nationally, above both the national and peer group average. For post-referral triage utilisation rate is in the fourth quartile (third nationally), significantly above the peer and national averages. This demonstrates the good progress that has been made in the system to support
- GHFT have been working on an extensive programme to optimise their theatre utilisation, encompassing late starts and early finishes as well as wider metrics such as utilisation and booking. The trust have carried out a review with specialists “Four Eyes” to develop effective theatre planning and management, as well as continuing to focus on the opportunities identified by GIRFT to further support utilisation and productivity in theatres. Gloucestershire system is performing in the top quartile of systems for average length of late starts (latest position – fortnight to 16th June 2024), with an average of 19 minutes per session – the best performing ICB for this period.

Improving Services & Delivering Outcomes

Primary Care

- 344,695 appointments were delivered in general practice in Gloucestershire in May 2024. The majority of these were offered on the same day of booking (155,372 appointments – 45.1%). The number of face-to-face appointments in Gloucestershire has increased by more than 40,000 from 206,501 in May 2019 to 247,837 in May 2024.
- Performance against the Appointments offered within 2-weeks metric now reflects the categories of appointment that would be expected to be offered an appointment within two weeks, rather than all primary care appointments. Latest performance showed that 81.9% of these appointments were booked within 2 weeks of the request, and this proportion has increased since the data first became available (January 2024). The operational planning target for this metric is 75%.
- Cervical cancer screening uptake has declined, with a 6.8% drop in uptake between March 2024 and June 2024 (latest data for June 2024 shows that 69.8% of those eligible for screening took up the offer). This trend has been seen across the South West, with continued decrease amongst younger women coming forward for screening, despite overall growth of eligible women in this cohort since late 2021. Additionally, the screening regional screening lead has advised that there has been a high number of symptomatic/high risk patients that have had to be prioritised within the service.

Dental

- Units of Dental Activity (UDAs) delivered in county have been rising throughout 2023/24 and are planned to increase further in 2024/25 – current performance for dental practices in Gloucestershire shows 68% of contracted dental units are delivered.
- The improvement of NHS Dentistry is a key priority for the system, in line with the national position. Current aims are focussing on:
  - delivery of consistent, high quality dental services and care, with a particular focus on improving access to dentistry, particularly in some of the county's most deprived areas
  - supporting providers to recruit, retain and train all dental staff by offering more flexible training and working opportunities
  - working with our communities to improve the oral health of people across the county, with a particular focus on health inequalities, children, and older people

Improving Services & Delivering Outcomes

Cancer

- In May, performance against the 28-day Faster Diagnosis standard improved for the second month, with 78.8% of Gloucestershire patients receiving their diagnosis or all clear confirmation within 28 days of referral. This met the 75% standard and is in line with the planned position for May 2024 (79% in our operational plan trajectory). The national target is increasing during 2024/25 to reach 77% by March 2025 (as an interim standard – the target is expected to rise to 80% by 2026).
- Performance against the 31-day treatment standard improved in May to 94.5% from 93.7% for Gloucestershire patients in April (though failing to meet the target of 96%).
- Pathways meeting the 62-day treatment target increased substantially to 68.6% for Gloucestershire patients in May, up on the 62.4% achieved in April. Most breaches were in Urology and Lower GI and were predominantly patients referred by their GP – performance against the 62-day target was higher for patients referred via the screening pathways or via a consultant upgrade. Cancer services at GHFT are currently focussing on improving adherence to best practice timed pathways across all specialties to support further improvement in 28 day and 62 day performance – as most patients breaching the 62-day standard also breached the 28-day Faster Diagnosis target.
- Alongside general actions focussed on unblocking pathways and streamlining cancer pathways, there are specific improvement plans in place for Lower GI and Urology to address the performance in these specialties. A weekly Urology working group is led by the Deputy COO at GHFT to continually drive improvement. Additional resource into the Urology pathway is due to commence, and further training for the urology nursing workforce is planned to improve productivity particularly around LAPT biopsy. Primary care training has also been delivered to minimise the need for repeat and unnecessary referrals. In Lower GI, the diagnostic pathway is under review to ensure the best practice timed pathway can be delivered.
- Referrals for patients with non-specific symptoms have increased throughout 2023/24 and have now stabilised with 38 made in May 2024. This is slightly below the planned trajectory, which will likely not be met in 2024 due to good availability of direct access GP diagnostics and effective use of existing single specialty cancer pathways.

Improving Services & Delivering Outcomes

Diagnostics

- Diagnostic performance remains stable with 15.9% of the waiting list over 6 weeks at the end of the month in both May compared to 16.1% in April 2024, GHFT performance was 16.8% - also stable to April. The waiting list has increased slightly to 15,519 people in May (across the ICS, at all providers), with Echocardiography, Audiology Assessment and Non-obstetric Ultrasound seeing increases in numbers waiting compared to the previous month. Modalities seeing the highest of 6-week breaches remain the endoscopies, echocardiography, peripheral neurophys, and audiology assessment.
- Endoscopy waiting lists currently have waits of over 6-weeks for 40.5% of the total list (as at the end of May), with the total waiting list across all 3 modalities (colonoscopy, flexi sigmoidoscopy and gastroscopy) stable at 1519. Detailed demand and capacity analysis has now been completed, with GHFT working with specialists Four Eyes in improving throughput and productivity. Additional locum and consultant capacity has been actioned, with recruitment for these posts complete. These posts along with other waiting list initiatives are supported by ERF and High-Risk investment funding, with the endoscopy transformation programme also working alongside this additional capacity to identify and support the change required to support sustainable recovery and performance. Current actions are focussed on process mapping across the department and data quality/cleansing to ensure marginal gains can be identified and actioned. An NHSE review planned for 19th July to assess progress against the recommendations made following the initial visit in December 2023.
- 6-week performance for echocardiography improved to 32.7% (patients waiting more than 6 weeks) at the end of May, however this is predominantly due to increasing overall size of the waiting list rather than a reduction in 6-week breaches. Echocardiography inpatient demand and overall activity has been stable; therefore, demand is driven by elective referrals. The service is currently recruiting to substantive posts and will look to appoint additional locums to support capacity if the recruitment is unsuccessful. Planned work with Four Eyes will also support demand and capacity analysis as part of a review of cardiology more widely.
- The Community Diagnostic Centre has continued to bring additional modalities online (FibroScan clinics commenced in May 2024). Further service design work is underway, for example the Complex Breathlessness service and Liver Disease “One-Stop” clinic. The centre is now working through final preparations to handover to GHFT for business as usual (this will take place in Q2 of 2024/25).

Improving Services & Delivering Outcomes

Mental Health

- CYP access continues to be strong across all providers, with latest national data showing access exceeded our target (8145 against the 7340 target). Compliance with the 4-week waiting time target has decreased with May performance for core CAMHS at GHC at 56.2% - capacity in the service has been reduced slightly by workforce constraints including vacancy and training. Additional capacity is being explored with other CAMHS services as demand and capacity modelling has shown that an additional 5 clinics/ month are required to bring the waiting time down to 28 days.
- Talking Therapies recovery rate remains excellent, at 52.3% in May 2024. Reliable recovery rates were 49% (meeting the operational planning commitment of 48%), while recovery was slightly lower on 64% (missing the operational planning target of 67%). Completed treatments in May 2024 was significantly higher than plan (615 against a plan of 462), however the referral rate into the service has decreased, and this in combination with a change in focus for the service (to reduce waiting times, particularly waits between 1st and 2nd treatment appointments) is expected to drive a reduction in completed courses in coming months.
- Perinatal mental health access continues to meet and surpass the trajectory (672 rolling 12-month access). The service has seen demand increase throughout 2023/24 putting pressure on the 2-week assessment threshold. This was missed in May with 44.2% of patients seen within 2 weeks. The latest month has seen delays for patients referred to the Birth Anxiety and Trauma Service (BATS) due to staff sickness – the service has responded by rolling out additional assessment training to staff to ensure service continuity.
- Access to mental health services has exceeded the plan for 2023/24 with 5,985 people receiving at least 2 contacts from community mental health services in the 12 months to March 2024 against a target of 4805. As the LCP model continues to be rolled out across the county, focus is now on ensuring reporting captures all community services and that the patient pathway between different providers is joined up effectively. As of March 2024, access to transformed services is reported nationally at 3,265 people, with this expected to continue to grow throughout 2024/25.
- Out of Area placement days continue to be low, in Q1 2024/25 there was 1 patient in each month inappropriately out of area at each month end, and a total of 54 days where people were inpatient out of area inappropriately.
- The Neurodevelopmental service development is continuing, the CYP service is now fully recruited and going live, while the adults service is in process, with some recruitment complete and the remainder ongoing.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Recruitment and Retention

- NHSE recruitment group set up to share best practice.
- The system met the 3.2% cap in months 1 and 2.
- Social care app, as part of the pastoral support for international recruits, has undergone user testing with initial pilot group. Content continues to be populated and further roll out planned throughout the year.
- GCC have launched a Proud to Care website to highlight training, education and career pathways for social care staff

Innovation

- The Housing Hub Homeshare scheme, supported by AgeUK is being promoted within Provider Trusts.
- Liaison with regional partners to establish collaborative Housing Hub offer
- Establishing relationships with local housing providers

Valuing and looking after our people

- Good partner engagement on staff health and wellbeing strategy, due to be submitted to People Committee for review and ratification.
- GHFT resources on suicide prevention shared with system partners.
- The first pilot of the System-wide New Starter Conversation was held on May 9th aimed at the independent social care sector. Evaluation although positive was based on low numbers of attendees, so agreed to adopt the concept and material within organisational induction programmes.
- Health and Wellbeing champions support day (face-to-face) held in July, focus in CPD and practical HWB support. Excellent feedback from participants, all ICS partners were represented

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Education Training and Development

- Careers engagement and outreach plans for 2024/25 school delivery being finalised. Aiming to have a T-Level student for industry placement
- Expansion of T-level opportunities continues to grow with expansion into social care planned for 24/25. Exploration of non-clinical T-Level industry placements across the system (business/finance/digital)
- ICS Apprenticeship Strategy out for final review – going to People Committee in July for ratification.
- Apprenticeship & Careers website – information collation started. One Glos website being populated.
- Care Leavers Covenant – Bespoke work experience/career support for individual care leavers being explored with system partners. Using QI methodology to shape the pathway process. Report being finalised
- ICS work experience 'one stop shop' being developed.

Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

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

- The first event of the Leadership Conference Series was held at the end of June, with a theme of Health Inequalities. Almost 200 delegates from over 30 organisations were represented, with excellent participation and feedback. A second event is being planned for October 2024.
- A consistent dashboard/infographic for EDI data from each of the (NHS) organisations has been drafted, this will make data more accessible and comparable.
- Agreement to coordinate activities for Black History Month (October)
- Digital Data and Technology workforce group established
- Collaborative Leadership programme options for first time leaders and more experienced leaders being developed in greater detail
- Inclusion Allies programme (cohort 3) planning commenced – looking to run in Q3
- ICB supporting 3 paid internships as part of 10,000 Black Interns Initiative

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One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

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Detail of Key Achievements & Areas of Focus

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- There has been no communication from the NHSE SW Collaborative Commissioning Hub (CCH) to the Clinical and Quality Directorate since the last report. We have received no notification of any immediate quality concerns regarding POD services and the quarter 1 Pharmacy, Optometry and Dental Services Quality Report has not yet been received from the CCH. We have started to work with other systems to discuss and develop oversight arrangements for POD alongside the individual quality reports flowing form the NHSE Southwest Quality Hub.

Maternity

- Following an unannounced CQC inspection in March the Trust have received a section 31 warning notice. The Trust remains rated inadequate. The ICB/LMNS have increased surveillance and oversight of the requirement for rapid improvement through a system quality improvement group (QIG). The QIG is chaired by Chief Nursing Officer of the ICB/LMNS SRO. Membership includes CQC, NHSE Regional Maternity Transformational Team, senior leaders from GHFT and LMNS/ICB and the chair of Maternity & Neonatal Voices Partnership. The QIG is bi-weekly to ensure rapid improvement is achieved. The Maternity service remains on the Safety Support Programme, the Maternity Improvement Advisors are now attending the QIG and weekly meetings with the LMNS/ICB to ensure joined up working and oversight.

- Section 31 identified 5 areas of focus which have formed a QI programme supported by the Gloucestershire Safety Quality Improvement Academy. Included in the QI programme are also 2 other areas identified locally as a concern, antenatal screening and scanning capacity. Updates and progress on all 7 are reported to the QIG. The trust also reports all progress monthly to the CQC.

Urgent and Emergency Care - Working as One

- Ongoing work to improve ED performance: 4-hour target and other metrics which include reduction in average ambulance handovers times. Continued focus on reduction of LOS in acute admissions areas using the flow hub to support P1 pathways and reduction in the use of P2. The ongoing challenges around maintaining long term delivery of strategy through uncertainty and constantly changing operational context. Work has progressed to establishing the approach to 7 days services including the flow hub, alongside the commitment to the system visibility dashboard.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Badgernet Maternity Information System interface with GPs and SystmOne

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

Community and Mental Health

- Following the CQC issuing a section 31 regarding the standards of care at Berkeley House, a period of enhanced surveillance continues. The Quality Improvement Group (QIG) continues to monitor the progress and implementation of the Trust's action plan following the inspection. The Trust is now embedding and testing actions. Discharge plans for residents of Berkeley House are progressing, two patients have now successfully moved into the community.
- It has been pleasing to note that GHC seen an overall reduction in pressure ulcer harm incidents in May. This is due to focussed work to support accurate assessment and categorisation within integrated care teams.
- The Trust continue to have focused work to improve the uptake and recording of clinical supervision for staff and have identified that further work is required to provide assurance in relation to the recording of rapid tranquilisation & associated post tranquilisation observations.
- The Quarter 4 (2023/24) Learning from Death Report has been presented to the GHC Quality Committee. GHC have now published their Quality Account for 2023/24.

Migrant Health

- The fourth hotel estate closed on the 5th June; the final hotel has seen a significant downturn in new arrivals. Beachley Barracks continues to see new arrivals with currently over 600 Entitled Persons (EP) on site, with 25 EPs who have now been living on the base since Nov 2023. Following a recent policy update from NHSE, all EPs across both sites now require permanent GP registration. There are currently >100 under 5-year-olds on the base, which is putting considerable strain on the FoD Health Visiting and Midwifery teams. There are also 10 pregnant women on site. The onsite medical provision through GDOC continues and is working well. MoD are planning for an additional 14 houses at Beachley over the next couple of weeks, indicating an increase of another 70+ EPs at the base.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Serious Incidents

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

Patient Safety Incident Investigations

- Under PSIRF organisations are prompted to respond proportionally. This might be through new SWARM huddles or After-Action Reviews. For the most complex events, organisations can open a Patient Safety Incident Investigation (PSII).
- In May and June 2024 five PSIIs have been opened; three at GHFT and two at GHC. Sadly, three related to potentially avoidable deaths, the other two potentially avoidable injuries. These will go forward for a full investigation with the respective Trusts' boards holding oversight, as is policy under PSIRF.

System Investigations

- Partners from across the ICS recently met to start to work out a process for any PSIIs that will need cross system support. This is a requirement of PSIRF and will become more important as the new ways of working are embedded. Partners have now agreed a process in principle, which has now been tested. The full policy has been drawn up for comment, prior to being included in future PSIRF policy development.

Quality Alert

- We are currently reviewing our 'Quality Alert' system following feedback from Primary Care colleagues. We want to improve communication and link with LFPSE, whilst finding a better way to support clinical colleagues to have direct conversations to resolve urgent issues.

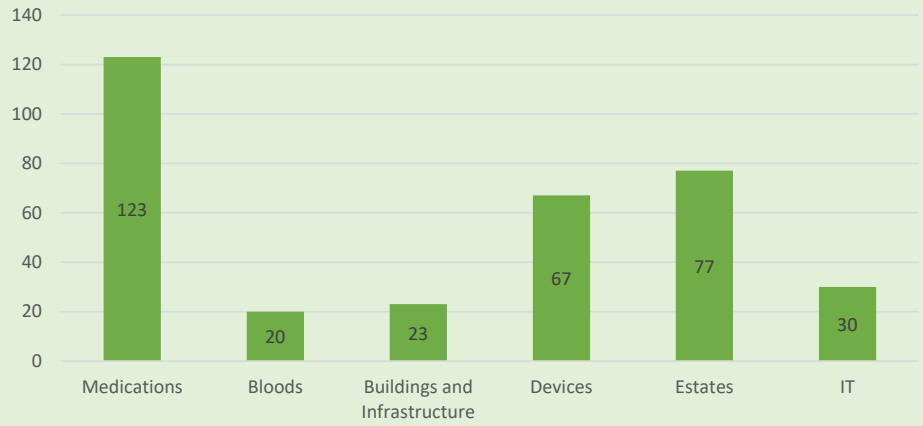
Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Learn from Patient Safety Events (LFPSE)

- NHS England have now launched the first version a new tool that will eventually enable the ICB to look at whole system data. While LFPSE is aimed to deliver Machine Learning of all incidents across the whole of England, we have now started to receive Gloucestershire data.
- In May 2024 we received data on 2053 events.
- These break down to GHFT = 1230, GHC = 795 and others = 28.
- While 1620 were unclassified, we are starting to be able to look at generic themes when staff add a category:



Patient Safety Huddles

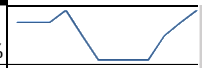
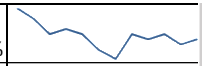
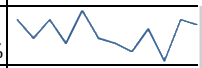
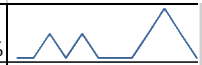
- Huddles continue every Tuesday morning at 9am. One key discussion was around how we can develop PSIRF and LFPSE in primary care.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

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

		Apr-23 Provider	May-23 Provider	Jun-23 Provider	Jul-23 Provider	Aug-23 Provider	Sep-23 Provider	Oct-23 Provider	Nov-23 Provider	Dec-23 Provider	Jan-24 Provider	Feb-24 Provider	Mar-24 Provider			Apr-24 Provider
GHT Inpatients	% Positive	93%	93%	93%	94%	92%	90%	90%	90%	90%	92%	93%	94%		GHT Inpatients	% Positive	92%
	% Negative	4%	3%	3%	3%	5%	6%	5%	5%	6%	4%	3%	3%			% Negative	4%
GHT A&E	% Positive	83%	81%	78%	79%	78%	75%	73%	78%	77%	78%	76%	77%		GHT A&E	% Positive	79%
	% Negative	12%	11%	14%	12%	13%	17%	16%	13%	15%	14%	17%	16%			% Negative	14%
GHC Mental Health	% Positive	87%	83%	87%	82%	89%	83%	82%	80%	85%	78%	87%	86%		GHC Mental Health	% Positive	86%
	% Negative	7%	6%	6%	7%	5%	10%	10%	10%	5%	10%	6%	6%			% Negative	6%
GHC Community	% Positive	94%	94%	95%	94%	95%	94%	94%	94%	95%	96%	95%	94%		GHC Community	% Positive	95%
	% Negative	3%	3%	3%	3%	2%	3%	2%	3%	2%	2%	2%	3%			% Negative	2%

The Friends and Family Test (FFT)

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

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

System Clinical Effectiveness Group

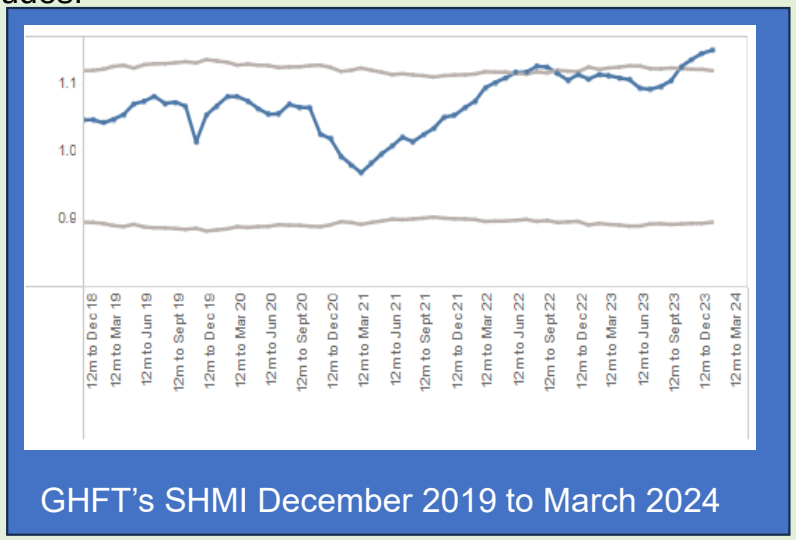
- The Chief Medical officer is now the chair of the Clinical Effectiveness Group (SCEG). The focus of SCEG is intending to shift to reflect how CPGs and Clinical Effectiveness could form closer links. A rolling program of CPG attendees presenting on a standardised list of themes could provide real insight for the group, plus an opportunity to assist with any challenges by diversifying oversight.

SHMI

- The Trust's Standardised Hospital Mortality Indicator (SHMI) rate continues to be outside of control limits. The latest data shows the Trust's SHMI to be at 1.149.

- GHFT and the ICB are working together look at influencing factors which includes:

    - Primary diagnosis audit
    - Dementia coding review
    - Excess mortality clinical audits/improvement plans:
    - COPD
    - Septicaemia
    - Fractured Neck of Femur
    - Weekend admission
    - ED Delay related Harm data review



GHFT's SHMI December 2019 to March 2024

- The outputs from these will be reviewed at the Trust's Hospital Mortality Group and the System Mortality Group.

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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ICS Finance Report

Month 3 2024/25

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Finance and Use of Resources

Key Financial Performance Indicators: Dashboard (1)

	Plan	Actual	Surplus/ (Deficit)	Previous Month	GHC	GHFT	GICB
Overall System Financial Performance							
Year to Date (£m)	(6.6)	(8.8)	**(2.2)**	**0.0**	(0.3)	(1.9)	0.0
Year End Forecast (£m)	0.0	0.1	**0.1**	**0.0**	0.1	0.0	0.0
Efficiency Plan Status							
Year to Date Delivery (£m)	19.8	17.9	**(1.9)**	**0.0**	(0.8)	0.7	(1.8)
Year to Date Delivery (%)	100%	90%	**(10%)**	**100%**	81%	114%	83%
Forecast Outturn Delivery (£m)	93.2	93.2	**0.0**	**0.0**	0.0	0.0	0.0
Forecast Outturn Delivery (%)	100%	100%	**0%**	**100%**	100%	100%	100%
System Capital			**Over / (Under)**				
YTD spend against total CDEL (£m)	9.0	4.9	**(4.1)**		(0.4)	(3.7)	0.0
FOT spend against total CDEL (£m)	61.6	59.6	**(2.0)**		0.0	0.0	(2.0)

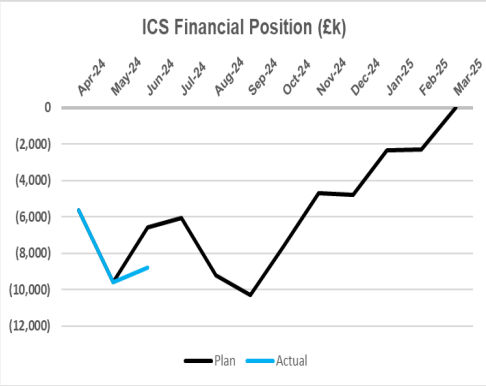
Finance and Use of Resources

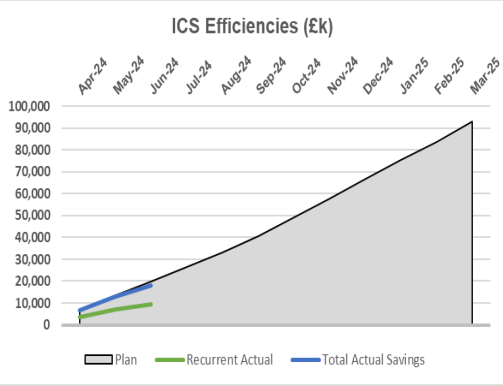
Key Financial Performance Indicators: Dashboard (2)

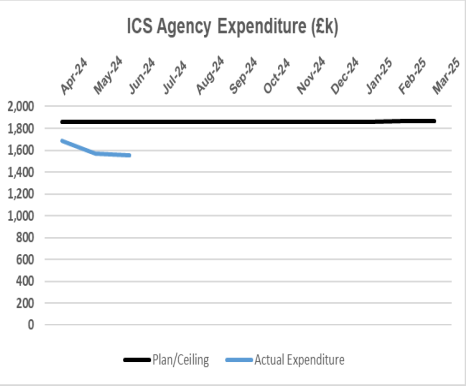
	Plan	Actual	Over/ (Under)	Previous Month	GHC	GHFT
Workforce						
Year to Date Agency expenditure v Cap (£m)	5.6	4.8	**(0.8)**	**(0.5)**	(0.6)	(0.1)
Forecast Outturn Agency expenditure v Cap (£m)	22.3	22.2	**(0.2)**		(0.2)	0.0
YTD Agency spend as % of total Staff costs	3.2%	2.7%	**(0.5%)**		2.0%	3.0%
Liquidity (Cash)						
Year to Date Cash Balance v Plan (£m)	96.3	98.2	**1.9**		6.9	(4.9)
Forecast Outturn Cash Balance v Plan (£m)	81.2	91.3	**10.2**		0.2	10.0
Other Key Financial Indicators						
Better Payment Practice Code (no. organisations not complying with 95% payment volume and value targets)			**1**			
Elective Recovery Fund fully coded flex performance v 19/20 baseline			**117.9%**			

Finance and Use of Resources

ICS Financial Performance Overview: Analysis (1)







Key risks to delivery of the financial plan

- Identification of plans to deliver unidentified savings and slippage delivery of identified savings
- Industrial action from junior doctors and the impact of collective action by GPs
- The impact of new NICE TAs
- Slippage in the delivery of the elective plan to achieve the elective recovery additional allocation

System Financial Position

- The System set a challenging financial plan with an additional stretch target of £15m to deliver a breakeven financial plan. Delivery plans for the £15m stretch are in various stages with some in delivery and others still being scoped. The financial risk therefore within the system is significant. Work to accelerate scoping and moving schemes into delivery or identifying alternatives is in progress across the system with reviews by Executives and weekly progress monitoring by Chief Executives.
- The year to date variance is a deficit £2.2m variance to plan, £0.3m with GHC due to phasing which will be resolved next month. £1.9m is attributable to GHFT, due to pay overspends in nursing and non pay overspends in the medicine division for non pass through drugs and clinical supplies. The ICB is breakeven versus plan.
- All organisations are forecasting breakeven by year end. Recovery actions are in place within organisations to manage expenditure back to plan and identify plans for unidentified savings.

Efficiency

- Delivery is £1.9m below plan for the year to date. Plans are being developed to recover this position. The recurrent level of savings constitute 51% of the total savings which is a lower value than required to maintain (not worsen the underlying financial position).
- Full delivery of efficiency plans by year end is forecast.

Agency

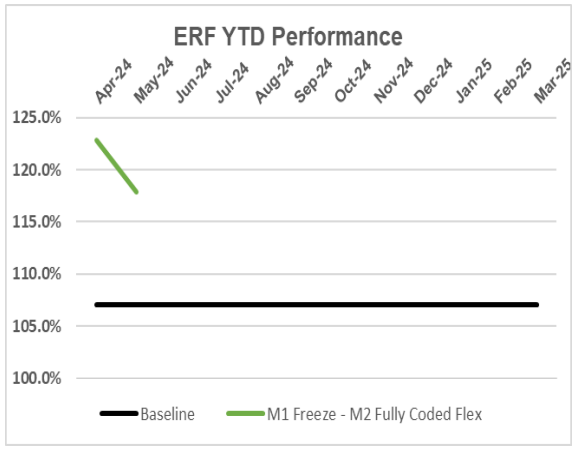
- M3 agency expenditure was £1,556k, compared to a plan of £1,861k. Providers are delivering spend below the agency cap.

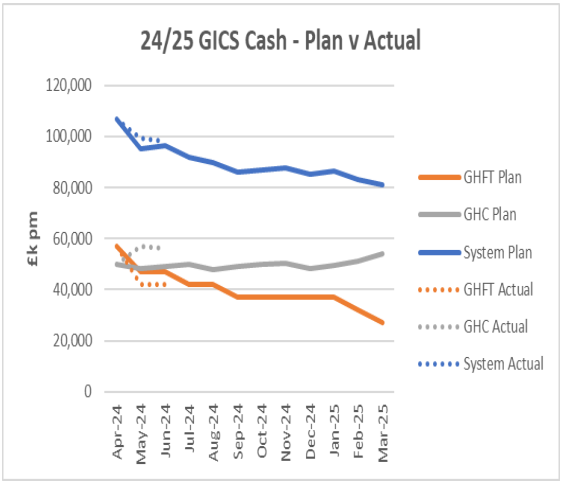
Finance and Use of Resources

ICS Financial Performance Overview: Analysis (2)

Full Year Charge Against Capital Allocation (£m)

System Capital Allocation	44.7
Disposal	4.0
Nationally Funded Schemes	4.3
IFRS 16 Leases	8.6
Operational Capital Allocation	**61.6**
Forecast System Capital expenditure	(44.7)
Disposal	(2.0)
Forecast NHSE Schemes expenditure	(4.3)
Forecast IFRS 16 Leases expenditure	(8.6)
Forecast Capital Expenditure	**(59.6)**
Forecast Variance to Capital Allocation	**2.0**





Better Payment Practice Code (BPPC)

Target = 95%

Organisation	YTD Volume %	YTD Volume Achieved ?	YTD Value %	YTD Value Achieved ?
GHC	81.0%	N	90.8%	N
GHFT	98.7%	Y	97.6%	Y
GICB	96.9%	Y	98.4%	Y
System Average	**92.2%**	N	**95.6%**	Y

Capital

- Capital expenditure is planned and forecast to be £2m below the capital allocation. This planned under commitment is to be carried forward into 25/26 to support next year's capital plan.

Elective Recovery Fund (ERF)

- The National expectation for Gloucestershire is to deliver 107% value weighted activity (VWA) compared to 19/20 activity. The ICS plan is 118% VWA of 19/20 activity.
- The m1 position showed a significant delivery over baseline. Within the m2 flex (interim) position there are a number of uncoded episodes of care which once coded may generate an additional c£1.1m to ERF achievement and improve the May position to 113.4% and the year to date position to 117.9% VWA.

Cash

- The year to date system cash position is positive against the plan. However, within this total, GHC is above plan, whereas GHFT are below. Cash forecasts are under regular review by organisations given the challenging financial position.

Better Payment Practice Code

- System achieving target in respect of YTD values paid.
- GHC below target due to focus on clearing old invoices, and tightening up on procedures for receipting that may have led to improved recording and reduction in achievement. Action plan in place to address.

Finance and Use of Resources

System Financial Risk: Overview

Key Financial Risks	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position. Unidentified savings c£10m, red rated savings £29m.	Savings monitored monthly through the Programme Delivery Group and Strategic Executive meetings as well as via internal governance routes, monitoring being strengthened. Recovery plans are in progress including further identification of savings to reduce the unidentified savings plus any additional non recurrent measures.
The ICB & Systems plan are dependent on delivery of the elective activity as per the plan; the Elective Recovery plan is 118%, the overall value of the additional elective recovery funding (ERF) above the baseline value is c£18.5m. The plan is currently on trajectory, however, industrial action and escalation will impact on delivery. The range of risk is c£8m-£10m.	Elective plan recovery is monitored at the Planned Care Programme Board (System group) and mitigating actions are discussed and agreed, in addition, Resources Steering Group also monitor to look at the overall financial impact and potential other mitigations.
Two new significant NICE TAs are in progress and, if issued will lead to large financial costs for all ICBs both in terms of drug and service costs. Estimated financial values are being calculated.	The potential impact on services and costs is being reviewed based on available information, the system is responding to consultations as they are issued and highlighting the operational and financial impacts.
Primary Care: high risk of contract handback due to growing operational & financial pressures. Indicative direct costs £0.6m - c£1m per practice.	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices is underway to identify issues early and work with practices on mitigating actions which can include investment in training and additional support.
Industrial action by junior doctors remains a risk, in addition, GP collective action is also planned, the impact of which is likely to be significant.	Planning for industrial action across the system is managed within organisations and across the system drawing on experience from 23/24 to minimise impact. GP collective action impacts are being assessed.

Finance and Use of Resources

System Efficiencies

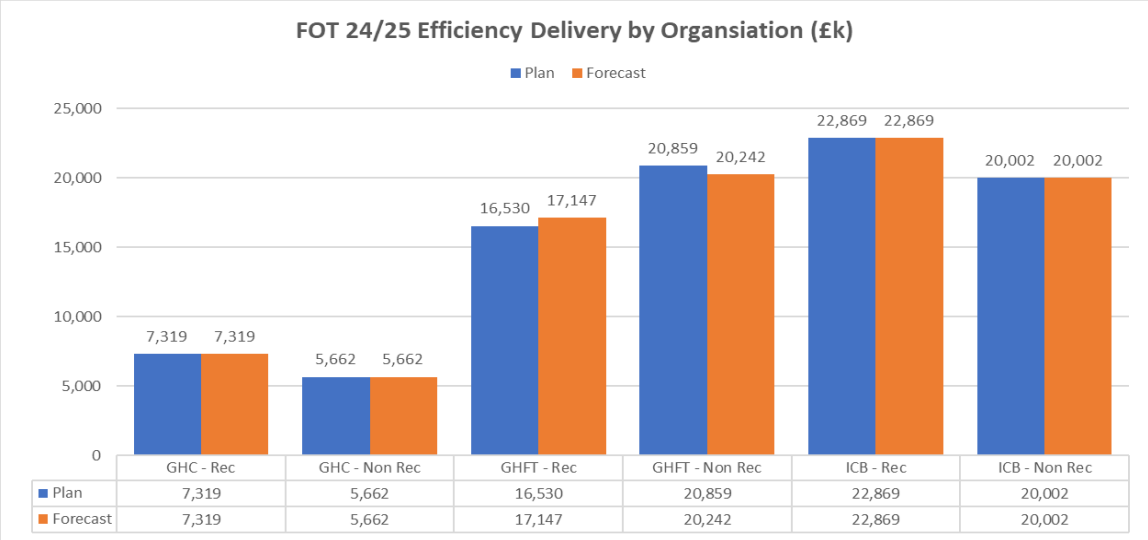
GLOUCESTERSHIRE SYSTEM SAVINGS SUMMARY - FORECAST

Organisation	Savings requirement	Unidentifed	Identified Schemes Total	High	Medium	Low	Recurrent	Non-Recurrent
	£000	£000	£000	£000	£000	£000	£000	£000
Gloucestershire Hospital's NHS Foundation Trust	37,389	5,298	32,091	15,388	10,583	11,418	17,147	20,242
Gloucestershire Health & Care NHS Foundation Trust	12,980	3,738	9,242	3,738	5,781	3,461	7,319	5,661
ICB	29,578	-	29,578	1,500	21,004	7,074	13,694	15,884
System-held (within 12/6/24 efficienices plan)	13,293	1,924	11,369	8,454	3,000	1,839	9,175	4,118
Gloucestershire System Savings Plan - 2024/25	**93,240**	**10,960**	**82,280**	**29,080**	**40,368**	**23,792**	**47,335**	**45,905**
Percentages compared to Savings Plan Requirement	**100%**	**12%**	**88%**	**31%**	**43%**	**26%**	**51%**	**49%**
Other Recovery Actions	**5,200**	**0**	**5,200**	**2,750**	**1,500**	**950**	**1,000**	**4,200**
Gloucestershire System Savings Plan + Other Recovery Actions - 2024/25	**98,440**	**10,960**	**87,480**	**31,830**	**41,868**	**24,742**	**48,335**	**50,105**
Percentages compared to Savings Plan Requirement	**100%**	**11%**	**89%**	**32%**	**43%**	**25%**	**49%**	**51%**

Finance and Use of Resources

System Efficiencies: Performance

	System Plan	System Actual	Over / (Under) Delivery	GHC	GHFT	GICB
Efficiency Plan Delivery (YTD £k)	19,778	17,875	**(1,903)**	(808)	680	(1,775)
Efficiency Plan Delivery (YTD %)			**90%**	81%	114%	83%
Efficiency Plan Delivery (FOT £k)	93,240	93,240	**0**	0	0	0
Efficiency Plan Delivery (FOT %)			**100%**	100%	100%	100%



ICB

- The medicines management programme is underway, a key risk is due to uncertainty on the timing of when Rivaroxaban price changes will commence, and this could materially impact on the potential in-year cost reduction for this drug.

GHC

- The Trust is focussing on the identification of the remaining unidentified recurrent savings as this is a significant risk to the underlying position. Recurrent savings delivered at month 3 were £2.368m, ahead of the plan by £0.627m. Non recurrent savings delivered at month 3 were £1.093m, behind plan by £1.435m but are expected to catch up in July through identified savings being released

GHFT

- The £0.7M favourable variance relates primarily to an interest benefit, and timings of some one-off items compared to plan, but offset by some other large items, centrally-held non-recurrent schemes.. Areas of additional savings are currently being developed within medicines management, digital, commercial income and reviewing the use of surgical wards to improve efficiencies.

Finance and Use of Resources

System Capital: Performance

YTD (£k)				
	GHC	GHFT	ICB	System
DIGITAL	0	1,004	0	1,004
MEDICAL EQUIPMENT	0	136	0	136
ESTATES	816	2,322	0	3,138
OTHER	0	(77)	0	(77)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**816**	**3,384**	**0**	**4,200**
IMPACT OF IFRS 16	11	446	0	457
Total Charge against Capital Allocation (including impact of IFRS 16)	**827**	**3,830**	**0**	**4,657**
NAT PROG. GRANTS, DONATIONS & OTHERS	0	983	0	983
Gross Capital Spend Total	**827**	**4,814**	**0**	**5,641**
Less Donations and Grants Received and PFI	0	(771)	0	(771)
Total Capital Departmental Expenditure Limit (CDEL)	**827**	**4,043**	**0**	**4,870**
Plan	1,252	7,700	0	8,952
Over / (Under) Plan	**(425)**	**(3,657)**	**0**	**(4,082)**

FOT (£k)				
	GHC	GHFT	ICB	System
DIGITAL	3,515	7,020	964	11,499
MEDICAL EQUIPMENT	903	8,953	0	9,856
ESTATES	426	20,157	150	20,733
OTHER	645	(77)	28	596
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**5,489**	**36,053**	**1,142**	**42,684**
IMPACT OF IFRS 16	1,215	7,412	0	8,627
Total Charge against Capital Allocation (including impact of IFRS 16)	**6,704**	**43,465**	**1,142**	**51,311**
NAT PROG. GRANTS, DONATIONS & OTHERS	2,000	6,022	2,000	10,022
Gross Capital Spend Total	**8,704**	**49,487**	**3,142**	**61,333**
Less Donations and Grants Received and PFI	0	(1,757)	0	(1,757)
Total Capital Departmental Expenditure Limit (CDEL)	**8,704**	**47,730**	**3,142**	**59,576**
Plan	8,704	47,730	5,142	61,576
Over / (Under) Plan	**0**	**0**	**(2,000)**	**(2,000)**

GHC

- Capital spend is minimal year to date but is expected to fully catch up by year end. There is a risk relating to the planned disposals due to planning delays. The Trust is currently developing mitigating actions should disposals be delayed.

GHFT

- GHFT has a year to date variance, this is due to delays in specific projects some of which are contractual, the most significant being the contracts with Cobalt for MRI and CT scanners, however, these are not expected to impact on the forecast outturn.

ICB

- The ICB capital plan is planned to take place from quarter 2 onwards.
- The system plan is an underspend of £2m against the system overall capital resources with the intention to use this for the 25/26 capital programme. The forecast outturn is to deliver the financial plan.

Finance and Use of Resources

Elective Recovery Fund (ERF): Overview

- ERF data reported in month 3 is based on the month 1 freeze (fixed), and month 2 flex(interim) position.

- NHSE have not yet released the baseline data for 24/25 reporting so all performance is based on those baselines issued for 23/24 uplifted for 24/25.
- The national baseline for Gloucestershire is 107% value weighted activity (VWA) against the 2019/20 baseline and Gloucestershire's plan is 118% VWA of the 2019/20 baseline.
- The Out of County position only includes to contracted providers (low value activity is now excluded).

			Apr	May	YTD Total
Performance Summary	Total ICB (incl. A&G)	Actual 2019/20	£ 12,530,391	£ 13,504,279	£ 26,034,670
		National Target (n)	£ 13,407,518	£ 14,449,579	£ 27,857,097
		National % Target	107.0%	107.0%	107.0%
		2024/25 (Excl. A&G)	£ 14,878,588	£ 13,874,425	£ 28,753,013
		Achivement to Target (excl. A&G)	£ 1,471,070	-£ 575,154	£ 895,916
		Advice & guidance	£ 504,763	£ 335,698	£ 840,461
		Achivement to Target (incl. A&G)	£ 1,975,834	-£ 239,456	£ 1,736,377
		Performance	122.8%	105.2%	113.7%

- Within the May position there are 772 episodes of care currently generating a UZ code, these could generate an additional c£1.1m to the overall ERF achievement, improving the May position to 113.4% and the year to date position to 117.9% VWA.

Finance and Use of Resources

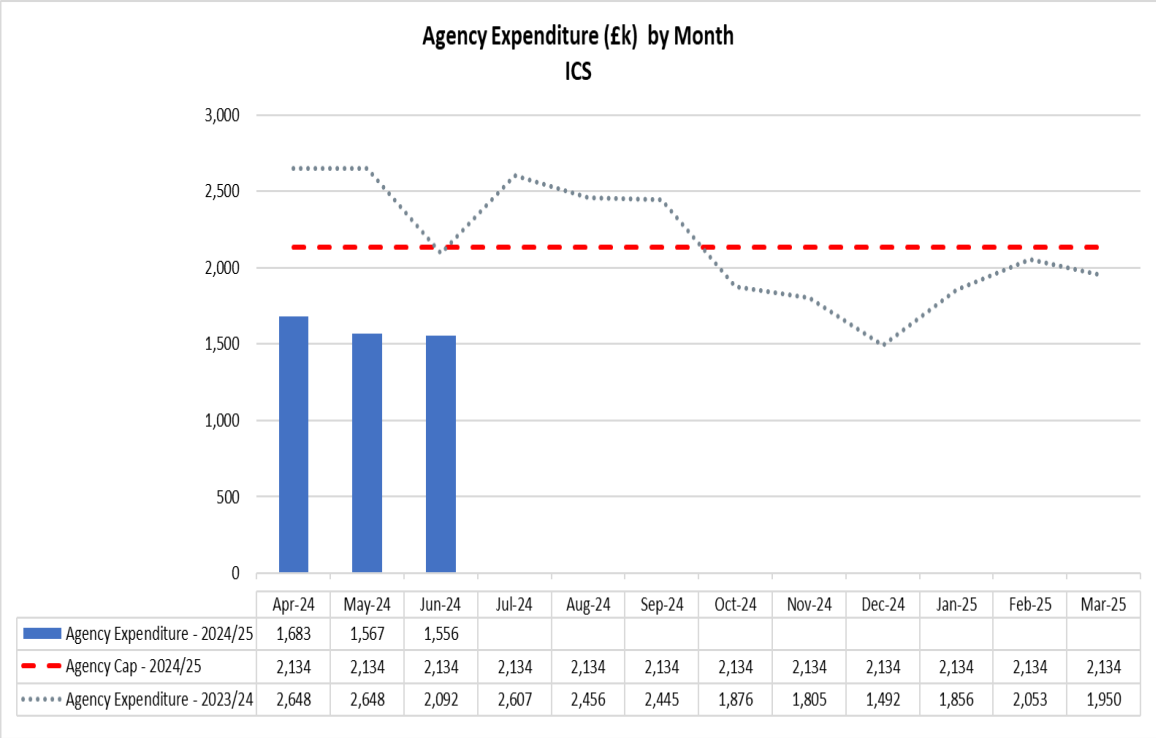
System Workforce: Worked WTE

Worked WTEs per Organisation (PWRs)						
	GHC	GHFT				System Total
		GHFT (excluding GMS)	GMS	Total		
March (M12) 22/23	**4,443.5**	**7,983.6**	**686.0**	**8,669.6**		**13,113.1**
Movement M1-7 of 2023/24	70.9	20.4	28.2	48.6		**119.5**
October (M7) 23/24	**4,514.4**	**8,004.0**	**714.2**	**8,718.2**		**13,232.6**
Movement M8-12 of 2023/24	46.2	299.9	46.7	346.6		**392.8**
March (M12) 23/24	**4,560.7**	**8,303.9**	**760.9**	**9,064.8**		**13,625.4**
Movement M1-3 of 2024/25	(22.2)			(190.8)		**(213.0)**
June (M3) 24/25	**4,524.2**			**8,889.4**		**13,413.6**
Increase/(Decrease) M12 22/23 Baseline to Current	**80.7**			**219.8**		**300.5**
Increase/(Decrease) M7 23/24 Baseline to Current	**9.8**			**171.2**		**181.0**

- System monitoring on workforce is developing and is focussed on both the budgeted and worked position. The NHS England focus is on worked whole time equivalent (WTE). Worked WTE figures will be subject to greater fluctuation on a month to month basis as they reflect vacancies, sickness, use of bank and agency as well as substantive staff.
- The position at month 3 reflects an overall reduction in worked, trend analysis is under development for future months.
- Overall, the GHFT position includes some increases due to specific investments including third Cath Lab, Cardiology Echo Service, Fibroscan, CDC Funding, Frailty virtual ward plus industrial action in June has also resulted in an increase in locum WTE. Overlaid on this nursing staff worked within GHFT have reduced month on month as the Trust have implemented agreed rosters.

Finance and Use of Resources

System Workforce: Agency Spend vs Cap



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency Expenditure - 2024/25	1,683	1,567	1,556									
Agency Cap - 2024/25	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134	2,134
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456	2,445	1,876	1,805	1,492	1,856	2,053	1,950

GHC

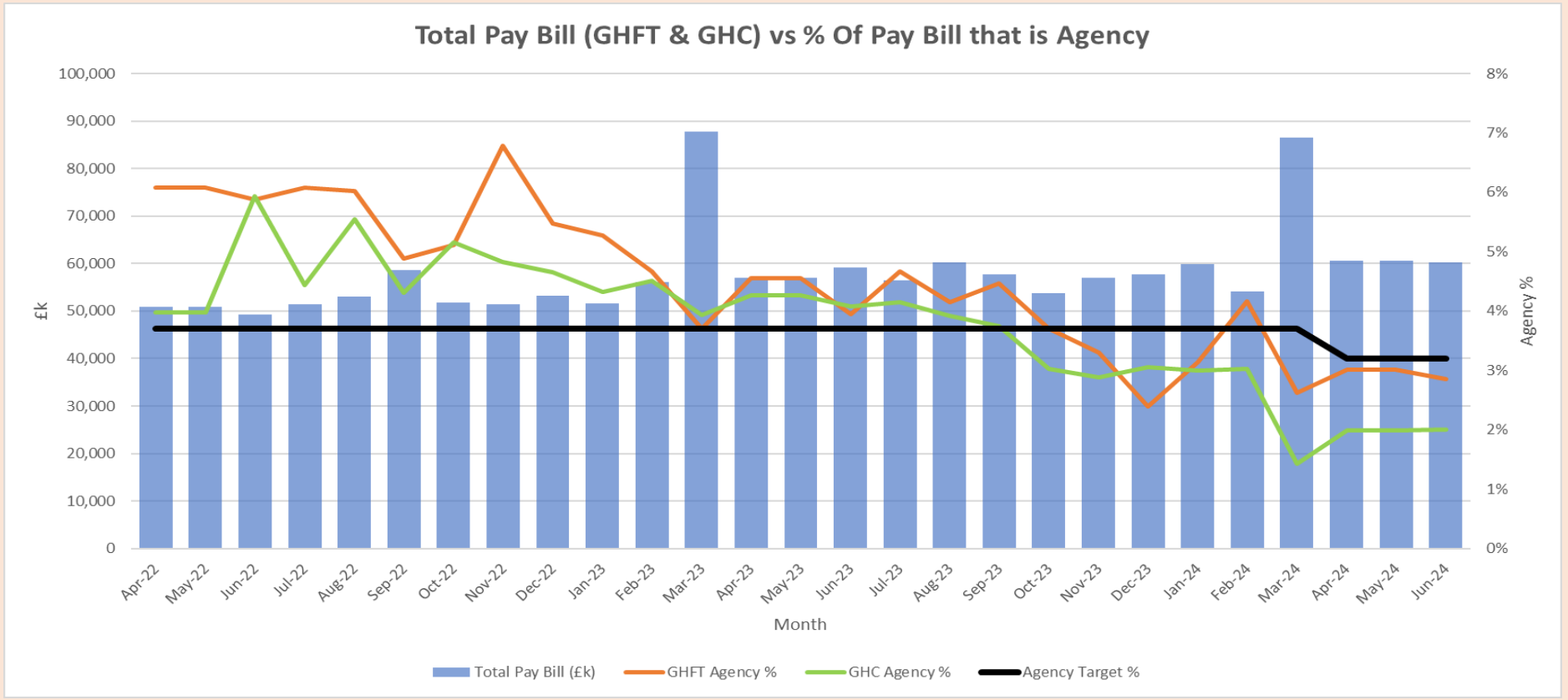
- In month shifts filled by agency totalled 843. Nursing, Midwifery & Health visiting (555) and Healthcare Assistants &other support (156) were the primary drivers.
- On framework but above price cap totalled 540 shifts.
- Off framework shifts totalled 91.
- The Trust has a strong process in place to ensure that all requests for agency go through appropriate governance, in particular the use of off framework agencies.

GHFT

- Ongoing Workforce Controls are in place, including Workforce Impact Group chaired by the GHFT DoF and Director of People & OD, and Finance Improvement Board chaired by CEO.
- Off Framework shifts in June totalled 2.

Finance and Use of Resources

System Workforce: Historical Agency Spend



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
GHFT Agency Spend (k)	£ 2,148	£ 2,148	£ 1,949	£ 2,171	£ 2,212	£ 1,977	£ 1,804	£ 2,362	£ 1,984	£ 1,774	£ 1,782	£ 2,296	£ 1,766	£ 1,766	£ 1,616	£ 1,818	£ 1,747	£ 1,744	£ 1,350	£ 1,304	£ 969	£ 1,323	£ 1,515	£ 1,561	£ 1,306	£ 1,179	£ 1,171
GHC Agency Spend (k)	£ 618	£ 618	£ 953	£ 693	£ 903	£ 782	£ 852	£ 799	£ 785	£ 777	£ 808	£ 1,020	£ 777	£ 777	£ 748	£ 726	£ 709	£ 702	£ 526	£ 501	£ 523	£ 533	£ 538	£ 389	£ 377	£ 388	£ 385
Total Agency Spend (k)	£ 2,767	£ 2,767	£ 2,902	£ 2,864	£ 3,116	£ 2,759	£ 2,656	£ 3,161	£ 2,769	£ 2,551	£ 2,589	£ 3,316	£ 2,543	£ 2,543	£ 2,364	£ 2,544	£ 2,456	£ 2,446	£ 1,876	£ 1,805	£ 1,492	£ 1,856	£ 2,053	£ 1,950	£ 1,683	£ 1,567	£ 1,556

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ICB Finance Report

Month 3 2024/25

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Finance and Use of Resources

Financial Overview and Key Risks

Overview

- The ICB month 3 position is showing a forecast outturn position of breakeven as per plan. However, the position contains a significant amount of risk as it is based on a high level of savings, delivery of the planned elective position and expenditure in areas such as prescribing and CHC progressing in line with the budgeted position.
- A prescribing forecast of breakeven is included within the position. Prescribing data for Month 1 has now been received and it is anticipated that No Cheaper Stock Option (NCSO) costs is likely to remain a pressure in 24/25. In addition, the volume and cost growth is being monitored as this remains a risk to the forecast outturn in this area.
- The Mental Health Investment Standard (MHIS) for 24/25 is £111.503m and is forecast to be on target.

Key Financial Risks	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position. Unidentified savings in the system position c£2m.	Savings monitored monthly through the ICB Operational Executive meeting, progress and remedial actions also followed up at System meetings as relevant
The ICB & Systems plan are dependent on delivery of the elective activity as per the plan; the Elective Recovery target is 118%, the overall value of the additional ERF above the baseline value is c£18.5m	Elective plan recovery is monitored at the Planned Care Programme Board (System) and mitigating actions are discussed and agreed, in addition, Resources Steering Group also monitor to look at the overall financial impact.
Two new significant NICE TAs are in progress and, if issued will lead to large financial costs for all ICBs both in terms of drug and service costs. Estimated financial values are being calculated.	The potential impact on services and costs is being reviewed based on available information, the ICB is responding to consultations as they are issued.
Increasing high cost placements, particularly children's and learning disabilities are a key financial risk for the ICB.	Regular monitoring of transitions from children to adults and also from specialist commissioning to plan for changes. Reviews of packages to ensure correct service and level of service being delivered.
Primary Care: high risk of contract handback due to growing operational & financial pressures. Indicative direct costs £0.6m -c£1m per practice	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices

Finance and Use of Resources

ICB Allocation: M03

- The ICB's confirmed allocation as at 30th June 2024 is £1,368m.

Description	Recurrent £'000	Non-Recurrent £'000	Total Allocation £'000
Balance Brought Forward M02	**1,317,791**	**44,086**	**1,361,877**
Adjustment to opening balance		(11)	(11)
CDC Activity & central costs		5,354	5,354
CDC Diagnostics		143	143
Childrens Hospice		260	260
COVID Vaccinations: Clinical Waste		12	12
COVID Vaccinations: SMS		11	11
CP PCN Leads retained	57		57
CVD Prevention: Optometry		60	60
Early Language and Support for Every Child (ELSEC) clawback		(252)	(252)
Endo diagnostics		30	30
Pay Award reversal		(56)	(56)
Pharmacy integration		61	61
Phys Sci diagnostics		7	7
Primary Care Access Recovery Plan (PCARP)		16	16
Talking Therapies		52	52
TOTAL IN-YEAR ALLOCATION 24/25 @ M03	**1,317,848**	**49,773**	**1,367,621**

Finance and Use of Resources

ICB Statement of Comprehensive Income In-Year Position

Statement of Comprehensive Income (£'000)							
Month 3 2024/25 - June	M3 Plan	M3 Actual Position	Year End Variance to Plan Favourable / (Adverse)		Full-Year Plan	Forecast Outturn Actual Position	Forecast Outturn Variance to Plan Favourable / (Adverse)
Acute Services	162,647	162,598	49		650,590	650,297	293
Mental Health Services	33,557	33,935	(378)		134,229	134,229	0
Community Health Services	30,233	30,177	56		120,933	116,774	4,159
Continuing Care Services	21,722	21,548	174		88,565	88,565	0
Primary Care Services	48,337	48,382	(45)		193,413	193,589	(176)
Delegated Primary Care Commissioning	32,438	32,371	68		124,796	124,796	0
Other Commissioned Services	8,328	9,910	(1,582)		34,850	34,851	(1)
Programme Reserve & Contingency	1,845	231	1,614		9,058	12,793	(3,735)
Other Programme Services	196	153	43		784	784	0
Total Commissioning Services	**339,304**	**339,304**	**(0)**		**1,357,218**	**1,356,678**	**540**
Running Costs	2,601	2,601	(0)		10,403	10,403	0
TOTAL NET EXPENDITURE	**341,905**	**341,905**	**(0)**		**1,367,621**	**1,367,081**	**540**
ALLOCATION	**341,905**	**341,905**	**0**		**1,367,621**	**1,367,621**	**0**
Outside of Envelope	**0**	**0**	**0**		**0**	**0**	**0**
Underspend / (Deficit)	**0**	**(0)**	**(0)**		**0**	**540**	**540**

Finance and Use of Resources

ICB Savings & Efficiencies: Overview

- Gloucestershire Integrated Care Board (GICB) has a savings programme amounting to £29.577m for the 2024/25 financial year. Additionally, there are currently £13.293m system-held savings, a combined savings requirement of £42.870m. A summary of key issues at month 3 is below.
- **Medicines savings** - Primary Care medicines optimisation savings include £1.5m in respect of national price changes in respect of Rivaroxaban (a direct oral anticoagulation drug). There is uncertainty on the timing of when prices changes will commence, and this could materially impact on the potential in-year cost reduction for this drug.
- **CHC / Placements** - The Continuing Health Care and placements savings include specific savings in respect of Fast-track, CHC (adult and children) and Learning disability review assessments. There are still shortfalls in capacity, both within the ICB and GCC around the level of additional review assessments taking place and this will limit the in-year savings delivery, potentially presenting a risk of financial pressure.
- **ERF** – Elective Recovery (ERF release) this is dependent on successful elective recovery. At month 3, updated performance information is currently awaited to assess the position.
- **Working as One** – Working as One (Urgent & Emergency Care transformation savings) - £8.2m savings. (£6.2m is within ICB savings plan and o £2m with GHFT). Work on how to realise cashable savings from the benefits currently in delivery is in development across the system.
- **Unidentified savings** – at month 3 there are c£2m unidentified savings, work is underway to identify these savings, it is likely that any savings will be non recurrent.
- **SDF Slippage review** – there is a savings requirement of £3.2m (£2.2m + further £1m within £15m recovery plan), at month 3 £1.8m has been identified with reviews underway to identify the remaining £1.4m.

Finance and Use of Resources

ICB Savings & Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB) 2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 3									
PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FULL YEAR OUTTURN EFFICIENCY PLAN £'000	FORECAST OUTTURN EFFICIENCY (YTD ACTUALS + FORECAST REMAINING MONTHS) £'000	FORECAST OUTTURN VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN AS % OF TARGET	HIGH LEVEL IN-YEAR RISK RATING
PRIMARY CARE MEDICATION	Primary Care Medicines Optimisation	1,248	1,248	0	5,000	5,000	0	100.00%	RED - High Risk
	Home Oxygen	39	39	0	150	150	0	100.00%	GREEN - Low Risk
	PRIMARY CARE MEDICATION OPTIMISATION - TOTALS	1,287	1,287	0	5,150	5,150	0	100.00%	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Individual Personal Commissioning - Continuing Healthcare (CHC) / Joint Placements	399	399	0	1,600	1,600	0	100.00%	Amber - Medium risk
	CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS	399	399	0	1,600	1,600	0	100.00%	
OTHER - RECURRENT	1) ICB Other Recurrent Efficiencies (E.g. Out of County Contracts, Independent Sector Providers, Non Contracted Activity (NCAs), Etc.)	1,736	1,736	0	6,943	6,943	0	100.00%	GREEN - Low Risk
	OTHER RECURRENT EFFICIENCIES - TOTALS	1,736	1,736	0	6,943	6,943	0	100.00%	
OTHER - NON-RECURRENT	ICB Non-Recurrent Efficiencies	3,971	3,971	0	15,884	15,884	0	100.00%	Amber - Medium risk
	OTHER NON-RECURRENT EFFICIENCIES - TOTALS	3,971	3,971	0	15,884	15,884	0	100.00%	
	2024/25 ICB SAVINGS PROGRAMME - TOTALS	7,393	7,393	0	29,577	29,577	0	100.00%	Amber - Medium risk

Finance and Use of Resources

ICB Savings & Efficiencies (System Efficiencies)

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD - SYSTEM HELD EFFICIENCIES
2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 3

PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FULL YEAR OUTTURN EFFICIENCY PLAN £'000	FORECAST OUTTURN EFFICIENCY (YTD ACTUALS + FORECAST REMAINING MONTHS) £'000	FORECAST OUTTURN VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN AS % OF TARGET	HIGH LEVEL IN-YEAR RISK RATING
URGENT EMERGENCY CARE	UEC transformation savings	1,294	-	(1,294)	5,175	5,175	0	100.00%	RED - High Risk
	URGENT EMERGENCY CARE SAVINGS - TOTALS	1,294	-	(1,294)	5,175	5,175	0	100.00%	
DISCHARGE	P2 Bed savings (System)	250	250	0	1,000	1,000	0	100.00%	RED - High Risk
	DISCHARGE SAVINGS - TOTALS	250	250	0	1,000	1,000	0	100.00%	
ELECTIVE	ERF Productivity	750	750	0	3,000	3,000	0	100.00%	Amber - Medium risk
	ELECTIVE SAVINGS - TOTALS	750	750	0	3,000	3,000	0	100.00%	
OTHER	SDF Slippage & Topslice	548	548	0	2,194	2,194	0	100.00%	RED - High Risk
	Unidentiied Savings - Non-recurrent	481	0	(481)	1,924	1,924	0	100.00%	RED - High Risk
	OTHER & UNIDENTIFIED SAVINGS - TOTALS	1,029	548	(481)	4,118	4,118	0	100.00%	
	2024/25 ICB SAVINGS PROGRAMME - TOTALS	3,323	1,548	(1,775)	13,293	13,293	0	100.00%	RED - High Risk

Agenda Item 11

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**2024/25 Capital Plan Update**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
					X	
Route to this meeting						
	ICB, ICS & Partners			**Date**		
	Capital plan prioritisation via Trust Committees CEO & DoF review System Resources Committee			Various		
Executive Summary	This paper covers the update to the 2024/25 Capital Plan The ICS receives a system capital allocation each year, in addition, other capital funding sources are available such as disposals and national allocations. The original budget was approved by the Board in March. Subsequently, NHS England announced that systems submitting a balanced revenue plan would receive additional capital, as a result, Gloucestershire has received an additional £7.46m and this has been prioritised by the system. The System had planned for disposals totalling £4m in 2024/25, following review of the current and 2025/26 plans, the system has built in a planned underspend in 2024/25 to be used in next year.					
Key Issues to note	The Gloucestershire NHS System has worked jointly to develop a capital focusing the key System priorities and risks within this it is acknowledged that prioritisation has been challenging due to the level of backlog maintenance and other estates risks across the system in order to ensure a safe environment for services.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The System plan includes: • Schemes to address some backlog and essential maintenance, however, backlog maintenance is still significant across the system and there is a risk that urgent remedial work may arise in year • The assumption that inflation will not increase further Mitigations include: • strong programme management within organisations to deliver capital programmes within plans without delay to ensure inflation can be managed • bids for national capital to release system capital, where appropriate, to address urgent capital expenditure needs 5 * 4 = 20 5 * 3 = 15					
Management of Conflicts of Interest	There are no conflicts of interests involved in producing this report.					

Resource Impact (X)	**Financial**	X	**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	The ICS is proposing a breakeven capital plan			
Regulatory and Legal Issues (including NHS Constitution)	ICBs and their partner NHS trusts and NHS foundation trusts should exercise their functions with a view to ensuring that local capital resource use does not exceed income in each financial year. NHS England has set the objective that each ICB, and the partner trusts that have their resource use apportioned to it, in accordance with the financial direction set out below, should seek to deliver a financially balanced system, which may be referred to as a 'breakeven duty			
Impact on Health Inequalities	Various programmes within the budget may impact on health inequalities and the impact will be assessed by the specific programmes			
Impact on Equality and Diversity	Various programmes within the budget may impact on inequalities and diversity and the impact will be assessed by the specific programmes			
Impact on Sustainable Development	Various programmes within the budget will impact on sustainable development and the impact will be assessed by the specific programmes			
Patient and Public Involvement	There is no public and patient involvement on the overall capital plan but the plan is in line with the ICP strategy which had public and patient involvement			
Recommendation	The Board is requested to: • Approve the updated 2024/25 capital plan noting the significant risks that the organisations within the ICS are holding and managing on an ongoing basis			
Author			**Role Title**	
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer			

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
RSG	ICS Resources Steering Group
NHSE	NHS England

1.0 Introduction

This paper outlines the updated 2024/25 capital plan for the ICS.

The original capital budget was approved by the Board in March. Subsequently, NHS England announced that systems submitting a balanced revenue plan would receive additional capital, as a result, Gloucestershire has received an additional £7.46m and this has been prioritised by the system. There have been some other minor changes to the programme.

2.0 Resources

System Capital Limit

The original budget included system CDEL of £37.2m, the system has now been allocated an additional £7.46m bringing total resources to £61.6m

	£'000
Notified capital resource limit	34,541
Estimated impact of ICS breakeven	1,568
Additional system CDEL	7,460
Potential System CDEL	**43,569**
Primary care capital allocation	1,114
Total Potential System CDEL	**44,683**

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In addition, the System has additional capital funding as follows:

	GHFT £'000	GHC £'000	Total £'000
Disposals		4,000	4,000
Nat Prog: Community Diagnostic Centres	1,637		1,637
Nat Prog: Diagnostic Digital Capability Programme	325		325
IFRIC12-GHFT	599		559
Donations Via Charitable Funds	500		500
Grant (salix)	999		999
IFRS16	7,412	1,215	8,627
Total other sources	**11,677**	**5,215**	**16,892**

Disposals in year enable the system to spend additional capital, however, there is a degree of risk relating to these as there are dependencies such as planning permissions and sale dates.

3.0 Capital Plans

The capital programme is set out in Appendix one. In determining the approach to using the additional capital there was agreement that back log maintenance, critical infrastructure and large equipment close to end of life would be prioritised. The following

		£'m
GHC	Pullman Court – backlog maintenance	1.10
GHFT	IT cost pressure	0.15
GHFT	MRI scanner replacement (close to end of life)	1.80
GHFT	Backlog maintenance and smaller critical infrastructure schemes	2.41
Total		5.46

Following a review of the current year programme and 2025/26, the decision was taken to deliver a planned underspend position in 2024/25 and to utilise this planned underspend in 2025/26.

4.0 Risk Management

The 2024/25 capital plan is balanced and does not include any contingency apart from a small medical equipment contingency budget in GHFT. Risks in year relate to:

- Inflation increases above budget plans
- Equipment breakdown requiring urgent replacement
- Estates issues requiring urgent capital work to replace/repair
- Delays in capital disposals leading to reduced capital resources in year
- IFRS16 allocations lower than planned expenditure

In year management of the capital programme is undertaken both within and between the System organisations to ensure that the capital allocation use is maximised and the position is managed jointly. This process is overseen by Directors of Finance. Risk management measures include:

- Tight project management of schemes to ensure that delays do not lead to inflation increases
- Slipping or ceasing schemes into a future year to manage unexpected capital expenditure in year
- Review of disposals to bring forward if possible
- Bids for national capital to release system capital, where appropriate, address urgent capital expenditure needs

9.0 Recommendation

The Board is asked to:

- Approve the updated 2024/25 capital plan noting the significant risks that are being held and managing on an ongoing basis

Appendices

- Appendix 1 – Updated 2024/25 capital plan

Appendix 1

Gloucestershire ICS Capital Plan 2024/25

Programme Area		24/25 Capital Plan				
		GHFT £000's	GHC £'000	Primary Care £'000	ICB £'000	Total £'000
Digital		8,687	3,515	964	0	13,166
Medical Equipment		9,477	903	0	0	10,380
Building / Medical equipment		7,412	976	0	0	8,388
Backlog / Lifecycle maintenance		599	0	0	0	599
Vehicles		0	239	0	0	239
Net Zero		0	645	0	0	645
Estates		21,554	4,426	150	28	26,158
Total Expenditure Plans		**47,729**	**10,704**	**1,114**	**28**	**59,575**
Funding Sources	Disposals	0	4,000	0	0	4,000
Funding Sources	National Prog	2,167	0	0	0	2,167
Funding Sources	IFRIC12-GHFT	599	0	0	0	599
Funding Sources	Donation Charitable	500	0	0	0	500
Funding Sources	Grant	999	0	0	0	999
Funding Sources	National Funding for new	7,412	1,215	0	0	8,627
Total Other Funding Sources		**11,677**	**5,215**	**0**	**0**	**16,892**
Call against System CDEL		**36,052**	**5,489**	**1,114**	**28**	**42,683**
System CDEL	Notified					**34,541**
	Primary care capital allocation					**1,114**
	CDEL Bonus					**9,028**
	Potential System CDEL					**44,683**
Net Position against System CDEL under/(over) commitment						**2,000**

Gloucestershire Integrated Care System

Joint capital resource use plan 2024/25

Introduction

Parliament and Treasury set the Department of Health and Social Care (DHSC) a limit for how much capital it can spend. Capital spending covers long-term spend such as new buildings, equipment and technology. It doesn't include spending such as staff costs or medicines (which is classed as revenue).

This budget limit, called the capital departmental expenditure limit (CDEL), covers all capital spending by the Department and the NHS. The Department and the NHS are legally obliged not to spend above this limit. A major part of the NHS capital is allocated to Integrated Care Systems and Systems prioritise this capital to develop a System plan with the majority going towards NHS Foundation Trusts and a small amount for General Practice requirements (covering information technology and minor improvement grants). Planning takes into account the need to upgrade estates, replace medical equipment and information technology equipment plus the strategic objectives for the System.

The Gloucestershire Integrated Care System is one of the smaller and less complex ICSs in the country. We are coterminous with our Local Authority: Gloucestershire County Council, have one Acute Hospital, Gloucestershire Hospitals' Foundation Trust (operating across two sites in Gloucester City and Cheltenham), one Community and Mental Health services provider, Gloucestershire Health & Care Foundation Trust (GHC).

This lays a foundation for close collaborative working to serve the Gloucestershire population of over 680,000 people expected to rise to 715,095 by 2030. Like many systems we have a number of demographic challenges.

About health and care services in Gloucestershire	
- Serving 682,262 people, projected to rise to 715,095 people by 2030. - +28,000 staff working in health & social care. - The combined workforce includes over 10,000 staff providing direct care and over 8,000 professionally qualified staff (nurses, medics and Allied Health Professionals) - 1 Integrated Care Board - 1 Acute Hospital Trust (2 sites)	- 1 Mental Health and Community Trust - 6 Integrated Locality Partnerships - 15 Primary Care Networks - 65 GP Practices - 62 Dental & 7 Orthodontist practices - 1 County Council with responsibility for education, public health, adult social care and children's social care - Over 5,500 independent social care providers

The proportion of the population aged 75-84 are expected to increase by 41.7% from 2018 to 2028, whilst from 2028 to 2043, the increase will be greatest in the age group 85 or over (an increase of 60%). These changes mean that by 2043, the proportion of people in the county who are aged 85 or over will have risen from 2.8% to 5.0%. Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds and a higher proportion of people aged 65+. The county experiences a net movement of over 400 people aged between 18-30 leaving the county each year. Average life expectancy at birth is 80 years for males and 84 years for females which is above the England average. On average people in Gloucestershire enjoy 67 years in good health.

While Gloucestershire has good outcomes compared with the rest of the country, we know that there are unfair differences in outcomes and wellbeing for different people. Our Integrated Care Strategy describes the disparity between those living in the wealthiest areas of the county and the least wealthy areas of the county, amounting to an average difference of 11 years of 'healthy life'. We want people to get the same good care and good outcomes no matter who they are or where they live.

58,707 (8.2%) of the population in Gloucestershire live in the 20% of most deprived areas in England. These are mainly within Gloucester and Cheltenham but also includes parts of the Forest of Dean and Tewkesbury. We have set out a commitment within this plan to improving health equity as we know good health outcomes can be lower amongst people living within these communities.

The provision of high quality care in the most appropriate settings is a fundamental strategic aim for the system. This includes the provision of buildings, equipment, and digital technology to ensure this care can be delivered on an ongoing basis.

Gloucestershire has two acute hospital sites, one in Gloucester and one in Cheltenham. Gloucestershire Health & Care NHS Foundation Trust operates six community hospitals, a learning disability unit and four mental health in patient units along with a number of smaller sites across the county. GP practices operate out of 83 buildings across the county of which 52 sites are owned by GPs, 20 sites are leasehold, 7 sites are owned by NHS Property services and 4 sites where the head lease is held by NHS property services.

The County is predominantly rural with an area of 1,220 sq miles, there are urban centres such as Gloucester City and Cheltenham but also large rural areas with smaller towns and villages.

Governance

The allocation of System capital funding for Gloucestershire was determined through a process of organisational prioritisation, via organisational committees, and then System

assessment of the proposed programme to assess against System priorities and known risks. System Governance is through the System Resources Committee. A key focus for this year has been on reducing risk relating to backlog maintenance and compliance risks plus completing developments that support our strategic plan such as the Forest of Dean Hospital and the Image Guided Interventional Surgery (IGIS) development within GHFT as part of the Fit for the Future Programme. In addition ensuring ongoing investment in equipment and digital.

Reporting on the capital programme takes place monthly and is reported to the ICS Resources Committee and ICB Board bi monthly.

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

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

The Integrated Care System has a Joint Forward Plan One Gloucestershire Joint Forward Plan (JFP) describes how we will deliver and improve the health and care elements of the integrated care strategy. The Joint Forward Plan is currently being refreshed.

Healthcare infrastructure is critical to the delivery of safe, high-quality clinical services and a key enabler for transformational change and quality improvement. A fit for purpose estate means that we can deliver the kind of modern, digitally enabled patient care pathways that we know result in significant improvements for patients, staff and anyone involved with the NHS. The ICS is developing an infrastructure plan to respond to the needs for the system in the future and help prioritise constrained resources.

Abbreviations used within this document:

Gloucestershire Hospitals NHSFT: GHFT

Gloucestershire Health & Care NHSFT: GHC

Gloucestershire Integrated Care Board: GICB

Gloucestershire County Council: GCC

2024/25 CDEL allocations and sources of funding

The main source of funding for the System capital programme is the System operational capital resource limit (resources through internally generated funding, cash and depreciation within organisations), other sources include disposals, national programme funding for specific schemes, capital grants and national funding for new leases under IFRS 16. The total programme funding is shown below.

		2024/25 Capital Plan				
		GHFT £000's	**GHC £'000**	**Primary Care £'000**	**ICB £'000**	**Total £'000**
Disposals		0	4,000	0	0	4,000
National Programme – community digital diagnostic capability		2,167	0	0	0	2,167
IFRIC12-GHFT		599	0	0	0	599
Donation Charitable		500	0	0	0	500
Grant		999	0	0	0	999
National Funding for new IFRS 16 leases (to be confirmed)		7,412	1,215	0	0	8,627
Total Other Funding Sources		**11,177**	**5,215**	**0**	**0**	**16,892**
System CDEL	Notified System CDEL	30,502	4,011		28	34,541
	CDEL Bonus (Impact of ICS 2023/24 breakeven)	1,341	227			1,568
	CDEL Bonus 2024/25	4,209	3251			7,460
	Primary care capital allocation			1,114		1,114
System CDEL		**36,052**	**7,489**	**1,114**	**28**	**44,683**
Total Funding		**47,229**	**12,704**	**1,114**	**28**	**61,575**

** technical adjustment, not true funding

Organisations, in line with their strategies, have a number of disposals planned in this and future years. These disposals form part of the overall capital planning and provide an

additional source of capital funding. It is anticipated that as part of the infrastructure strategy currently in development, other opportunities to dispose of land and buildings may be identified and built into capital planning for future years.

Capital prioritisation

The allocation of System capital funding for Gloucestershire was determined through a process of prioritisation via organisational committees followed by System review to assess against priorities and known risks. Existing programmes of work contractually committed were a first call against the capital programme. Reviews took into account the differing funding sources, priorities, risks and issues across the system and resulted in a balanced capital plan for 2024/25. The agreed focus for includes several key strategic programmes started in previous years which should all complete in 2024/25:

- The new Forest of Dean Hospital
- Image Guided Interventional Surgery (IGIS), this final phase of the project will see the establishment of two interventional radiology labs, a third cath lab and the creation of a shared recovery ward. This scheme is due to be completed in December 2024.
- Diagnostic digital capability programme to support the new Community Diagnostic Centre which opened in 2023/24.

And to ensure that the following areas were prioritised for the remaining funding available:

- Backlog maintenance (critical and high risk areas)
- Any fire, electrical and water infrastructure
- Replacement programmes for medical and digital equipment and vehicles
- Theatre refurbishment requirements
- Replacement IT

Net zero is a part of the criteria against which within business cases are reviewed.

The prioritisation of the capital programme has been undertaken in the context of five year planning, as such there are a number of areas where programmes will take place over several years such as a planned theatre replacements at GHFT.

Programme Area	24/25 Capital Plan				
	GHFT £000's	GHC £'000	Primary Care £'000	ICB £'000	Total £'000
Digital	8,687	3,515	964	0	13,166
Medical Equipment	9,477	903	0	0	10,380
Building / Medical equipment	7,412	976	0	0	8,388
PFI Lifecycle & Residual Interest	599	0	0	0	599
Vehicles	0	239	0	0	239
Net Zero	0	645	0	0	645
Estates	21,554	4,426	150	28	26,158
Total Expenditure Plans	**47,229**	**10,704**	**1,114**	**28**	**59,575**
Funding					**61,575**
Planned underspend					**2,000**

The plan for the year results in an underspend of £2m, this planned underspend from a disposal will be carried forward to 2025/26.

The majority of expenditure for vehicles, digital and medical equipment is part of the replacement and upgrade programme for equipment and digital systems rather than new developments, within this programme there is

- a planned replacement of a linear accelerator which is end of life (£2.1m).
- MRI scanner replacement which is end of life (£1.5m)
- Radiotherapy Treatment Planning System Replacement (£1.3m); this scheme will run into future years to enable dual running period

The key exceptions to this being the diagnostic digital capability programme which is funded from national programme funding and the GHC digital transforming clinical care programme (£1.6m).

Expenditure on land and buildings is primarily addressing backlog maintenance and other remedial works, with the exception of the IGIS programme which supports the Fit for the Future programme of work. Backlog maintenance within the system is high and reducing high risk backlog maintenance is a key priority for the system to enable a safer environment for patients and staff over the coming years.

Backlog maintenance (based on 22/23 ERIC submission)

Backlog Maintenance	**GHC £'m**	**GHFT £'m**
Sig & High risk	6.10	55.81
Medium & low risk	8.30	24.42
Total	**14.40**	**80.23**

National Programme Bids

GHFT have been successful in receiving £0.5m of national programme seed funding to design the Gloucestershire Cancer Institute scheme taking it through to full business case. The scheme is included within future capital years plans with the majority of the funding planned to be raised through charitable donations.

There are a couple of other smaller approved amounts of national programme capital for digital projects (iRefer and Image Sharing) These are from the Diagnostic Digital Capability Programme.

In Year Capital Management

The capital programme will be managed by organisations during the year. Where risks relating to either reductions in funding (eg, slippage in a disposal, reduced

IFRS16 allocation) or unexpected increases in costs, organisations take steps to manage this within their existing capital allocation, where this is not possible, then the system will look at steps that can be taken across organisations to managed the overall capital position.

Risks and contingencies

The System has taken a risk-based approach to prioritise expenditure within the capital budget for NHS trusts. The capital budget is limited and we need to ensure that our services and environments are safe and fit-for-purpose for patients, staff and the public, balancing investment between backlog maintenance, replacing old and ageing medical scanners, investment in cyber security and major estates developments.

Key risks to monitor and manage throughout 2024/25 include:

- Not being able to deliver to the timelines built into the plan, for instance, due to underestimating the timelines required for business case approval processes. If these processes take longer than we anticipate, this can impact the phasing of expenditure and estimated prices, should this occur we will reprioritise the schemes in the plan.

- There are three asset sales totalling £4m planned for 2024/25, if these do not progress within the financial year, leading to a lower than planned funding level for 2024/25. In this situation, smaller schemes would be slowed to ensure that the system capital budget remained at breakeven

- Rising inflation is a significant risk that could materially change estimated costs in the plan and that the system will no longer be able to afford all of the schemes planned. Contingencies are included in plans to offset this but inflation may exceed these in the current financial climate. If this takes place then schemes will be re prioritised

- Lease liabilities can vary during the year leading to additional costs. Systems are in place to manage variation as far as possible, however, if this occurs then the programme will be reassessed to ensure there is no overspend.

- Cash: As described above, operational capital is funded through a combination of depreciation and cash. There is a risk that some organisations may not have sufficient cash to support capital investment in 2024/25 due to challenging revenue plan positions.

- Specific Risks There are further specific risks from Trusts which are highlighted on their published risk registers.

Gloucestershire will continue to monitor these risks throughout the year and regular reports are taken to organisational Boards and the System Resources Committee.

Net zero carbon strategy

The ICS developed a green plan in 2022 and each provider organisation has a more specific green plan to support the overall move to net zero for the NHS. The NHS net zero delivery plan for Estates sets out the approach for decarbonising our hospital buildings.

GHC

Existing hospital buildings will be decarbonised through the implementation of retro-fit projects in order to reduce energy demand and carbon emissions. Retro-fit projects within Gloucestershire Health & Care NHSFT have included LED lighting upgrades which are 69% more energy efficient and installing roof mounted solar-pv to provide between 21-25% self-generation of power to the hospital campus. The next phase of the decarbonisation plan will be making the gas boilers at Charlton lane redundant, and installing new air-source heat pumps which will be powered by renewable energy from the grid. At Charlton Lane, the proposed switch from the gas boiler to a Heat Pump for the space heating will save a predicted 86.6 tonnes CO2 per annum. representing a 81.5% improvement compared to the existing emissions.

Scoping of net zero schemes for 2024-25: Roof mounted solar PV in a number of community hospitals and LED lighting schemes in three centres

GHFT

The Trust's current focus around delivering a net zero NHS is to complete the final phases of the Salix programme of works. The works within this programme include a new insulated façade for the Tower Block, replacement of all Tower Block windows, ward level heating zone controls, replacement and insulation of the catering building roof and a new air source heat pump to serve the Pathology building.

System CDEL

		GHFT £'000	GHC £'000	Primary Care £'000	ICB £'000	Total £'000
Provider	Operational capital	36,052	8,844			44,896
ICB	Operational capital			1,114	28	1,142
	Total system operational capital	36,052	8,844	1,114	28	46,038
Provider	Impact of IFRS 16	7,412	1,215			8,627
ICB	Impact of IFRS 16				0	0
Provider	Grants & donations	500				500
Provider	National programmes - net zero	999	645			1,644
	National Programme-diagnostic digital capability programme	1,667				1,667
	National Programme-Gloucestershire Cancer Centre	500				500
Provider	Other (technical accounting)	599				599
	Total System CDEL	**47,729**	**10,704**	**1,114**	**28**	**59,575**

Agenda Item 12

NHS Gloucestershire ICB Confidential Board Meeting

31st July 2024

Report Title	**2024/25 Budget**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting					
	ICB, ICS & Partners			**Date**	
	Updates on the financial plan have been presented to various meetings Jan to May: ICB Operational Execs, ICS Strategic Execs			Various throughout the period	
Executive Summary	The ICB submitted a draft plan to NHS England as part of a wider system plan in March, this showed a system deficit of c£28m for the Gloucestershire system and the Board approved an interim, deficit budget at its meeting in March. Following this, further discussions within the system and with NHS England the System submitted a balanced financial plan on the 12th Jun 2024. The plan includes a high level of savings for all organisations and the system including a stretch target to get to breakeven. Work is ongoing to reduce this risk. Measures to help mitigate the financial position, including the system financial lock, remain in place. Close financial control and monitoring will need to be maintained during the year within the Gloucestershire NHS System and across all budget areas within the ICB in order to deliver the financial plan and identify further areas to reduce the underlying expenditure to improve the recurrent expenditure run rate.				
Key Issues to note	The Gloucestershire NHS System has worked jointly to develop a budget focusing on delivery of the System joint operational plan with the system plan now set at breakeven, each organisation is also at breakeven.				

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

Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The ICB and System risks include:

• Non delivery or slippage of savings plans
• An assumption of no industrial action and, if there is, that NHSE fund costs
• Lack of delivery against the elective recovery target and thus loss of elective recovery funding
• The presumption that urgent care demand and flow will be managed via the additional programmes of work being implemented driven by national policy

Mitigations include:

• Strong programme management within organisations across savings, elective, urgent care and other programmes
• The ongoing identification of other savings, particularly non recurrent, to mitigate slippage in savings, demand pressures and potential increases in inflation
• Strong workforce controls across the system

5 * 5 = 25
5 * 4 = 20</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">There are no conflicts of interests involved in producing this report.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td>X</td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">The ICB is proposing a breakeven budget</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">ICBs and their partner NHS Trusts and NHS foundation trusts should exercise their functions with a view to ensuring that local revenue resource use does not exceed income in each financial year.

NHS England has set the objective that each ICB, and the partner trusts that have their resource use apportioned to it, in accordance with the financial direction set out, should seek to deliver a financially balanced system, which may be referred to as a ‘breakeven duty</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">Various programmes within the budget will impact on health inequalities and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">Various programmes within the budget will impact on inequalities and diversity and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">Various programmes within the budget will impact on sustainable development and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">There is no public and patient involvement on the overall budget but the budget is in line with the ICP strategy which was informed by public and patient involvement</td></tr>
<tr><td>Recommendation</td><td colspan="4">The Board is requested to:
• Approve the 2024/25 updated budget, revenue, noting the ongoing work to reduce the inherent risk within the system and each organisation’s plans
• Support the measures required to deliver the proposed budget and improve the overall financial sustainability of the System and ICB</td></tr>
<tr><td>Author</td><td colspan="2"></td><td>Role Title</td><td></td></tr>
<tr><td>Sponsoring Director (if not author)</td><td colspan="4">Cath Leech, Chief Finance Officer</td></tr>
</table>

1.0 Introduction

The ICB submitted a draft plan to NHS England as part of a wider system plan in March, this showed a system deficit of c£28m for the Gloucestershire system and the Board approved an interim, deficit budget at its meeting in March. Following this, further discussions within the system and with NHS England the System submitted a balanced financial plan on the 12th Jun 2024. Within the plan, each organisational position is breakeven.

Close financial control and monitoring will need to be maintained during the year within the Gloucestershire NHS System and across all budget areas within the ICB in order to deliver the planned system changes and manage expenditure within or below budget levels.

The proposed budget is at Appendix 1.

2.0 Resources

The System has been issued with allocations for the full year of 2024/25, allocations total £1.377bn and are shown in appendix 1.

3.0 Changes since interim budget

Changes to the budget are shown below

£'m	
(19.9)	March 2024 interim budget
4.5	Additional savings, shared across three organisations
0.6	Small budget reductions identified within ICB
(14.8)	Position 30/04/2024
14.8	Agreed stretch target for system (approved by the Board 29th May 2024
0.0	**Plan position submitted 12th June 2024**

The additional savings of £4.5m have been split across the three organisations and added to individual savings targets.

An initial list of schemes, totalling c£13m, to close the final gap of c£15m has been developed and scheme scoping is close to being finalised. To date £4.2m has been confirmed as deliverable. Discussions are underway to identify alternative schemes where scoping shows a lack of opportunity in 2024/25 and also to close the remaining £2m which does not currently have a plan.

4.0 Productivity and Efficiency Requirements

Savings for the system are c£93m or which c£47m are recurrent and £46m non recurrent.

The focus currently is on delivery of savings, identification of schemes to reduce the value of unidentified savings and working through the route to cashable savings for the Working as One Programme.

The value of non recurrent savings within the plan is just under 50%, we will need to focus on bringing forward recurrent schemes to try to reduce this value throughout the year, if we are able to do this then we put the system and organisations into a better financial position for 2025/26.

Organisation	Savings requirement	Unidentifed	Identified Schemes Total	High	Medium	Low	Recurrent	Non-Recurrent
	£000	£000	£000	£000	£000	£000	£000	£000
Gloucestershire Hospital's NHS Foundation Trust	37,389	5,298	32,091	15,388	10,583	11,418	17,147	20,242
Gloucestershire Health & Care NHS Foundation Trust	12,980	3,738	9,242	3,738	5,781	3,461	7,319	5,661
ICB	29,578	-	29,578	1,500	21,004	7,074	13,694	15,884
System-held (within 12/6/24 efficienices plan)	13,293	1,924	11,369	8,454	3,000	1,839	9,175	4,118
Gloucestershire System Savings Plan - 2024/25	**93,240**	**10,960**	**82,280**	**29,080**	**40,368**	**23,792**	**47,335**	**45,905**
Percentages compared to Savings Plan Requirement	**100%**	**12%**	**88%**	**31%**	**43%**	**26%**	**51%**	**49%**

5.0 Reserves

Reserve balances relate to approved commitments or allocations received for a specific purpose which have been approved in either this or a previous financial year.

Any investments, where an approved business case or contract variation has yet to be signed off, will be held in reserves until approval and additional spend is incurred.

6.0 Risk Management

The interim System budget includes significant risk for all organisations:

- High levels of savings to be delivered
- Inflation risk, particularly, energy, food, care market, prescribing
- Risk of non delivery of the elective recovery leading to reduced income to the system but an inability to remove costs
- The assumption that demand can be managed within the current financial budgets
- Industrial action will lead to reduced elective activity, reduced savings and additional direct costs
- New NICE TAs could lead to significant increases in costs

In year risk management measures will include:

- System review of all bids for both revenue and capital in year to ensure that no decisions impacting on the overall recurrent cost base for the system are taken without full sign off
- Use of additional allocations in year
- The use of non recurrent slippage in year
- Ongoing development of recurrent savings plans
- Other non-recurrent measures to be determined

- Vacancy and other staffing controls for all types of staff

In order to manage in year financial risks the following actions were agreed previously by Boards and remain in place:

- Developments funded which are not unavoidably committed will be retained within reserves. Release of developments will be subject to a business case sign off. Non recurrent slippage will be retained to support the overall system financial position
- All additional allocations/successful bids will be reviewed by Executive teams in advance of any commitment to test whether a contribution to the financial position can be identified.
- No controllable expenditure will be committed if there is no identified funding source unless the risk of not proceeding is deemed to be too significant.
- Underspends will be removed from budgets periodically throughout the year on a recurrent or non-recurrent basis, depending on the situation, in year following discussion with the relevant Director.
- The first call on any budgets released whether recurrently or non recurrently will be to support the overall management of the System financial position
- Workforce changes will be reviewed by a system group to ensure they align to agreed changes
- System Lock remains in place (three system organisations)

8.0 Next Steps

- Ensuring delivery of the 2024/25 identified savings plans with a focus on increasing the level of recurrent savings and testing every area of potential opportunity to increase savings further
- Maintaining controls in place to manage expenditure within budgets
- Focus on improving productivity so we can manage increasing demand within current costs and, in some circumstances, take cost out. This will include widening the focus to include community and mental health services where possible
- Staffing review across the system to test changes and undertake further work as required
- Continued development of the medium term plan that delivers operational recovery and performance and moves the System back to financial sustainability

9.0 Recommendation

The Board is asked to:

- Approve the 2024/25 updated budget, revenue, noting the ongoing work to reduce the inherent risk within the system and each organisations plans

- Support the measures required to deliver the proposed budget and improve the overall financial sustainability of the System and ICB

Appendix

- Appendix 1 – updated revenue budget

2024/25 Interim Budget **Appendix 1**

			Admin/Prog £'000	Delegated Co-Commissioning £'000	Total ICB £'000
ICB	Allocations	Programme Allocation	1,104,407	2,854	1,107,261
		Pharmacy, Ophthalology and Dental Allocation		53,993	53,993
		Elective Recovery Funding	27,222	1,083	28,305
		Additional Allocations including SDF	55,690		55,690
		Primary Care Co-Commissioning		121,570	121,570
		Running Costs Allocation	10,403		10,403
	Total Allocations		**1,197,722**	**179,500**	**1,377,222**
	Expenditure	Acute	650,592		650,592
		Community, CHC & Placements	233,325		233,325
		Mental Health	138,282		138,282
		Primary Care (including prescribing)	137,763	124,424	262,187
		Pharmacy, Ophthalology and Dental		55,076	55,076
		Other commissioned services	27,357		27,357
		Corporate (Running Costs)	10,403		10,403
			0	0	0
	Total Expenditure		**1,197,722**	**179,500**	**1,377,222**
	Net Position Surplus/(deficit)		**0**	**0**	**0**

		GHC £'000	GHFT £'000	Total Provider £'000
Provider Position	Income from patient care activities - external to the system	16,809	190,271	207,080
	Other operating Income	16,993	46,191	63,184
	Total income external to System	33,802	236,462	270,264
	Income from patient care activities (internal to System)	255,529	524,231	779,760
	Total Income	**289,331**	**760,693**	**1,050,024**
	Employee expenses	223,520	479,412	702,932
	Other operating expenses	63,887	267,040	330,927
	Non operating expenditure	1,924	14,241	16,165
	Total expenditure	**289,331**	**760,693**	**1,050,024**
	Net Position Surplus/(deficit)	**0**	**0**	**0**

System Position	**0**

Agenda Item 12

NHS Gloucestershire ICB Public Board Meeting

Wednesday 31st July 2024

Report Title	**Development of Health Services in Lydney, Forest of Dean**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					x		
Route to this meeting	The paper has been discussed at ICB Operational and Strategic Executive. The plans for the new health centre in Lydney have been through the Primary Care Commissioning Committee of the Integrated Care Board. The proposals set out in this document have been shared with local stakeholders and members of the public in the Forest of Dean district.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	ICB Operational Executive	11/06/2024	ICB Strategic Executive	20/06/2024			
Executive Summary	The paper sets out several areas that relate to the development of health services in the Lydney area of the Forest of Dean. This includes an overview of a new practice development planned for the area, an outcome of an engagement exercise completed in 2021 and an options appraisal commissioned as a result of the engagement exercise to examine whether it would be possible to develop an additional urgent care service specifically located in the Lydney area following the recommendation (which was accepted) made by the Citizens Jury to locate the new Forest of Dean hospital in Cinderford.						
Key Issues to note	The paper includes an engagement report that was produced in 2021 but has not yet been shared in public. This was due in part to competing priorities during the COVID pandemic, and the considerable delays in securing the way forward for the capital scheme for Lydney health centre. These have been outside of the control of the ICB team, but the Board will wish to be aware of the delay and the concerns that some local stakeholders have raised with regards to this.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	There are no specific risks relating to this paper that need to be referenced here. There are references to our UEC programme (both strategic and operational), and our system financial and workforce challenges set out in the options appraisal presented at Annex 3, but this paper sets out an options appraisal set in the context of the accepted risks already present to the system and does not, in the way forward proposed, either increase or reduce the risk profiles already described. Add a risk rating, even if low: (4x2) 8 (3x2) 6 (residual meaning accepted risk)						

<table>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">Answer the following questions:
There are no conflicts of interest that have had to be managed in relation to the production of this paper. The work done to complete the options appraisal was delivered by an external consultant employed by the ICB to do a full and in-depth assessment of the factors that needed to be considered.</td></tr>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td></td></tr>
<tr><td>Financial Impact</td><td colspan="4">There is no specific financial impact for the ICB because of the options appraisal or the outcome of engagement report. The capital scheme has an impact, but this has been approved under separate governance through the Primary Care Commissioning Committee, and the update relating to the new capital scheme for Lydney is provided only for information / background context in this report.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="4">There are no legal issues that relate to this paper that the author is aware of. There is a statutory requirement to give ‘due regard’ to the outcome of engagement report. In part this has been delivered through the commitment to undertake the level of detailed work that has been put into completing an options appraisal to consider the potential viability of an urgent care offer for Lydney, but it is also important that the Board review in depth the feedback that has been received. The feedback was clear that the local population in the South of the Forest would prefer a local solution for the South of the Forest, and this feedback needs to be considered when reviewing the issues presented in the options appraisal report.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="4">Local people have told us that some people will face some increased challenge in accessing services delivered from the new Forest Hospital when they need to travel from addresses in the south of the district. A comprehensive travel analysis is set out in the options appraisal for consideration on the scale / acceptability of this increased travel time.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="4">An EIA has been completed and the outcome indicates that the proposed way forward should not have a material impact on equality and diversity.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="4">The proposed way forward ensures that the most efficient use will be made of the new community hospital in the Forest of Dean.</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="4">There has been considerable engagement with the public on issues relating to health services in the Forest of Dean, there is an outcome of engagement report relating specifically to the options appraisal presented in this pack. There are plans to share the proposed way forward with local stakeholders and members of the public via the Forest Health Forum in July when the pre-election period has ended.</td></tr>
</table>

Recommendation	The ICB Board is requested to: • Note: the new proposed practice development for the Lydney area, which is the next stage in developing the infrastructure for services delivery in the Forest of Dean • Discuss: and give 'due regard and consideration' to the public engagement report which gave the opportunity for further feedback to be collected relating to urgent care services in the Forest of Dean, particularly the access to urgent care services from the South of the Forest of Dean • Approve: the proposed way forward for urgent care services for the Forest of Dean as set out in the options appraisal paper attached
Author	**The different parts of the paper have several different authors includes Andrew Hughes, Caroline Smith, Ellen Rule, Helen Bailey (independent consultant employed by the ICB to complete the options appraisal)**
Sponsoring Director (if not author)	**Ellen Rule; Director of Strategy & Transformation / Deputy CEO**

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

Executive Summary / Overview

1. Introduction

The paper sets out an overview of the development of health services in Lydney specifically and considers these in the context of service development across the Forest of Dean district. This will include a new GP practice development for the Lydney area with incorporated wellbeing services, which is the next stage in developing the infrastructure for services delivery in the Forest of Dean. The new community hospital for the district has now opened, and new health centres developed for Cinderford and Coleford. A public engagement report is shared alongside this paper relating to further feedback that was collected in 2021 relating to urgent care services in the Forest of Dean, particularly hearing feedback relating to the access to urgent care services from the South of the Forest of Dean. Alongside this, there is a paper setting out an options appraisal which has considered the way forward for urgent care services across the Forest of Dean as set out in the options appraisal paper attached. Three papers are attached to this executive summary:

- A set of slides providing an overview of the planned development of a new Primary Care Centre for Lydney and district
- An outcome of engagement report relating to an engagement exercise completed in 2021 to consider the specific issue of access to urgent care services from the south of the Forest.
- An in-depth options appraisal to consider the viability providing a minor injuries service in Lydney following the feedback received in the engagement exercise that this would be welcomed by the local population

2. A new Primary Care Centre for Lydney and District

The Lydney and Severnbank practices with a combined list size of around 12,000 patients will be collocating and moving to new premises situated in the centre of Lydney. This will be a reconfiguration and transformation of the existing Coop building that will have a completely new and purpose-built feel. It is sized for 15,000 with the ability to expand further, if required. The building will include a range of clinical and clinical support spaces to deliver general medical services. It will include a large community wellbeing activity space. The booking of this space will be managed by an appropriate local organisation on behalf of the practices. It should also be noted that Assura are also providing some additional space for this at no extra rental charge. Subject to final approval, Gloucestershire Health & Care Foundation NHS Trust will also move into the facility to deliver a number of services including community outpatients, and the old Lydney Health Centre and Severnbank surgery will be closed.

The development gives the long-term assurance and confidence to patients in Lydney that there is suitable infrastructure in place to support a sustainable primary care service and responds to the increasing local population over the next 10 years and beyond. This supports delivery of key service strategies, particularly around placed based service provision, delivery of the ICB's primary care strategy and delivery of an aligned element of the Forest of Dean Community Service review. It creates a single primary and community health and wellbeing hub, which provides further opportunities to develop integrated neighbourhood services and facilitate more flexible service delivery.

More specifically, it leads to an expansion of training at student, foundation year and GP registrar levels. There will be an increase in number of clinical rooms with 20 in total for both practices and more appropriately sized to modern standards. It allows for the provision of flexible space available for use by local community groups and other general wellbeing activities. The total capital costs of the new facilities are around £7.5m. This will be funded by the Assura, the Developer, who will receive rental from the Practices, who will sign a 30- year lease. The lease costs will be reimbursed by the ICB along with rates. Subject to planning approval

and successful tender, building work is expected to start by the end of February 2025 with the building fully open by March 2026. *(Please see detailed set of slides included as Annex 1 to this paper for further details*)

3. Outcome of engagement report:

Following a period of Consultation in 2017, the Board of Gloucestershire Care Services NHS Trust (now Gloucestershire Health and Care NHS Foundation Trust; GHC) and the Governing Body of NHS Gloucestershire Clinical Commissioning Group (CCG) approved the option to build a new community hospital in the Forest of Dean. This new hospital will replace The Dilke Memorial Hospital and Lydney and District Hospital. A Citizens' Jury, made up of local people, met over four days in August 2018. Having reviewed extensive information, they recommended that the new hospital should be in Cinderford. This recommendation was formally approved by the boards of the then CCG and GHC.

Further engagement, followed by a period of Consultation with local people and staff during 2020 informed the make-up of services for the new hospital. The site for the new hospital was announced in December 2019 as the Collingwood Skatepark and Lower High Street Playing Field in Steam Mills Road, Cinderford. The Board of GHC approved the Full Business Case for the new hospital in July 2021. The new hospital opened in the spring of 2024 and is now operational.

During the last phase of engagement regarding the services for the new hospital, concerns were raised by some local residents around the availability of urgent care in the southern areas of the Forest and the challenge for residents in terms of distance and accessibility to the new hospital in Cinderford. Alongside the consultation in late 2020, the CCG therefore gave a public commitment to explore if it might be possible to develop other options for the provision of additional urgent care services in the Lydney area. Throughout the consultation exercise for the new hospital, local people were given the opportunity to register an interest in being involved in this explorative work and consequently an online workshop was arranged for 16 June 2021 (online due to the pandemic). The workshop was independently facilitated by The Consultation Institute.

The workshop provided an opportunity to discuss ideas and take account of potential opportunities and constraints. It was not intended to reconsider the decision to build a new hospital in Cinderford, which will replace the two existing hospitals in the Forest of Dean. The view of many attending the workshop (who were largely from the south of the Forest) was that urgent care services should be provided in the south of the Forest. The rationale for this focussed on the potential rise in population and the difficulties with travel and transport from the south of the Forest to both Cinderford and Gloucester.

A commitment was made to complete an in-depth options appraisal to consider whether this would be deliverable.

4. Options appraisal

As can be seen from the summary, there was a clear response to the outcome of engagement report asking us to consider whether it would be possible to deliver urgent and emergency care services for the South of the Forest, in addition to the services that would be provided in the new hospital and from Primary Care. To consider this question carefully a detailed options appraisal has been completed. This is attached to this paper in full for consideration by the board.

The options have been evaluated against a range of criteria within four domains as outlined below (Strategic, Financial, Quality and Practicality):

Strategic	**National**	Does the option align with national policy and national direction of travel?
	Local	Does the option align with local policy and direction of travel?
Financial	**Affordability**	Does the ICB have (or can make available) sufficient funds to invest in the option?
	Value for Money	Does the option use public resources in a way that ensures that they are being well used and their contribution maximised?
	Return on Investment	Will system savings be made elsewhere in the Gloucestershire system as a result of implementation of the option?
Practicality	**Resourcing**	Is there sufficient and appropriate clinical and non-clinical workforce available to implement the option?
	Continuity of Service	Will the service be able to be consistently available in the short, medium and long term? Will resourcing the option negatively impact on other services?
	Accessibility	Does the option provide "reasonable access" within the context of the wider ICS?
Quality	**Patient Safety**	Does the option provide a service that consistently meets the required standard of care for patients without unnecessary risk?
	Parity of Experience	Does the option provide patients with a similar experience to patients accessing care elsewhere in the ICS?

It should be noted that the practicality question did not include a question regarding premises in Lydney, as we have received assurance that in the context of the new practice development now being agreed to proceed there would be sufficient space to accommodate a small UEC service in Lydney should this be required as an outcome of the options appraisal. Space may have been an issue within existing facilities, but this has not been assessed now that we are confident the new development is secure and proceeding as planned.

Following careful consideration of all the domains above, the outcome of the options appraisal is that it is not considered viable to deliver an urgent care service in Lydney. The Board is asked to approve this outcome, in the clear understanding that this will be not the preferred approach for those local people who contributed to the engagement exercise in 2021.

5. Annexes

Annex 1: Overview of the development of a new Primary Care Centre for Lydney and district
Annex 2: Outcome of Engagement Report
Annex 3: Appraisal of Options for the Provision of Minor Injuries Services in Lydney

Annex 3:

Appraisal of Options for the Provision of Minor Injuries Services in Lydney

1. Background

The decision with regards to the provision of community urgent care, that is, minor injuries and minor illness services (MIIUs) in the South of the Forest of Dean is the final step on a journey that has taken place within Gloucestershire ICS over the last five years. Significant engagement and consultation have been undertaken to establish where the new community hospital in the Forest of Dean will be, and the services that will be delivered within the hospital and from other locations in the Forest district. It is recognised that the new community hospital is only one feature in the overall health and care landscape, and that alongside this there has been the development of key primary care infrastructure across the district with new health centres already built for Cinderford and Coleford, and with a development now underway for Lydney.

January 2018	Following earlier engagement and Consultation, Gloucestershire CCG (the then commissioner of health care services for Gloucestershire) Governing Body and Gloucestershire Health and Care NHS Foundation Trust ((GHC), formerly GCS) Board approved the proposal to develop a new community hospital in the Forest of Dean.
August 2018	Approval of the Citizens' Jury recommendation to build the new hospital in, or near, Cinderford.
August 2019	Engagement to help develop ideas about the range of services in the new hospital.
December 2019	Site for the new hospital announced.
October – December 2020	Consultation regarding services to be provided in the new hospital.
January 2021	Decision regarding services in the new hospital and a commitment to involve people further in discussions about access to urgent care services in the south of the Forest of Dean.
2022- 2024	Development of a business case to develop a new Primary Care Centre for Lydney
November 2023 – January 2024	Appraisal of options for provision of community urgent care services in the Forest of Dean.

Figure 1: Key steps in developing services for the South of the Forest of Dean

The proposal for the Forest district developed through the new hospital business case was for urgent care services to be delivered from the new hospital, however it was acknowledged that transport and accessibility in the Forest of Dean is difficult, and an agreement was made to consider options to deliver Urgent Care in the district in response to local feedback. Specifically, local stakeholders have been keen to revisit whether there should be some form of community urgent care provision within Lydney in addition to the service delivered from the Cinderford site.

This options appraisal takes these concerns into consideration alongside the wide range of responsibilities of the ICB and ICS in relation to healthcare provision. It provides up to date analysis and consideration of changes that have occurred in the intervening period between the original planning for services on the Cinderford site and the present, including changes driven by the Covid-19 pandemic.

As set out in the ICS Joint Improvement Plan, all programmes of work are expected to be robustly tested, to demonstrate their impact whether that be financial, increased productivity or quality and outcome improvements

2. The Three Options Under Consideration

This paper explores three potential options for community urgent care provision for patients in and around Lydney. An outline of those options is set out in Figure 2 below. Several of the criteria will need further discussion and agreement if the option becomes the preferred option.

Option Number	Option 1	Option 2	Option 3
Option Description	Establish a new MIIU in Lydney	Undertake all MIIU provision within the new Community Hospital in Cinderford	Commission a primary care led minor injuries service similar to the Winchcombe model
Provider	TBC if agreed	GHC	TBC if agreed
Hours of Operation	Not yet identified	08:00 to 20:00 Seven days per week	08:00 to 20:00 5 days per week
Xray	No	Yes	No
Age Profile	Not yet identified	All ages (including under 5s)	Not yet identified
Available Capacity	Not yet identified	17,364 attendances per year (baseline based on original modelling in 2018-2019)	2018-19 presumption of 3,460 attendances per year / agreement by potential provider

Figure 2: Outline of options for community urgent care provision within the Forest of Dean

3. Evaluation Criteria

Each option has been evaluated against a range of criteria within four domains as outlined below (Strategic, Financial, Quality and Practicality).

Strategic	National	Does the option align with national policy and national direction of travel?
	Local	Does the option align with local policy and direction of travel?
Financial	Affordability	Does the ICB have (or can make available) sufficient funds to invest in the option?
	Value for Money	Does the option use public resources in a way that ensures that they are being well used and their contribution maximised?
	Return on Investment	Will system savings be made elsewhere in the Gloucestershire system as a result of implementation of the option?
Practicality	Resourcing	Is there sufficient and appropriate clinical and non-clinical workforce available to implement the option?
	Continuity of Service	Will the service be able to be consistently available in the short, medium and long term? Will resourcing the option negatively impact on other services?
	Accessibility	Does the option provide "reasonable access" within the context of the wider ICS?
Quality	Patient Safety	Does the option provide a service that consistently meets the required standard of care for patients without unnecessary risk?
	Parity of Experience	Does the option provide patients with a similar experience to patients accessing care elsewhere in the ICS?

Figure 3: Evaluation criteria applied to appraising options for community urgent care in the Forest of Dean

Each of the three options have been evaluated across each individual domain and assigned a RAG rating. This domain-based appraisal is presented at the end of each section of this paper. Finally, the evaluations across the Strategic, Financial, Quality and Practicality domains are brought together into an overall evaluation and a resulting recommendation.

4. Strategic

4.1. National Strategy

Development of Urgent Treatment Centres (UTCs) has remained a focus and priority within National Urgent Care Strategy on an ongoing basis for a significant period. The most recent iteration of national direction in relation to UTCs, *The Delivery Plan for Recovering Urgent and Emergency Care Services (2023)*, builds on expectations set out in:

- The *"Next Steps on the NHS Five Year Forward View (5YFV)"* published on 31 March 2017, outlining a focus on roll-out of standardised Urgent Treatment Centres
- *"Urgent Treatment Centres – Principles and standards"* in January 2017, subsequently updated in 2021 and 2023 outlining clearly the standards that Urgent Treatment Centres need to meet
- *The Long-Term Plan (2019)* reaffirming the commitment to development of Urgent Treatment Centres, with an additional requirement to provide the option of appointments booked through a call to NHS111
- The *Clinically Led Review of Urgent and Emergency Care Standards (2020)* again identified UTCs as one of five key themes

The rationale behind the development of UTCs is to maximise the role that community urgent care services can play in preventing unnecessary ED attendances. This is to be achieved by providing a comprehensive alternative option where, whenever possible, patients can have their urgent care needs diagnosed and treated in a single visit to a single site.

Nationally, patients have reported confusion as to what is available at sites with a variety of names, MIUs, MIIUs, Walk in centres, urgent care centres and so on and therefore by standardising the offer nationally, this lack of understanding will be removed with patients able to navigate the urgent care landscape even when they are in an area outside of their own place of residence.

The full list of standards for a UTC is extensive, however, in summary, UTCs are expected to:

- Open 7 days a week, 12 hours a day as a minimum
- See both booked and walk-in patients
- See both minor injuries and minor illness
- See patients of all ages including young children
- Have a named senior clinical leader supported by an appropriate multi-disciplinary workforce
- Have a consistent diagnostic offering (Xray, blood testing etc.) on site or where this is not possible, have clear, seamless pathways that ensure that the patient is not re-triaged on arrival at the site of the diagnostic
- Accept appropriate ambulance conveyance
- Have access to patient records and the ability to send a post event message (PEM) that is, details of the consultation undertaken at the UTC (including appropriate clinical information) to the GP practice where the patient is registered
- Comply with specific technical requirements including national reporting and the ability to have patients directly booked into the service from NHS111

To meet the requirement for the breadth of provision in a cost-effective manner, a UTC, requires a significant number of patient attendances per year. NHS England continue to recommend ICSs where possible should move towards a UTC model.

4.2. Local Strategy

4.2.1. Treatment of Minor Illness in Primary Care

4.2.1.1. General Practice Capacity

There is a commitment within Gloucestershire ICB that patients with a primary care need should have that need met in primary care where possible, as this is the most appropriate setting. A significant proportion of attendances at Gloucestershire's MIIUs are by patient's experiencing a minor illness, for example earache, sore throat, pain when passing urine. When a patient attend's their own GP practice, the clinician attending to their needs has access to their full patient record to support diagnosis and treatment, this is particularly

important where patients have ongoing needs or long-term conditions.

The development of the new Lydney Primary Care Centre has now been agreed. The co-location of the current Lydney practice and Severnbank surgeries on a newly developed site will impact around 15,000 to 16,000 patients. The Primary Care Centre will have the ability to expand up to 19,000 patients delivering the full range of general medical services. The ICB has committed considerable funds to the establishment of the Lydney Primary Care Centre and the expectation is that this will be open to patients by early 2025.

Work has been undertaken in Gloucestershire to ensure that there is additional capacity within primary care including implementation of Enhanced Access. Enhanced Access refers to the provision of pre-bookable routine GP appointments outside of core contractual hours (8:00am to 6:30pm on weekdays). Enhanced Access is currently in place in Gloucestershire between 6.30pm and 8:00pm Monday to Friday, for four hours on a Saturday morning and with some cover on Saturday afternoons or Sunday mornings. Enhanced Access in Gloucestershire is provided by Primary Care Networks, groups of GP practices working together. The ICB currently spend £436,000 per month (£5.119m per year) on this additional capacity, £0.5m of which is spent in the Forest of Dean. As well as increasing capacity in primary care, the service is intended to provide patients with more convenient access to GP services, including physical and digital appointments. It is recognised that there is considerable pressure on primary care capacity at the present time due to a significant increase in demand over recent years.

4.2.1.2. Pharmacy Services

It should be noted that the primary care offer within Gloucestershire is not limited to general practice. Pharmacy has always been an important and valued service for patients. The community pharmacy offer has been further enhanced by the introduction of the national NHS Community Pharmacist Consultation Service (CPCS). The CPCS was launched by NHS England on the 29th October 2019, to facilitate patients having a same day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine. The service is helping to alleviate the recognised pressure on GP and emergency departments capacity, in addition to harnessing the skills and medicines knowledge of pharmacists. Should the patient need to be escalated or referred to an alternative service, the pharmacist can arrange this.

The first phase of the CPCS offered patients the option of having a face-to-face or remote consultation with a pharmacist following an initial assessment by an NHS111 call advisor. Urgent Treatment Centres are now able to refer into the service and additional pathways are in development. From Spring 2023, Pharmacies have the option to register for the NHS Pharmacy Contraception advanced service for the ongoing supply of oral contraception (All community pharmacists offering the service will have demonstrated competence in the specific skills and knowledge required). Twelve pharmacies within the Forest of Dean provide the Community Pharmacist Consultation Service.

In addition to the services outlined above, under the new name of “Pharmacy First”, further services are being added to the CPCS offer including seven new minor illness clinical pathways (uncomplicated UTIs, shingles, impetigo, infected insect bites, sinusitis, sore throat and acute otitis media). Patients with these symptoms or conditions will be able to attend the pharmacy to received diagnosis and treatment including the prescribing of medications such as antibiotics.

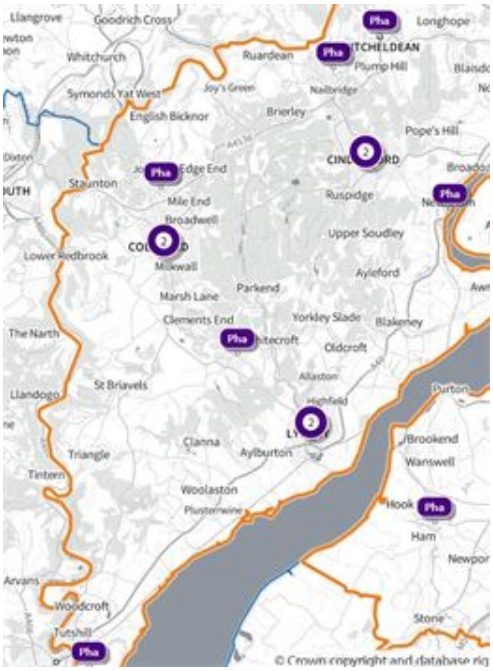
Pharmacies in The Forest of Dean Providing the CPCS	
Badham (Newnham)	
Boots (Bream)	
Boots (Cinderford)	
Cinderford	
Coleford	
Day Lewis (Berry Hill)	
Day Lewis (Chepstow)	
Day Lewis (Coleford)	
Day Lewis (Newent)	
Forest (Lydney)	
Lydney	
Mitcheldean (Mitcheldean)	

Figure 4: Pharmacies in the Forest of Dean offering the CPCS Service

4.2.2. Effective Direction of Patients by NHS111

In line with national policy as stated in the national *"Delivery plan for recovering urgent and emergency care services 2023",* Gloucestershire ICS is committed to making NHS111 the first port of call for patients with an urgent care need. Increasingly, patients requiring services will be encouraged to contact NHS111 rather than self-present at a service that may or may not be the most suitable for meeting their needs. Gloucestershire ICB is re-procuring the Integrated Urgent Care Service (111 and out of hours) with a new service specification and associated investment. Use of NHS111 (both telephony and online) provides a valuable opportunity for patients to "talk before they walk". This increase in effective direction of patients provides the opportunity to direct patients with minor illnesses towards primary care including general practice and community pharmacy. It also provides the opportunity to support patients who do not require a service to self-care.

4.3. Strategic Domain Evaluation

Based on the national and local strategic positions outlined above, each option has been evaluated, the outcome of this evaluation is outlined below.

Option Number	Option Description	Evaluation	
Option 1	Establish a new MIIU in Lydney	**National**: Given the size of the population that would be served by a community urgent care service in Lydney, within the context of the ongoing commitment to a community urgent care site in Cinderford, it would not be possible to consider commissioning a Lydney UTC in line with national policy. Whilst Gloucestershire has not prioritised moving to a UTC model of community urgent care and continues to have sites that are not compliant with national policy, adding a further non-compliant site (noting that the Forest has now been serviced by a single site for more than three years) would be viewed dimly by NHS England as it would take Gloucestershire further away from compliance. **Local**: Creating additional capacity for minor illness attendances at an MIIU site goes against local policy on ensuring that minor illness is managed in primary care. Such a move could only be justified if there were to be sufficient genuine minor injury demand requiring provision more than that which is commissioned to be met from general practice, community pharmacy and NHS111. Even in this scenario, local strategy suggests solutions and / or additional capacity would first be sought from within primary care (primary care in this instance includes primary medical, pharmacy, dental or optometrists).	
Option 2	Undertake all minor injuries provision within the new Community Hospital in Cinderford	**National**: Whilst Gloucestershire is not compliant with national policy with regards to UTC implementation, the consolidation of minor injuries activity on a single site within the Forest of Dean is in line with the principle of moving to a more comprehensive model of provision for patients that meets patients' needs without the requirement to be referred to a different site for diagnostics or treatment. Subject to compliance with the national UTC specification, the considerable number of attendances expected at the Cinderford site, in a single site model, would suggest that Gloucestershire ICB could look to have the Cinderford site designated as a UTC. This would be a major step towards complying with national policy. **Local**: Consolidation of all MIIU activity onto the Cinderford site would be compliant with local policy as it would not create additional minor illness capacity within community urgent care. Making this option fully compliant with local policy would require an ongoing focus on increasing the use of: • NHS111 as the gateway to urgent care services so that patients attend the most appropriate service to meet their need • General Practice appointments, including those made available through Enhanced Access • The Community Consultation Scheme as an effective and convenient way of meeting some patient's needs	

Option Number	Option Description	Evaluation	
Option 3	Commission a primary care led minor injuries service similar to the Winchcombe model	**National**: As outlined in relation to Option 1, a primary care led minor injuries service in Lydney would, through necessity driven by size, be a significant deviation from national policy and the drive for standardised UTC provision. **Local**: General practice is currently commissioned to meet minor illness demand through the core GP contract and through Enhanced Access and as such, care would be needed to ensure that only those MIIU cases that are not within the remit of primary care within the current general practice contract are funded separately through an MIIU contract.	

Figure 5: Evaluation of options against the criteria within the strategic domain

5. Financial

5.1. Affordability

5.1.1. The ICB Financial Position

Gloucestershire ICS is committed to fiscal responsibility. In the Gloucestershire Joint Improvement Plan the ICS lays out four key principles, the second of which is:

"We will live within our financial means and ensure that we robustly test what we do to ensure that it delivers value."

Like other systems, Gloucestershire ICS has a challenging financial position. Although the 2023-24 financial plan was breakeven for the system, this included a high level of savings and non-recurrent financial savings, efficiencies and income. The system is developing a detailed medium term financial plan which will include detailed planning for 2024-25 with the aim of delivering a breakeven financial plan. The focus within the plan is on:

- Reviewing and reducing the recurrent expenditure in 2023-24 and going into future years
- The development of savings plans

The System has implemented system control processes regarding any investment requests, and any investment will effectively worsen the underlying recurrent deficit position and extend the challenge regarding the need to find material savings across other service lines.

5.1.2. Urgent Care Funding In the Forest of Dean

Whilst the funding of the new Cinderford Community Hospital has been agreed and is available to fund the delivery of both the infrastructure and the ongoing service delivery, no funding has been assigned to the maintenance of an MIIU in Lydney once the Cinderford site is live. New monies would need to be identified to fund a second MIIU site in the Forest of Dean. The decision to fund a second site would sit alongside other competing demands for funding, not just within urgent care, but across the full range of service areas for which the ICB is responsible.

5.1.3. Service Costs

There are a number of cost pressure issues that will increase the ongoing costs associated with service delivery within MIIU provision these include:

- Inflation pushing up the cost of supplies - Julian Kelly, NHSE Deputy Chief Executive and Chief Financial Officer stated in October 2023 that inflation was running at 10.2% compared with reasonably planned levels of 2%
- NHS staff pay rises - Rather than the planned pay increase of 2%, a 5% award was agreed

Cost of service delivery in MIIUs across Gloucestershire is currently around £6,621,790 with £4,894,674 attributable to the treatment of Gloucestershire patients. As well as applying pressure to existing ICS service commitments, the cost pressures identified mean that the cost of a Lydney MIIU whether run by GHC or as a primary care led service are likely to be considerably higher than the figures of £201,787 previously quoted in 2018-19 given the rate of inflation since this time.

5.2. Value for Money

5.2.1. What constitutes Value for Money?

Intelligence generated through discussion with community urgent care leads across the South West suggests that the minimum size for a cost effective MIIU is approximately 9,000 patients per year. This is on the following basis:

Number of hours of MIIU operation per day	10 Hours 9 Hours excluding breaks	Based on 08:00 – 18:00 or 09:00 – 19:00
Number of patients seen per hour by a single clinician	3 Patients	This is a conservative estimate, 4 patients per hour used as a benchmark in some systems
Patients seen per day	27	3 patients x 9 hours
Patients per year	9,855	27 * 365

Figure 6: Activity required to deliver value for money in an MIIU

It is reasonable to expect that variation in the flow of patients will result in some inefficiencies and hence the figure of 9,855 has been rounded down to 9,000, however, beyond a certain point, fewer than three patients requiring diagnosis and treatment per hour builds in a significant degree of wastage in terms of investment in human resources, both clinical and any administrative support working alongside the clinician in place. Furthermore, activity volumes that leave clinicians without clinical activity for significant periods of time are unfulfilling for the clinician involved and can have an impact on the currency of their experience as well as recruitment and retention.

In addition to consideration of clinician capacity, consideration also needs to be given to Xray provision. As with clinical capacity, it is important to ensure that both radiology equipment and radiographers are as close to fully occupied as possible to ensure that the benefit of both resources can be fully leveraged. Where a unit does not have Xray capacity, patients are required to travel to a second site in order to have their investigation undertaken and diagnosis made. It is generally considered that Xray provision on sites providing only MIIU services (i.e without the full range of hospital services) is difficult to justify in terms of the volume of patients requiring the diagnostic and the requirement to have a radiographer available to undertake the investigation.

5.2.2. Volume of Activity:

In a self-reported return to the NHSE National Team[1] in May 2023, it was reported on average 1,270 patients per month were being seen at Lydney and District Hospital MIIU[2] equating to 15,240 attendances per year. This is during the period when Lydney has been operating as the only MIIU for the Forest of Dean following the closure of the MIIU at the Dilke during the pandemic (which did not reopen due to IPC and workforce constraints). Emergency Care Data Set (ECDS) figures for the twelve months ending 30th September 2023 suggest that there were 15,558 attendances at the unit during that period. Those attendances breakdown as follows:

[1] UTC Regional Reports - UTC Regional Reports - All Documents (sharepoint.com)
[2] ECDS data extract provided by NHSE SW Business Intelligence Team

Patient Type	Attendances	Comments
All Patients Attending Lydney MIIU	15,558	Includes: • Patients attending Lydney MIIU regardless of where the patient is from or registered with a GP practice • Patients with no GP practice recorded (***125***) • Welsh patients "commissioned" by Gloucestershire ICB (***2171***) • Patients registered outside of Gloucestershire who are not Welsh patients (***903***)
Gloucestershire Commissioned Patients Attending Lydney MIIU	14,530	Includes: • Patients registered with a Gloucestershire GP practice (***12,234***) • Patients with no GP practice recorded (1***25***) • Welsh patients "commissioned" by Gloucestershire ICB (***2171***)
Gloucestershire Registered Patients Attending Lydney MIIU	12,234	Includes: • Only those patients registered with a GP practice in Gloucestershire

Figure 7: MIIU attendances at Lydney MIIU between 1st October 2022 and 30th September 2023

As demonstrated in the table above 21.4% of all attendances at Lydney MIIU are by patients who are not registered with a Gloucestershire GP practice. It should be noted that it is Gloucestershire patients that Gloucestershire ICB has responsibility and funding for.

Calculation: 15,558 – 12,234 = 3,324
(3,324 / 15,558) *100 = 21.4%

Figures suggest that approximately three quarters (3/4) of attendances between 1st October 2022 and 30th September 2023 were self-presentations at the unit with no prior triage. This suggests that there is further work to be done (and benefits to be leveraged) in Gloucestershire to achieve the local ambition of "talk before you walk" and redirection to the most appropriate service. Self-presentation figures are slightly higher at Lydney MIIU than at other MIIUs where on average approximately two thirds (2/3) of patients self-presented.

12% of cases are identified in the ECDS for the period 1st October 2022 to 30th September 2023 as having received radiology, that is on average:

- 866 patients per year
- Approximately five per day
- Less than one per hour

The number of patient attendances at all Gloucestershire MIIUs for the period 1st October 2022 to 30th September 2023 are outlined below. Based on ECDS data for each of the MIIUs in Gloucestershire (all patients regardless of GP practice registration), Lydney saw the second highest number of patients. In each case the figures for each MIIU suggest that they are seeing (more or less) the 9,000 patients required to deliver a value for money service.

Provider	Total Attendance	Rank
Cirencester Hospital	18,080	1
Lydney Hospital	15,558	2
North Cotswold Hospital	10,690	4
Stroud General Hospital	15,428	3
Tewkesbury General Hospital	9,833	6
Vale Community Hospital	10,181	5

Figure 8: MIIU activity within Gloucestershire 1st October 2022 to 30th September 2023

It should be noted that the attendances at Lydney MIIU were all Forest of Dean attendances as Lydney was the only MIIU service based in the district following the closure of Dilke MIIU during the Covid-19 pandemic. Activity figures for the financial year 2018-19 suggest that across the Forest of Dean there were 18,866 attendances at Lydney or Dilke MIIUs. This suggests that there has been a reduction in attendances within the Forest of Dean of around 3,300 (18%) since 2018-19. There are a number of potential explanations for this reduction in activity. Whilst this reduction in usage could be perceived as an indicator of unmet need within the north of the locality, it is of note that not all attendances at an MIIU are 'appropriate'. It is generally known that attendance levels at ED and community urgent care services such as MIIUs is higher amongst those living close to the service. One piece of secondary research[3] that reviewed 38 primary UK and international studies identified 15 studies that suggest convenience in terms of location, not having to make an appointment, and opening hours as one of six drivers of urgent care service attendance. It therefore may be that the reduction in convenience for patients in the north of the Forest to visit an MIIU has led patients to seek (potentially more appropriate) services to meet their needs, including NHS111, primary care and pharmacy. The availability of Enhanced Access may have at the same time increased the convenience of general practice for some of those experiencing minor illness. Other factors driving attendance were identified in the afore mentioned research included:

- Confidence in primary care and access to care appointments
- Perceived urgency, anxiety, and the value of reassurance from urgent care services
- Views of family, friends or healthcare professionals
- Perceived need for treatment, or investigations

Addressing of these factors through promotion and increased use of NHS111, public engagement and communication and improvement in general practice performance where appropriate could further reduce use of MIIUs (and EDs) where they are not the most appropriate route to meeting actual health need. Commissioners and providers alike are acutely aware that the way in which patients are accessing services has changed and continues to change over time. This change has been accelerated because of necessary amendments to service access during the Covid-19 pandemic but has also been impacted by advances in, and the proliferation of, technology. Increased use of remote assessment and treatment has impacted on the numbers of cases that can now be managed without face to face treatment, particularly where illness rather than injury is concerned. This is likely to be a significant contributing factor in attendance numbers. Similar patterns have been seen in relation to face to face attendances and home visits in out of hours primary care.

5.2.3. Distribution of MIIU Activity Across the Forest of Dean

To understand the distribution of patients attending Lydney MIIU, analysis has been undertaken using the location of patient 'base' practices and patient home addresses. Each methodology has its positives and its limitations.

	Based on Registered Practice	Based on Patient's Home Address
Positives	Allows for measurement of travel to MIIU locations by car travel time, a more accurate measure of accessibility	Has an increased probability of measuring travel time from the patient's location at the point at which they decided to access the MIIU, however, only where the patient begins their journey from their home address
Limitations	Does not measure distance from patients exact starting point of travel	Only allows for measurement of distance to MIIU locations "as the crow flies" rather than the more meaningful car travel time measure

Figure 9: Pros and cons of different travel time / distance calculations

[3] Why Do People Choose Emergency and Urgent Care Services? A Rapid Review Utilizing a Systematic Literature Search and Narrative Synthesis - PMC (nih.gov)

5.2.3.1. Distribution Based on Registered Practice

Analysis of the registered practice of the "Gloucestershire commissioned"[4] patients attending Lydney MIIU between 1st October 2022 and 30th September 2023 was undertaken to establish those practices where 50 or more attendances have been seen during the year (see fig 11 below). This analysis identified 91.3% of patients attending Lydney MIIU in the period. 662 further practices from within and outside of Gloucestershire had fewer than 50 attendances, this figure will include not only those patients living on the borders of Gloucestershire, but also visitors to the area. For context, of those 662 GP practices, 460 practices are included in the list on the basis of a single attendance by a single patient. Figure 10 (directly below) provides an overview of all patients attending Lydney MIIU[5]. The full list of attendances at Lydney MIIU during the period 1st October 2022 and 30th September 2023 can be found in Appendix 1.

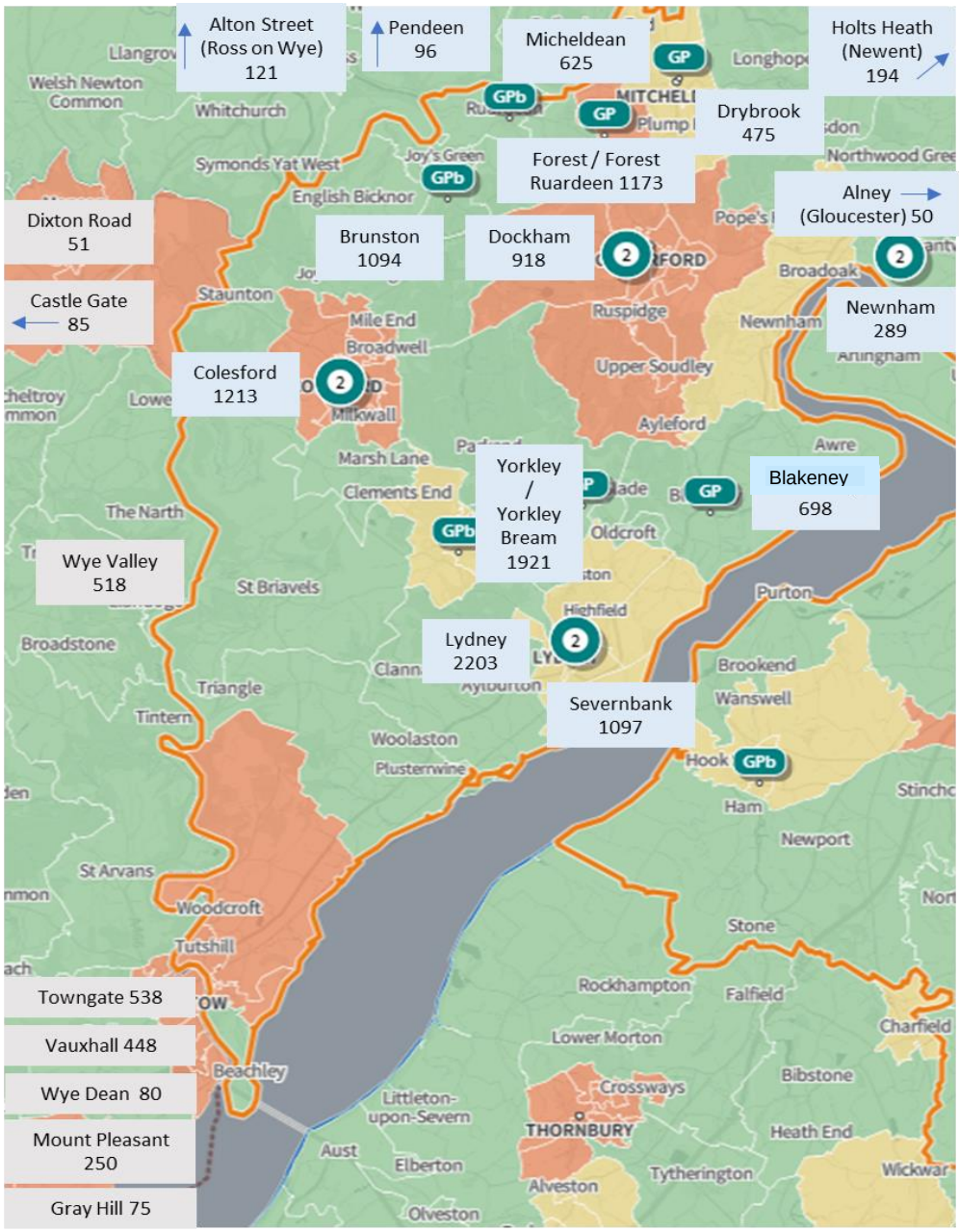


Figure 11: Registered GP practice of patients attending Lydney MIIU between October 2022 and September 2023[6]

[4] As per the definition outlined in Figure 7, including Welsh registered patients

[5] Note that the source of this data is GHC and the timescales differs from the period used elsewhere

[6] The shading on the map indicates the ONS assessment of the rurality or urban nature of the super output area in question on a sliding scale of dark red (highlight urban) to dark green (highly rural).

The mapping of attendances by GP practice suggests that of those patients attending Lydney MIIU a significant number are registered with GP practices that are closer to and/or with better road links to the new Cinderford Hospital site. It also highlights that there are a significant number of patients attending from across the Welsh border. If a primary care led MIIU model were to be put in place, it is highly likely that the service would only run five days per week. The distribution of Lydney MIIU attendances between 1st October 2022 and 30th September 2023 by day of the week is highlighted in the chart below.

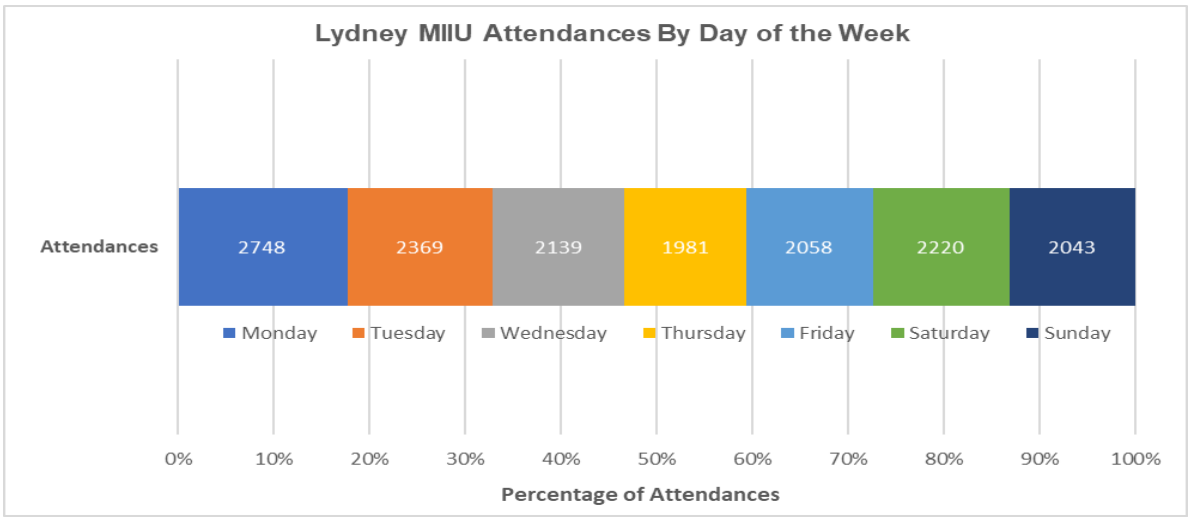
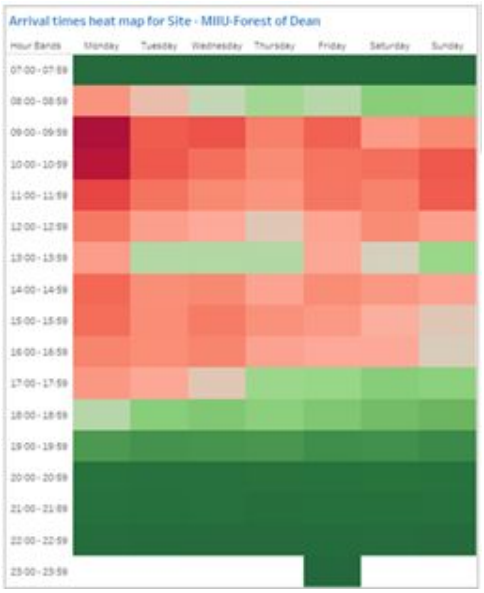


Figure 14: Attendances at Lydney MIIU by day of the week (October 2022 to September 2023)

During the period 1st October 2022 to 30th September 2023, 4,263 attendances[7] at Lydney were on a Saturday or Sunday, this equates to 27.4% of attendances being on Saturday or Sunday. If the weekday hours of operation of a primary care led service were less than 08:00 until 20:00 the figures for a Lydney MIIU would reduce further. Furthermore, if only Gloucestershire registered patients are included, that is, Lydney attendances are reduced by 21.4%[8] the figure for Lydney reduces to a figure more in the region of 5,583 attendances per week for a five day model. The distribution of patients attending the current Forest of Dean MIIU across time of day and day of the week is illustrated below with the darkest red representing the highest number of patients attending and the darkest green representing the lowest attendance numbers.



[7] All attendances regardless of where the patient is registered

[8] See calculation in section 5.2.2

Figure 16: Attendances at MIIU Forest of Dean by day of the week and arrival time

5.2.3.2. Distribution Based on Home Address

The attendances at the Lydney MIIU for Gloucestershire commissioned patients have been mapped by home address to assess the number of patients who are closer to Lydney and closer to Cinderford (it should be noted that this mapping is from the period when only the Lydney MIIU was open which will introduce a degree of 'proximity bias's). Please note that distances have been measured "as the crow flies" rather than car travel time outside of rush hour[9].

Closer to Lydney or Cinderford Site	Number of Attendances	Proportion of MIIU Attendances Based on Home Address
Cinderford	6006	41.3%
Lydney	8504	58.5%
No Postcode / Data Quality Issue	20	0.1%
Grand Total	**14,530**	**100.0%**

Figure 17: Attendances at Lydney where the patient's home address is closer to each MIIU

Based on these figures, it would suggest there is a limited impact in terms of the one MIIU site for the Forest moving to Cinderford from Lydney, although it is acknowledged there is a small increase in the number of people who will find the unit to be slightly further away, compared to those who will find it to be nearer to their home address.

5.2.4. Future Levels of Activity

5.2.4.1. Movement of Patients into the Most Appropriate Care Setting

5.2.4.1.1. Minor Illness Attendances to Primary Care

As outlined in section 4 of this options appraisal, local strategy in Gloucestershire is to focus MIIUs on provision of diagnosis and treatment of minor injuries, whilst supporting appropriate management of minor illness within primary care. An audit of activity at North Cotswolds Community Hospital in January 2019 suggested that 62% of MIIU activity is minor illness related. Data does not routinely exist to update this figure. However, within the context of 9,000 attendances per year being the minimum requirement for an MIIU that is delivering value for money, reductions in minor injury attendance far smaller than 62% have a significant impact on the viability of MIIU provision within the Forest district. The tables below calculate 10% reductions as a result of reduction in minor injury activity and demonstrate:

- Splitting all activity (all minor injuries and minor illness) across two sites in the Forest significantly impacts on the value for money being derived from the new Cinderford site even before consideration is given to redirection of minor injuries
- Even without a reduction for redirection of minor injuries, one site (Cinderford) is considerably lower than the 9,000 attendances required to represent a value for money MIIU
- Based on attendances for Gloucestershire patients only, the same is true for the second site (Lydney)
- When considering all patients whether registered with Gloucestershire GP practices or not, a decrease in attendance of only 10% makes the Lydney site no longer value for money
- In a single site scenario, a 50% plus reduction in minor injuries is required to take the site below 9,000 attendances for all patients and a 40% plus reduction is required when considering Gloucestershire only patients

[9] Measurement by car travel time for all attendances by postcode is not possible as there are too many postcodes to manually enter the data into Google maps

5.2.4.1.2. Movement of Wound Dressings to the Most Appropriate Service

The figure below outlines the number of wound dressing related attendances. Lydney has by far the greatest number of attendances for wound dressings for any MIIU in the county. Almost half of all attendances for wound dressings at Gloucestershire MIIUs are at Lydney, almost double the number of any other site.

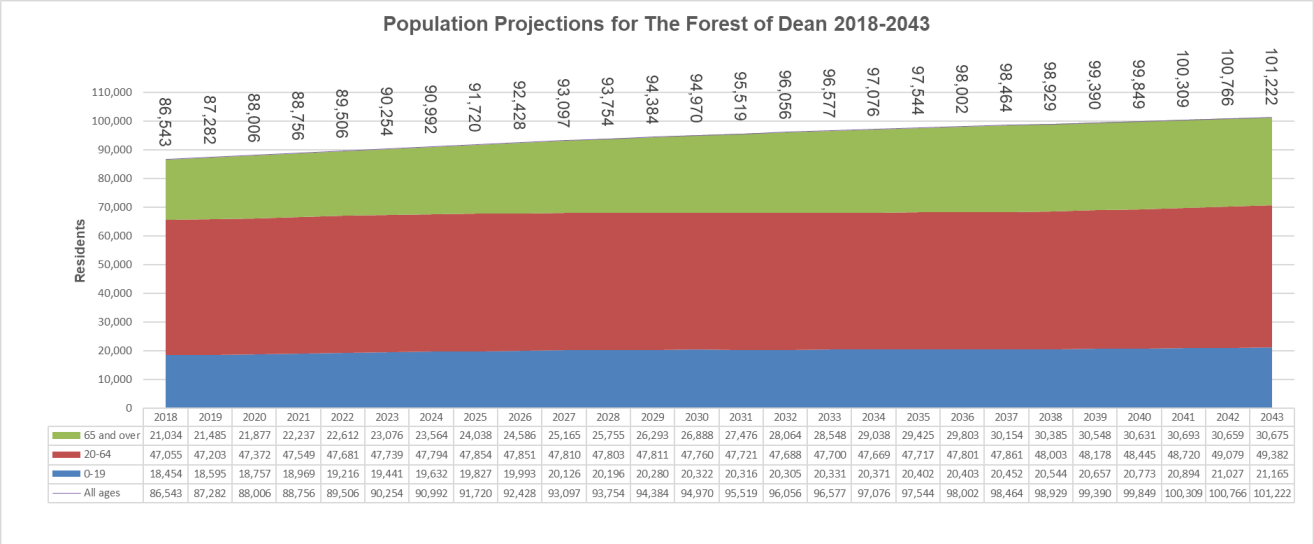
Provider	Attendances	Rank	Percentage
Cirencester Hospital	9	6	1%
Lydney Hospital	355	1	48%
North Cotswold Hospital	164	2	22%
Stroud General Hospital	93	4	12%
Tewkesbury General Hospital	17	5	2%
Vale Community Hospital	108	3	14%

Figure 20: Patients attending MIIUs in Gloucestershire for wound dressings

The question of who is responsible for wound dressings is often a contentious issue. Different ICSs implement different solutions, including provision within general practice and commissioning of separate wound care services. It is unlikely that walk in urgent care services such as an MIIU are the most appropriate setting. This issue is flagged just for further consideration work has not been done as part of this consideration to look at alternative options.

5.2.4.2. Population Growth

Population projections produced by the Data & Analysis Team at Gloucestershire County Council suggest that between 2018 and 2043 there will be a population increase of 17% within the Forest of Dean. The distribution of this increase over time is depicted in the chart below[10]. The increase in population between 2023 and 2043 is projected to be 12.2%.



	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043
65 and over	21,034	21,485	21,877	22,237	22,612	23,076	23,564	24,038	24,586	25,165	25,755	26,293	26,888	27,476	28,064	28,548	29,038	29,425	29,803	30,154	30,385	30,548	30,631	30,693	30,659	30,675
20-64	47,055	47,203	47,372	47,549	47,681	47,739	47,794	47,854	47,851	47,810	47,803	47,811	47,760	47,721	47,688	47,700	47,669	47,717	47,801	47,861	48,003	48,178	48,445	48,720	49,079	49,382
0-19	18,454	18,595	18,757	18,969	19,216	19,441	19,632	19,827	19,993	20,126	20,196	20,280	20,322	20,316	20,305	20,331	20,371	20,402	20,403	20,452	20,544	20,657	20,773	20,894	21,027	21,165
All ages	86,543	87,282	88,006	88,756	89,506	90,254	90,992	91,720	92,428	93,097	93,754	94,384	94,970	95,519	96,056	96,577	97,076	97,544	98,002	98,464	98,929	99,390	99,849	100,309	100,766	101,222

Figure 21: Population projections for the Forest of Dean (2018 to 2043)

Work has been undertaken to understand the impact of these population increases on MIIU attendance numbers in the Forest of Dean. The table below demonstrates that whilst there is an expected population increase of 12.1% over the next 20 years, the increase in attendances is more likely to be in the region of 10.4%. This is because the population group seeing the biggest increase are the over 65s who are lower users of the current Lydney MIIU (0.10 attendances per head of population) than those under 65 (0.15

[10] Figures in the table below the graph can be viewed by zooming in on the table, alternatively they can be found in appendix 2

attendances per head of population). In the Forest district, 81.7% of MIIU attendances are for patients who are under the age of 65, this figure is in line with the figures for Gloucestershire as a whole.

	Attendance Figures Minus 21.4% Non Gloucestershire Patients				
	Number of Lydney Attendances (October 22 - September 23)	2023 Population	Attendance Per Head of Population	2043 Population	Attendances 2043
Under 65	9,877	67,180	0.15	70,547	10,372
65 and over	2,357	23,076	0.10	30,675	3,133
Total	12,234[11]	90,256	0.14	101,222	13,505

Figure 22: Projected increase in MIIU attendances based on population projections and current usage – Gloucestershire patients only

To understand whether the population projections are transpiring, a comparison has been made between the projected population figure for 2021 and the actual population in the Forest of Dean in 2021.

	2018	2019	2020	2021
Projection (All ages)	86,543	87,282	88,006	88,756
Percentage change from 2018		100.9%	101.7%	102.6%
Actual Population[12]				87140
Percentage change from 2018				101.7%

Figure 23: Comparison between projected population figures for 2021 and actual population size in 2021

The figures suggest that the rate of population increase has been slower than projected with an increase of 1.7% rather than the expected 2.6% and therefore the increase in MIIU attendances may be lower than the 17,448 (14,831 for Gloucestershire patients) projected for 2024.

5.2.5. Delivery of Value for Money Through Flexibility

One of the ways in which greater value for money can be achieved in services where the volume of MIIU activity is not sufficient to keep clinical and non-clinical staff fully occupied is to base the service within a location where other healthcare provision is being undertaken and use the staff from within the MIIU to undertake tasks across multiple services. This option is possible for clinical, radiography and administrative staff at the Cinderford site given the range of other services scheduled to be delivered from the new Cinderford Community Hospital, however, an MIIU service in Lydney would be stand alone and therefore the potential for Lydney staff to undertake physical tasks for other services to ensure that they are fully occupied does not exist.

There is some potential for staff within MIIUs to contribute virtually to other services, however, this takes significant collaboration and flexibility by all parties involved. For example, in theory, there is nothing to stop an Advanced Care Practitioner within an MIIU also working with the local Integrated Urgent Care Service (IUCS) provider to manage NHS111 calls within the IUCS provider's Clinical Assessment Service, providing clinical input to patients who have called 111. Such arrangements can be challenging in terms of rota planning as the clinician's availability will not be known in advance (as it will depend on the degree of 'walk ins' to the service which cannot be known until they occur).

This virtual approach is potentially more easily achieved where nonclinical administrative support is concerned. For example, a receptionist at an MIIU, who, without additional tasks to undertake during a shift would be underutilised, may also be able to undertake electronic based tasks such as data entry or collation for another service.

[11] As per Figure 7

[12] Data & Analysis Team at Gloucestershire County Council

5.3. Return on Investment

One of the opportunities for Gloucestershire ICS and other ICSs around the country to increase efficiency and make either savings or offset increases in demand is through diverting patients who do not require an ED attendance to alternative services such as primary care and minor injuries units. Successfully achieving this reduces pressures on ED which in turn reduces ambulance handover delays (and the associated costs) and admissions (and the associated cost) of patients who, had they been seen in a timelier manner may not have required admission.

Therefore, one argument for increasing MIIU capacity with a Lydney MIIU would be the benefits derived from reducing ED attendances from patients who:

- Currently attend ED for minor injuries but who could, with appropriate communications and use of NHS111 in future attend a minor injury unit
- Currently use Lydney MIIU but who in future could present at ED for the treatment of minor injuries rather than the Cinderford MIIU

The table below identifies for the period October 2022 to September 2023 the number of attendances by patients living closer to Cinderford MIIU[13] and Lydney MIIU at an ED department for a need that could have been met by an MIIU. ED attendances where the patient's needs could have been met by an MIIU attendance have been identified as:

- ED attendances that did not have an MIIU attendance up to 24 hours prior to the ED attendance.
- The ED attendance was a walk-in.
- The attendance did not result in admission.
- The attendance was classed as a "minor".

Distances to the MIIU sites have been calculated using the haversine formula. This does not consider different routes, it measures 'as the crow flies'[14]

Closer to Lydney or Cinderford Site	Number of ED attendances
Cinderford	1557
Lydney	678
No postcode location	3
Grand Total	**2238**

Figure 24: Attendances at ED that would have been suitable for an MIIU

When considering whether the absence of an MIIU in Lydney will drive more patients to ED, it is necessary to consider patients' ED alternatives to the Cinderford MIIU. To access an ED based in Gloucestershire a patient in Lydney and surrounds (including Chepstow) would have to travel 42 minutes from the current Lydney site to Gloucestershire Royal Hospital or 51 minutes to Cheltenham General Hospital both via routes that whilst not travelling through Cinderford do involve driving past and beyond Cinderford. (For some residents in the south of the Forest it is possible an ED in Bristol may be nearer, but this analysis has not been done).

This, alongside the relatively low number of minor ED attendances, suggests that whilst the Cinderford MIIU may not be as convenient for patients as the Lydney Hospital site was, the closure of the site will be unlikely to significantly drive-up ED attendances.

[13] Identified as Steam Mills Road Cinderford, Forest of Dean Postcode GL14 3HY

[14] It should be noted that different software systems calculate distances in different ways

5.4. Financial Domain Evaluation

Based on the analysis outlined above, each option has been evaluated, the outcome of this evaluation is outlined below.

Option Number	Option Description	Evaluation	
Option 1	Establish a new MIIU in Lydney	**Affordability**: New funding would need to be identified and agreed from the ICB's overall budget to fund any additional services. Given the financial position within Gloucestershire and the competing pressures on limited funds there is reason to question whether two MIIUs within the Forest of Dean is the most effective use of public funds given that whilst access times to the service could be improved for some patients by a second site, there is already provision within the district as part of current plans. **Value for Money**: The distribution of attendances at the potential Lydney and Cinderford sites, as outlined in this appraisal, will have been impacted by current provision being (only) based in the south of the Forest. A two-site model of service provision may well redistribute attendance in different patterns to that which has been generated by looking at 2022 and 2023 data. However, overall attendance numbers suggest that regardless of the distribution of patients across Cinderford and Lydney MIIUs, two sites would not represent value for money. Attendance figures for the whole Forest are currently and are predicted to remain for the next 20 years, below the levels that would justify two units both of which offered value for money. This is before taking into consideration any decreases over the next 20 years associated with redirecting minor illness cases to primary care. When some degree of redirection to primary care is taken into consideration, a two-site option reduces attendances at both sites even further below the level required to deliver value for money. Whilst there is an increase in attendances at an MIIU of 10% predicted over the next 20 years as a result of population increases, this level of increase does not bring the number of attendances to a level to suggest that two MIIU sites would be a cost-effective model. Given that the Lydney MIIU site would be a single service site with no other services being delivered, there is little opportunity to drive up value for money through flexing clinical and non-clinical staff across a variety of services on site. **Return on Investment:** Figures suggest that there is little in the way of system savings to be generated from reduction in ED attendances, admissions and ambulance handover delays from the establishment of a Lydney MIIU as attendances figures for patients in the proximity of Lydney are relatively low. Whilst there may be an element of the convenience of Lydney MIIU driving these low numbers, even without an MIIU in Lydney, Cinderford MIIU is closer than the nearest ED service in the county.	

Option 2	Undertake all minor injuries provision within the new Community Hospital in Cinderford	**Affordability:** The cost of minor injuries attendances across the whole of the Forest has already been built into the financial envelope for the new Cinderford Community Hospital, therefore this option is affordable. There would be no requirement for additional funding to be found. **Value for Money**: Overall activity within the Forest of Dean is at a level that supports a 'value for money' MIIU (or potentially UTC). Increases in population over the next 20 years take the volume of attendance well over the 9,000 attendances value for money threshold. It would take a reduction in minor illness attendances of more than 50% to bring the overall number of attendances for the Forest below the 9,000 attendances value for money threshold. It should be noted that 9,000 is a minimum figure and higher levels of activity provide greater opportunities for efficiency and maximum return on investment made. **Return on Investment:** There is potential for the Cinderford MIIU to reduce the number of ED attendances for patients living in the vicinity of Cinderford given that Cinderford is closer to ED provision that other parts of the Forest of Dean. The number of ED attendances is also relatively high when compared to Lydney. However, it should be noted that these benefits would be seen with or without a Lydney MIIU.	
Option 3	Commission a primary care led minor injuries service similar to the Winchcombe model	**Affordability:** Whilst the original 'estimate' for a primary care led unit in Lydney was £201,787 there is little doubt that this cost will now be higher. This is funding that has not been identified and within the context of the financial pressures being experienced in the Gloucestershire health and care economy is likely to be difficult to secure. **Value for Money:** As with Option 1, overall attendance numbers suggest that regardless of the distribution of patients across Cinderford and Lydney MIIUs, two sites would not represent value for money. If the proposed model were to be for the MIIU service to be collocated with a GP practice, there is potential for staffing to be used flexibly across the practice and the minor injuries service this would improve efficiency. However, due diligence would need to be taken to ensure that the ICB were not double paying for primary care activity being completed by staffing funded through the MIIU service. With both a weekday only and a seven day per week service, the Lydney MIIU would be running at lower levels of activity than are deemed to be cost effective. Furthermore, the transfer of five or seven days of activity would impact on the efficiency and value for money of the Cinderford MIIU. **Return on Investment:** As with Option 1, figures suggest that there is little in the way of system savings to be generated in reductions in ED attendances, admissions and ambulance handover delays from the establishment of a Lydney MIIU.	

Figure 25: Evaluation of options against the criteria within the financial domain

6. Practicality

6.1. Resourcing

6.1.1. Workforce Availability

A two MIIU model for the Forest of Dean would require a greater level of resourcing than a single MIIU at Cinderford. This resource would have to be recruited in addition to the staffing currently in place as the staff currently providing the minor injuries service are all required to deliver the new Cinderford service. Even though there were previously two units in the Forest of Dean, this is the case because the new hospital site has a greater number of MIIU consulting rooms, allowing for a more efficient use of the staff within the unit (for example, one reception team to support the unit, single triage function).

Workforce availability is a universal issue across the NHS. Despite continuous national workforce growth, vacancies across the NHS have been increasing until very recently. Total vacancies were 110,281 FTE staff in Quarter 1 of 2018-19. They had fallen to a low of 76,084 by Quarter 4 of 2020-21 but steadily rose to an all-time high of 131,596 in Quarter 2 of 2022-23, an increase of 55,512. Vacancies have since decreased and stood at 112,498 in Quarter 4 of 2022-23[15].

Nationally, absence rates in the NHS due to sickness have been much higher since the start of the pandemic, compared with the preceding 10 years. The average rate of absence between April 2009 and February 2020 was 4.2%, compared with 5.1% between March 2020 and October 2022, with the rate standing at 5.6% in October 2022[16].

6.1.2. Lone working

The attendance numbers per site associated with a two site MIIU model increases the probability that there will be significant periods where clinicians are lone workers at a Lydney site. Lone workers are those who work by themselves without close or direct supervision and hence whilst there may be a receptionist or administrative support on site, clinicians working solo in a small MIIU would be lone workers – especially if any extended hours option were considered. The exception to this is, as would be the case at Cinderford Community Hospital, where there are collocated services where clinical expertise, advice and assistance could be sought from colleagues associated with other services in the building.

The law does not prohibit lone working, but employers are required to ensure that their employees are reasonably safe. Employers must consider the health and safety risks of the job being carried out, and also any risks caused by the employee working alone.

Risks that particularly affect lone workers include:

- ***Violence in the workplace***: The Health and Safety Executive (HSE) defines violence as 'any incident in which a person is abused, threatened or assaulted in circumstances relating to their work', this includes verbal threats[17]
- ***Stress and mental health or wellbeing:*** According to research by the British Occupational Health Research Foundation, 64% of lone workers face psychological distress, which is significantly higher than employees working alongside colleagues in a secure environment[18]

HSE's Stress Management Standards[19] include the importance of relationships with, and support from, other workers. Being away from managers and colleagues could make it difficult to get proper support. In the case of an urgent health service such as an MIIU there are further risks associated with lone working. Whilst it is not the intention that MIIUs should be used for emergencies at times patients present with significant levels of need, similarly patients who presented with an urgent rather than emergency need can deteriorate. In each of these cases the patient would require the full attention of the clinician on site potentially leaving a waiting room of patients unattended each of whom could also deteriorate and require attention, which in the absence of multiple clinicians would not be available and would present a significant level of risk.

[15] Access to unplanned or urgent care (nao.org.uk)
[16] Access to unplanned or urgent care (nao.org.uk)
[17] Lone workers: how employers should protect them - violence - HSE
[18] The Impacts Of Lone Working On Mental Health | Peoplesafe
[19] Stress and mental health at work - HSE

There are conditions or injuries that require more than one practitioner to complete, example of this include:

- Administration of a tetanus injection to a child, where one clinician is required to settle the child and ensure that they remain still, whilst the second clinician undertakes the injection.
- Some wound dressings where one clinician is required to hold the affected area (for example a limb) whilst the other clinician wraps the dressing.
- Movement of non-weight bearing patients who require support on both sides to move.

In the event the there was a single clinician in a Lydney MIIU, these patients whilst initially presenting at Lydney would be required to travel to Cinderford for treatment.

6.1.3. Workforce Underutilisation

Being underutilised at work can have a negative impact on morale. Employees who do not have enough work to keep them occupied may feel bored, unchallenged, and undervalued. Studies have found that boredom increases the likelihood of employee turnover and early retirement intentions, as well as poor self-rated health and stress symptoms. A single site MIIU arrangement with more than 15,500 attendances per year is likely to see staff within the unit fully engaged throughout each shift, albeit that some periods may be busier than others. A two-site service model would likely result in significant amounts of “downtime” for clinicians and receptionists or administrators.

6.2. Continuity of Service

6.2.1. Risk of Short Notice Closure

Nationally, there are usually two key causes of short notice closure of MIIU and UTC services:

- Staff sickness
- Pressures within other services run by the same provider that require the redeployment of staff

Review of a random sample of submissions provided by GHC to the commissioner suggests that currently across all the MIIUs in Gloucestershire, there is little in the way of short notice closure. Where closure does occur, it is usually for a small number of hours in the evening. It should be noted that each of the MIIUs currently sees more than 9,000 patients in some cases considerably more, reducing the potential for unit opening to be reliant on a single member of staff.

Based on the sample reviewed, the two units that have experienced the most closures were Tewkesbury and Vale which as noted in Figure 8 are the two smallest units within Gloucestershire. This is consistent with experience elsewhere, the services most at risk of closure because of staff sickness are those that are staffed by small numbers because of seeing a comparatively small number of patients. Larger services can proceed with opening in the face of staff sickness, although they may take action to control demand such as not making the service available via NHS 111 so that they are only managing walk in demand.

Gloucestershire is well positioned in terms of closure relating to redeployment of staff elsewhere. All MIIU activity is met by the ICS’s community provider. Where units are delivered by acute providers, pressures in ED can result in consolidation of staff back on the acute site. Were a Lydney MIIU to be provided by a one or more GP practice, sickness within the core practice/s could result in staff being redeployed to meet booked demand in the practice rather than being left available to manage referred or walk in demand for MIIUs services, in effect, closing the MIIU service.

6.2.2. Long Term Contract Stability

Gloucestershire ICB currently has an ongoing contract with GHC for provision of services within the current MIIUs in Gloucestershire. Any contract awarded to a PCN, practice or other provider securing the contract via a procurement will have an expiry date and clauses within the contract that allows the provider, within reasonable parameters, to “hand the contract back” if the attractiveness of the contract changes. This may be provoked by any number of reasons including:

- A change in partnership or ownership of one or more practices
- Concerns with regards to the profitability of the contract

- Difficulties in securing staffing for the service
- Changes in the priorities of an individual or organisation

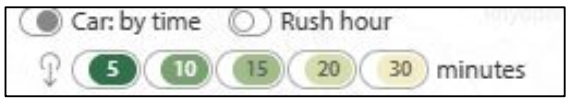
Within the Southwest there is at least one primary care led service where the provider has in recent months issued a contract termination notice, leaving the commissioner with a requirement to secure an alternative solution at relatively short notice.

7. Accessibility

7.1.1. Travel Times to Access Urgent Care With a Cinderford MIIU Only

Analysis has been undertaken to assess the accessibility of urgent care based on having a single MIIU in Cinderford and for MIIU sites at both Cinderford and Lydney. Within this options appraisal, for Cinderford community hospital, maps and assessment of distances have been calculated based on Dockham Surgery as this is the closest current NHS site to the new Cinderford Hospital[20]. The distance between the Dockham Surgery and the new Cinderford hospital is 0.7 miles with a driving time of two minutes[21]. Whilst clearly travel times will be impacted by traffic and weather conditions on any given day, this methodology provides a sound starting point for considering access to urgent care in the Forest. It also provides a sound basis for comparative analysis.

Figure 23 below shows the traveling distances for patients to Dockham Surgery. The darkest green represents a traveling time by car of five minutes or less, this graduates through lightening shades of green to represent ten minutes, 15 minutes and 20 minutes to the lightest green at 30 minutes as outlined in the key to the right.



The map suggests that in a scenario where there is a single MIIU site in Cinderford, there are no areas of the Forest of Dean that are, in normal conditions without rush hour traffic, significantly more than 30 minutes travel time from Dockham Surgery. This is in line with the original standard that was identified as part of the original work undertaken in reaching the decision to place the new Community Hospital in Cinderford. It is likely that those patients highlighted in section 5 of this options appraisal as attending Lydney MIIU who are registered with Chepstow practices and live to the west of Chepstow are not within 30 minutes. However, these are not patients for whom Gloucestershire ICB is responsible for the commissioning of health care services.

Figure 26: Travel times to Dockham Surgery

[20] The software used to generate the map above pinpoints locations by NHS service sites SHAPE Place (shapeatlas.net)

[21] Google maps travel time by car

Review of Gloucestershire suggests that whilst there is a significant proportion of the ICS with faster access to an MIIU than 30 minutes, there are other portions of the county where access to an MIIU takes 30 minutes. The travel times to an ED or MIIU in Gloucestershire are presented in the diagram below.

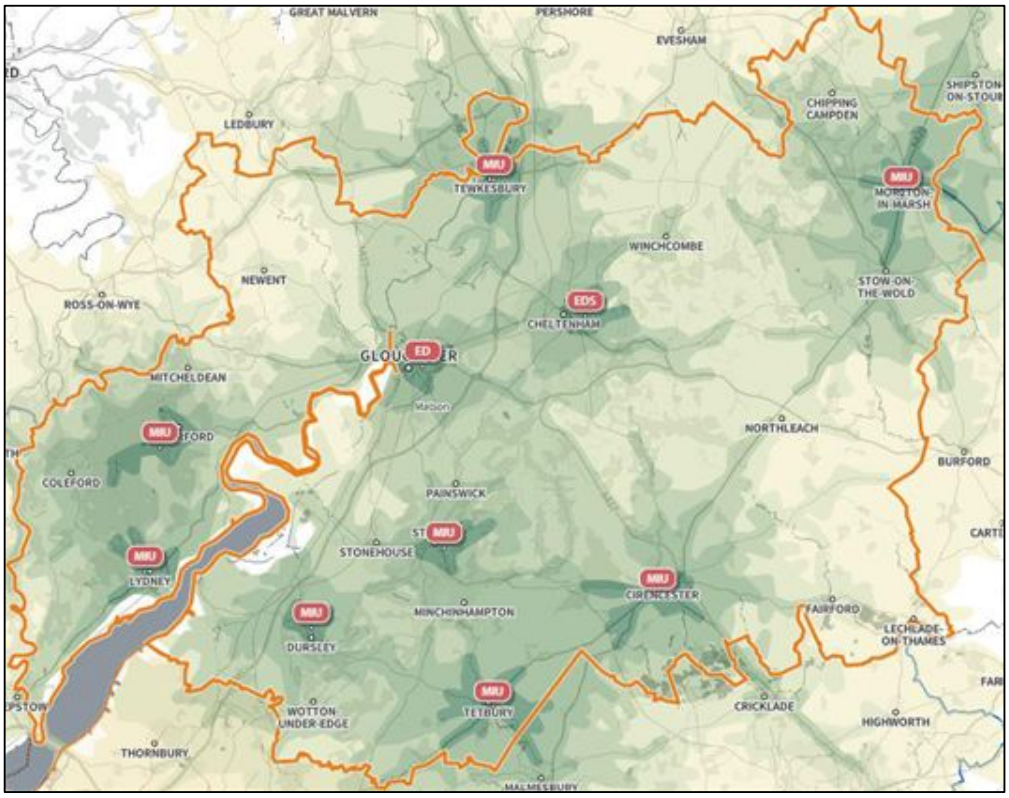


Figure 27: Travel times to urgent care in Gloucestershire (MIIUs and ED)

7.1.2. Comparative Analysis of Access in Gloucestershire

The picture in Gloucestershire is not dissimilar to that of other ICSs that share some of the characteristics of Gloucestershire. Each has sections of the ICS where travel time to urgent care (MIU or ED) is 30 minutes.

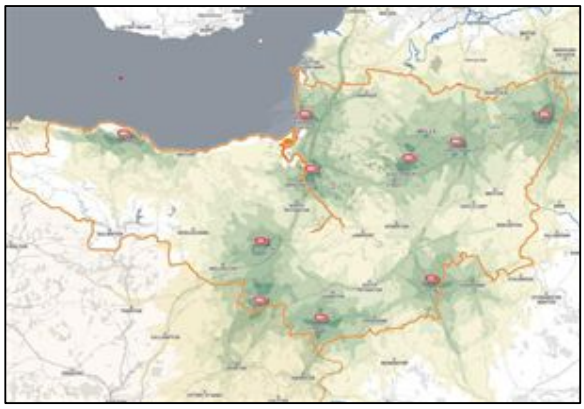
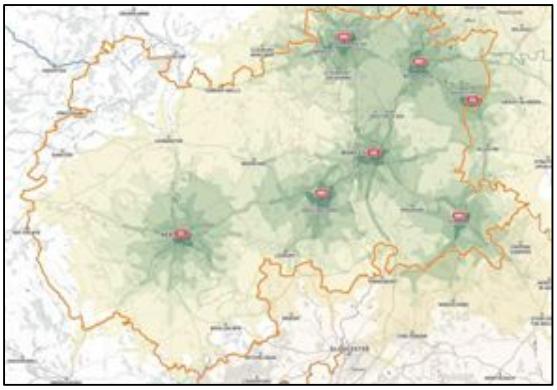
Buckinghamshire, Oxfordshire & Berkshire ICS	Somerset ICS
	
Herefordshire & Worcestershire ICS	**Hampshire & Isle of Wight ICS**
	
Coventry & Warwickshire	**Bath and NE Somerset, Swindon & Wiltshire**
	

Figure 28: Travel times to ED or community urgent care in similar comparable ICSs to Gloucestershire

7.1.3. Travel Time to Urgent Care Provision With MIIUs at Cinderford and Lydney

It should be noted that for the purposes of this options appraisal, the site of the current Lydney MIIU has been used as the site of any potential future Lydney minor injuries service, however, the site is due to be sold and as such the exact location of any Lydney service was not known at the time this options appraisal was completed but is assumed to be close by. The addition of a Lydney MIIU reduces the travel time for some patients from 30 minutes to 20 minutes as outlined in the map below. However, to establish a second MIIU within the Forest of Dean for the purposes of reducing travel time for these individuals would be out of line with the approach that has been taken in planning provision elsewhere in Gloucestershire and elsewhere in similar geographies.

Lydney and Cinderford	Cinderford Only
	

Figure 29: Travel times for patients with one and two sites with an MIIU

7.1.4. Changes to Travel Times for Patients

Analysis has been undertaken to understand the impact of the transfer of MIIU provision from the current site in Lydney to the new site in Cinderford. In the absence of being able to predict where exactly future MIIU patients will come from, this analysis has been based on distance from each of the GP surgeries in Gloucestershire where there have been 50 or more attendances between 1st October 2022 and 30th September 2023. Whilst some patients registered in those surgeries will have shorter or longer journeys to either the Cinderford or Lydney sites, the GP surgery location can be the centre of a “catchment area” for patients living in different parts of the Forest of Dean.

Ten of the 22 surgeries are closer to the Cinderford site than the Lydney MIIU with the difference in travel time ranging from one minute less to 19 minutes less. The other 12 surgeries are further from the Cinderford site with the difference in travel time ranging from one minute longer to 23 minutes longer. However, the longest increase in distance for a Gloucestershire surgery is 16 minutes.

GP Practice Name	Distance to Dockham Surgery (In Minutes)	Distance to Lydney MIIU (In Minutes)	Difference to get to Dockham Surgery compared with Lydney MIIU
Dockham Surgery	0	19	-19
Forest Health Care	1	19	-18
Mitcheldean Surgery	9	24	-15
Drybrook Surgery	5	20	-15
Holts Health Centre	24	39	-15
Alton Street Surgery	19	31	-12
Pendeen Surgery	19	30	-11
Newnham Surgery	13	21	-8
The Alney Practice	29	36	-7
Castle Gate Medical Practice	26	27	-1
Coleford Family Doctors	14	13	1
Brunston Practice	14	11	3
Yorkley Health Centre	13	9	4
Wye Valley Practice	32	25	7
Blakeney Surgery	17	9	8
Wye Dean Practice	30	22	8
Lydney Practice	19	3	16
Severnbank Surgery	19	3	16
Vauxhall Surgery	36	18	18
Mount Pleasant Practice	38	20	18
Gray Hill Surgery	47	29	18
Town Gate Practice	38	15	23

Figure 30: Changes in travel times as a result of MIIU provision being sited in Cinderford rather than Lydney, those highlighted in blue fall under the commissioning responsibility of the Aneurin Bevan Health Board

7.2. Practicality Domain Evaluation

Based on the national and local strategic positions outlined above, each option has been evaluated, the outcome of this evaluation is outlined below.

Option Number	Option Description	Evaluation	
Option 1	Establish a new MIIU in Lydney	**Resourcing:** Where there to be two MIIU services within the Forest of Dean, this would require a larger quantity of clinical workforce than a single site. This recruitment is not planned or funded and would be taking place within the context of a difficult health care professionals' workforce. **Continuity of Service:** Whilst short notice closure of MIIU services does not appear to be a particular issue in Gloucestershire, it is of note that those closures that do occur tend to be in the small units. Splitting the levels of activity across two sites poses a higher level of risk than consolidation on a single site. **Accessibility**: An MIIU at Lydney would provide faster access to urgent care to patients in the vicinity reducing travel times from 30 minutes to 20 minutes for a population of just under 11,000 patients. However, this does bring in to question why a travel time of 30 minutes is deemed acceptable for other patients in Gloucestershire and indeed elsewhere in the south and the midlands, but not for Lydney patients. It should also be noted that a practical task of identifying a new site for the Lydney MIIU would be required as the existing site is due for sale.	
Option 2	Undertake all minor injuries provision within the new Community Hospital in Cinderford	**Resourcing:** The resourcing associated with a single site solution is already established with the transfer of the existing workforce from the Lydney site to the Cinderford site. **Continuity of Service:** Consolidation of all Forest of Dean minor injuries activity and staffing on a single site, collocated with other services reduces the probability of unplanned closure because of either sickness or movement of staff into other services. **Accessibility**: A single site offering for community urgent care in the Forest of Dean provides parity of urgent care access, not only within the context of Gloucestershire but is also widely in line with other similar ICSs.	
Option 3	Commission a primary care led minor injuries service similar to the Winchcombe model	**Resourcing:** Significant care and attention would need to be given to ensuring that any primary care led was increasing their workforce to meet MIIU need. **Continuity of Service:** Pressures within primary care compounded by the issue of increased levels of sickness within the NHS have the potential to divert staff from the MIIU element of the practice into the core general practice element in effect closing the MIIU service due to lack of staff. **Accessibility**: As with Option 1 there are patients who will have their travel time reduced from 30 minutes to 20 minutes as a result of implementation of this option. However, in the absence of provision at	

		the weekend, the number of patients impacted will be significantly reduced compared with a seven day service. This option requires there to be a willing and able practice or PCN in the right location to enter a contract with the ICB for MIIU provision without negative consequences for patients registered with the practice for their primary care needs. Commissioners would need to seek significant levels of assurance that the practice or PCN in question was in a position to make a long term commitment to the minor injuries contract to ensure stability of provision going forward. It is difficult to envisage a scenario where the risk associated with potential withdrawal of service can be overcome. This is further complicated by the ICB's responsibility to ensure that primary care provision is consistently available as the ICB would be unable to ignore the potential impact on the General Practice element of the provider were the rationale for withdrawal be related to the overloading of the practice and its staff.	

Figure 31: Evaluation of options against the criteria within the practicality domain

8. Quality

8.1. Patient Safety

8.1.1. Service Size

As outlined in the section of the financial appraisal a Lydney MIIU would, by virtue of the number of patients likely to be seen, be a small service potentially with lone working or a limited-service offer. The issue of lone working within a small service is discussed in detail in the Practicalities section of this options appraisal, however more specifically in relation to quality and safety, potential quality concerns include:

- Clinicians seeing some conditions rarely, potentially impacting on the quality of care provided
- Levels of professional oversight and consultation available where a clinician is lone working on site

As noted in the lone working section of this options appraisal, at times patients present with significant levels of need, similarly patients who presented with an urgent rather than emergency need can deteriorate. There is potential for a patient safety issue in the event that the number of patients requiring a clinician's full attention exceeds the number of clinicians available. Similarly, whilst MIIUs are intended to meet the needs of patients with minor injuries or conditions, it is known that on occasion, patients present with significant levels of need that may require multiple clinicians, diagnosis and treatment within a rapid timescale. The level of risk associated with a patient presenting at a site with insufficient staffing and equipment to meet their needs is significantly higher than were they to present at a comprehensive site such as Cinderford.

8.1.2. Primary Care

Whilst provision of activity more appropriately seen in primary care could increase the levels of demand within a Lydney MIIU, GHC as the provider of MIIU services within Gloucestershire have highlighted that some of the patients presenting are doing so with conditions that do not sit within the skills set of the MIIU workforce. Similarly, as a site primarily set up to manage minor injuries rather than illnesses, the most appropriate equipment may also not be available.

Ensuring patient safety requires the service to have an appropriately trained and experienced workforce, recognising that the MIIU skill set can differ from that which is readily available in primary care. As such any primary care led service would need to ensure that an appropriately qualified workforce is available throughout the opening hours of the MIIU service. It would also be imperative that appointments are made available regardless of the demand for the general practice element of the surgery to avoid delay in the treatment of patients with an urgent requirement.

8.2. Parity of Experience

The new Cinderford hospital site will provide patients with access to the following facilities in a single visit

- X-ray
- Ultrasound
- Endoscopy

As identified elsewhere in this options appraisal, the size of a standalone MIIU in Lydney would not make it possible to provide these diagnostic investigations on the site and therefore in the event of requiring any one of the diagnostics referenced, a patient would be required to travel to a second site, most likely the Cinderford Hospital Site. This means that the 12% of patients requiring Xray would need to attend two different units in two separate visits in order to have their needs met if they were to attend a Lydney MIIU whilst those attending Cinderford would have their needs met in a single visit. The same would apply to those patients requiring ultrasound or endoscopy. Whilst use of NHS111 as the first port of call for accessing urgent care would allow for patients with a high likelihood of a requirement for an Xray to be directed in the first instance to Cinderford, the high number of walk in patients at Gloucestershire's MIIUs suggest that this may not be the case in the majority of instances.

As well as diagnostics, as outlined in the section of this options appraisal relating to lone working, there are a number of interventions that require more than one clinician to undertake. At a small single clinician MIIU this would not be possible and again, a further attendance would be required to secure treatment of the complaint.

Given that the MIIU site in Lydney is being sold, it is not possible to evaluate the parity of experience within the context of the physical space of the service, however, given the new and comprehensive nature of the Cinderford development, it is fair to assume that patient experience within the Cinderford setting will be maximised.

8.3. Quality Domain Evaluation

Option Number	Option Description	Evaluation	
Option 1	Establish a new MIIU in Lydney	**Patient Safety**: There are a number of potential safety issues associated with operating a small minor injuries unit. Whilst these are risks rather than inevitable events, they cannot go without consideration **Parity**: Given the number of patients requiring the MIIU service in Lydney and the absence of any other services on site requiring Xray facilities it is not possible to put in place Xray provision when it will only be required on average less than once per hour. Therefore the 12% of attendances will require patients to attend Cinderford in order to have an Xray increasing their travel requirement considerably when an initial attendance at Cinderford would have completed their diagnosis and treatment in a single visit, as is the case at other MIIU sites. Xray is not the only diagnostic identified as potentially not available within a Lydney site with ultrasound and endoscopy also identified by GHC as tests that would not be available in Lydney but which would be available in Cinderford. Similarly the inability for some interventions to be undertaken by a single clinician increases further the potential for additional individuals to require onward travel in order to complete their care episode.	
Option 2	Undertake all minor injuries provision within the new Community Hospital in Cinderford	**Patient Safety:** The Cinderford community hospital development brings with it the ability to establish a modern, well-staffed, safe multi-delivery space. Consolidation of all activity on the Cinderford site provides the opportunity to implement a more comprehensive well-staffed MIIU, potentially moving to the UTC specification which brings with it standards that maximise patient safety. **Parity**: By consolidating MIIU activity at Cinderford, this provides all patients attending a community urgent care venue within the same level of service and probability of having all their needs met in one visit.	
Option 3	Commission a primary care led minor injuries service similar to the Winchcombe model	**Patient Safety:** The collocation of the minor injuries activity with primary care has the potential to reduce levels of risk in relation to issues such as professional supervision. These issues are not eliminated altogether and require strong coordination between the two services. **Parity**: An MIIU service delivered from a primary care setting will not have Xray provision increasing the likelihood that patients will be required to travel to Cinderford for treatment even if their initial presentation is at a Lydney venue. Whilst this diagnostic issue would remain within a primary care setting there is potential that clinicians from the collocated primary care service could, subject to availability, provide the additional clinician required to undertake some interventions that required more than one clinician.	

Figure 32: Evaluation of options against the criteria within the quality domain

9. Overall Evaluation

When each of the options is evaluated against each of the four domains, the following RAG rated summary can be identified. It can be seen that the option that delivers best against the criteria applied is Option 2, undertaking all minor injuries provision within the new Cinderford Hospital site.

	Option 1	Option 2	Option 3
	Establish a new MIIU in Lydney	Undertake all minor injuries provision within the new Community Hospital in Cinderford	Commission a primary care led minor injuries service similar to the Winchcombe model
Strategic			
Financial			
Practicality			
Quality			

Figure 33: Evaluation of options against the criteria across all domains

The rationale for this evaluation is laid out in full throughout this options appraisal, however, a summary is provided below.

Strategic: Whilst Option 2 does not automatically deliver the strategic national requirement for movement towards Urgent Treatment Centres that deliver the national UTC specification, the size and breadth of the new Cinderford service would, as the only site providing minor injury provision, offer an opportunity to move towards the national UTC standards. All other options, as smaller, less comprehensive services, move Gloucestershire further away from the national direction of travel. From a local strategic perspective, the only way to move closer to having sufficient demand within two MIIUs in the Forest of Dean would be to increase the level of primary care work being undertaken within each service which goes against the local stated direction of travel, which is to manage care in the most appropriate setting.

Financial: Option 2 is the only option that is costed within the ICSs current plans, both Option 1 and Option 3 require identification of additional investment against the backdrop of a very difficult financial situation and within the context of significant competing pressures for funding. Were the funding to be secured it is hard to suggest that the ICS would be securing value for money as activity levels in each of the two services would result in significant wastage of human resources.

Practicality: There is little doubt that there are patients within the Forest of Dean who would benefit from lower travel times to an MIIU because of the implementation of Option 1 or Option 3. However, the traveling time to a single Cinderford site is not out of line with the driving times associated with other MIIU sites across Gloucestershire or in similar ICSs. It should be noted that the Cinderford site was chosen by the Citizens Jury there was the understanding that it would be the only site in the Forest of Dean.

There are several significant practical issues that impact on the evaluation of Option 1 and Option 3. These include several workforce related issues associated with implementing a second site including both recruitment of appropriately skilled staff and resourcing the service sufficiently to ensure that it is not fragile. Only Option 2 has the resourcing and staffing model in place to effectively meet demand without risk to successful delivery.

Quality: A service as outlined in Option 1 or Option 3 will inevitably deliver a poorer experience when compared with the comprehensiveness of the offer in Option 2 both in terms of the available diagnostics and the ability to undertake all minor injury interventions including those that require more than one clinician. The potential for lone working or a small workforce present on site brings with it risks in terms of managing multiple patients requiring intensive support including potential emergencies. These risks are significantly mitigated through the adopting Option 2.

10. Appendices

10.1. Appendix 1 – Registered Practice for all Lydney MIIU Attendances October 22 – September 23

Gloucestershire GP Practices	Attendances	Gloucestershire GP Practices	Attendances
Lydney Practice	2203	Upper Thames Medical Group	3
Yorkley Health Centre	1921	The Stoke Road Surgery	3
Coleford Family Doctors	1213	Hucclecote Surgery	3
Forest Health Care	1173	Sixways Clinic	3
Severnbank Surgery	1097	The Homeless Healthcare Team	3
Brunston Practice	1094	Beeches Green Surgery	3
Dockham Surgery	918	Prestbury Park Medical	2
Blakeney Surgery	698	Chipping Surgery	2
Mitcheldean Surgery	625	High Street Medical Centre	2
Drybrook Surgery	475	Regent Street Surgery	2
Newnham Surgery	289	Acorn Practice	2
Newent Doctors Practice	194	St. George's Surgery	2
The Alney Practice	50	Royal Crescent Surgery	2
Rosebank Health	29	Rendcomb Surgery	1
Aspen Medical Practice	22	Phoenix Health Group	1
Gloucester Health Access Centre	19	Winchcombe Medical Centre	1
Hadwen Health	16	Walnut Tree Practice	1
Staunton & Corse Surgery	15	Cotswold Medical Practice	1
Brockworth Surgery	11	West Cheltenham Medical	1
Partners In Health Pavilion Family Drs	11	Stonehouse Health Clinic	1
Quedgeley Medical Centre	11		
Kingsholm Surgery	9		
Underwood Surgery	9		
Weston House Practice	9		
Church Street Practice	7		
Churchdown Surgery	6		
Longlevens Surgery	6		
Rowcroft Medical Centre	6		
Cirencester Health Group	5		
Yorkleigh Surgery	5		
St. Catherine's Surgery	5		
Cleevelands Medical Centre	5		
Five Valleys Medical Practice	5		
Severnside Medical Practice	5		
Frithwood Surgery	4		
Culverhay Surgery	4		
The Royal Well Surgery	4		
Overton Park Surgery	4		
Cam and Uley Family Practice	4		
Chipping Campden Surgery	3		
Mythe Medical Practice	3		
The Leckhampton Surgery	3		

GP Practice outside of Gloucestershire	Attendances	GP Practice outside of Gloucestershire	Attendances
Town Gate Practice	537	Tylorstown Surgery	1
Wye Valley Practice	518	Meddygfa Hafan	1
Vauxhall Surgery	446	Fishguard Health Centre	1
Mount Pleasant Practice	250	Meddygfa Padarn Surgery	1
(blank)	125	Strathmore Medical Practice	1
Wye Dean Practice	80	Forest View Medical Centre	1
Gray Hill Surgery	75	The Grove Medical Centre	1
Castle Gate Medical Practice	69	Meddygfa'R Llan	1
Dixton Road Surgery	42	The Practice Of Health	1
Underwood Health Centre	9	Felinheli&Porthaethwy Su	1
The Surgery	5	The Waterfront Medical Centre	1
Pengam Health Centre	5	Blackwood Medical Group	1
University Health Centre	4	Ty Elli Group Practice	1
Malpas Brook Health Centre	4	Morlais Medical Practice	1
Risca Surgery	4	Churchwood Surgery	1
Ty Henry Vaughan	4	Mostyn House Medical Practice	1
Llynyfran Surgery	4	Lliswerry Medical Centre	1
Richmond Clinic	4	Blaen-Y-Cwm Group Practice	1
Montgomery Medical Practice	4	Ash Grove Medical Centre	1
Strawberry Place Surgery	3	New Chapel Street Surgery	1
Wellspring Medical Centre	3	Hmp Channings Wood	1
Brynderwen Surgery	3	North Celynen Practice	1
War Memorial Health Centre	2	Isca Medical Centre	1
Eryl Surgery	2	North Road Medical Practice	1
St David's Clinic	2	Taff Vale Practice	1
Bellevue Surgery	2	Oak Street Surgery	1
Vale Of Neath Practice	2	The Medical Centre	1
Meddygfa Taf	2	Oakfield Surgery	1
Health Centre	2	The Penylan Surgery	1
Meddygfa'R Tymbl	2	Ballasalla Medical Centre	1
St Julians Medical Centre	2	The Rugby Surgery	1
Old Station Surgery	2	Eglwysbach Medical Practi	1
Cathays Surgery	2	The Surgery James House	1
Practice 3	2	Pengorof Surgery	1
Clifton Surgery	2	Caritas Surgery	1
Whitchurch Road Surgery	2	Pontcae Medical Practice	1
Glan Rhyd Surgery	2	Trosnant Lodge	1
Bryngwyn Surgery	2	Harbourside Health Centre	1
Rumney Primary Care Centre	2	Alfred St Primary Care Centre	1
Blaina Medical Practice	2	Finch Hill Health Centre	1
Hillcrest Medical Centre	1	Llandrindod Wells Medical Practice	1
Treharris Primary Care Centre	1	Ringland Medical Practice	1
The Mount Surgery	1	Llanedeyrn Health Centre	1
Marches Medical Practice	1	Hereford Road Surgery	1
Llanfyllin Group Practice	1	Llanishen Court Surgery	1
Market Street Practice	1	Riverside Health Centre	1
Tabernacle Surgery	1	Westfield Medical Centre	1
Meddygfa Glan Cynon Surge	1	Roath House Surgery	1

Bryntirion Surgery	1	Cowbridge & Vale Medical Practice	1
Meddygfa Gwydir	1		
Highlight Park Med Practice	1		
Bishops Road Medical Centre	1		
St Athan Medical Centre	1		
Grand Total	**14530**		

10.2. Appendix 2 Population Projections for the Forest of Dean

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
0-19	18,454	18,595	18,757	18,969	19,216	19,441	19,632	19,827	19,993	20,126
20-64	47,055	47,203	47,372	47,549	47,681	47,739	47,794	47,854	47,851	47,810
65 and over	21,034	21,485	21,877	22,237	22,612	23,076	23,564	24,038	24,586	25,165
All ages	**86,543**	**87,282**	**88,006**	**88,756**	**89,506**	**90,254**	**90,992**	**91,720**	**92,428**	**93,097**
	2028	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**
0-19	20,196	20,280	20,322	20,316	20,305	20,331	20,371	20,402	20,403	20,452
20-64	47,803	47,811	47,760	47,721	47,688	47,700	47,669	47,717	47,801	47,861
65 and over	25,755	26,293	26,888	27,476	28,064	28,548	29,038	29,425	29,803	30,154
All ages	**93,754**	**94,384**	**94,970**	**95,519**	**96,056**	**96,577**	**97,076**	**97,544**	**98,002**	**98,464**
	2038	**2039**	**2040**	**2041**	**2042**	**2043**				
0-19	20,544	20,657	20,773	20,894	21,027	21,165				
20-64	48,003	48,178	48,445	48,720	49,079	49,382				
65 and over	30,385	30,548	30,631	30,693	30,659	30,675				

10.3. Appendix 3 - Pharmacies Delivering the CPCS

Service Name	Address	Monday	Tuesday	Wednesday	Thursday	Friday	Sat	Sun
Pharmacy: Badham (Newnham) - Gloucestershire	9 High Street, Newnham-On-Severn, Gloucestershire	09:00-13:00,14:00-17:30	09:00-13:00,14:00-18:00	09:00-13:00,14:00-17:30	09:00-13:00,14:00-18:00	09:00-13:00,14:00-17:30	09:00-13:00	Closed
Pharmacy: Boots (Bream) - Gloucestershire	1 High Street, Bream, Gloucestershire	09:00-18:00	09:00-17:30	09:00-18:00	09:00-17:30	09:00-17:30	09:00-12:00	Closed
Pharmacy: Boots (Cinderford) - Gloucestershire	9-11 Market Street, Cinderford, Gloucestershire	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-16:00	Closed
Pharmacy: Cinderford Pharmacy - Gloucestershire	The Co-Op Foodstore, Dockham Road, Cinderford, Gloucestershire	09:00-13:30,14:00-17:30	09:00-13:30,14:00-17:30	09:00-13:30,14:00-17:30	09:00-13:30,14:00-17:30	09:00-13:30,14:00-17:30	09:00-14:00	Closed
Pharmacy: Coleford Pharmacy - Gloucestershire	9/10 Pyart Court, Railway Drive, Coleford, Gloucestershire	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Pharmacy: Day Lewis (Berry Hill) - Gloucestershire	42 Park Road, Berry Hill, Coleford, Gloucestershire	08:30-13:00,14:00-17:30	08:30-13:00,14:00-17:30	08:30-13:00,14:00-17:30	08:30-13:00,14:00-17:30	08:30-13:00,14:00-17:30	Closed	Closed
Pharmacy: Day Lewis (Chepstow) - Gloucestershire	Beachley Road, Sedbury, Chepstow, Gloucestershire	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-12:30	Closed
Pharmacy: Day Lewis (Coleford) - Gloucestershire	14 Pyart Court, Old Station Way, Coleford, Gloucestershire	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-18:00	09:00-12:30	Closed
Pharmacy: Day Lewis (Newent) - Gloucestershire	19 Broad Street, Newent, Gloucestershire	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	08:30-18:00	09:00-17:00	Closed
Pharmacy: Forest Pharmacy (Lydney) - Gloucestershire	41-43 Newerne Street, Lydney, Gloucestershire	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-18:30	09:00-17:30	Closed
Pharmacy: Lydney Pharmacy - Gloucestershire	33 Newerne Street, Lydney, Gloucestershire	08:30-13:00,13:30-18:00	08:30-13:00,13:30-18:00	08:30-13:00,13:30-18:00	08:30-13:00,13:30-18:00	08:30-13:00,13:30-18:00	09:00-14:00	Closed
Pharmacy: Mitcheldean Pharmacy (Mitcheldean) - Gloucestershire	5 Churchill Way, Mitcheldean, Gloucestershire	09:00-13:00,14:00-18:30	09:00-13:00,14:00-18:00	09:00-13:00,14:00-18:00	09:00-13:00,14:00-18:00	09:00-13:00,14:30-18:00	Closed	Closed
Pharmacy: Boots Pharmacy, Ross-on-Wye, Herefordshire	5 Market Place, Ross-On-Wye, Herefordshire	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:00-17:30	09:30-16:00	10:00-16:00

One Gloucestershire
Transforming Care, Transforming Communities

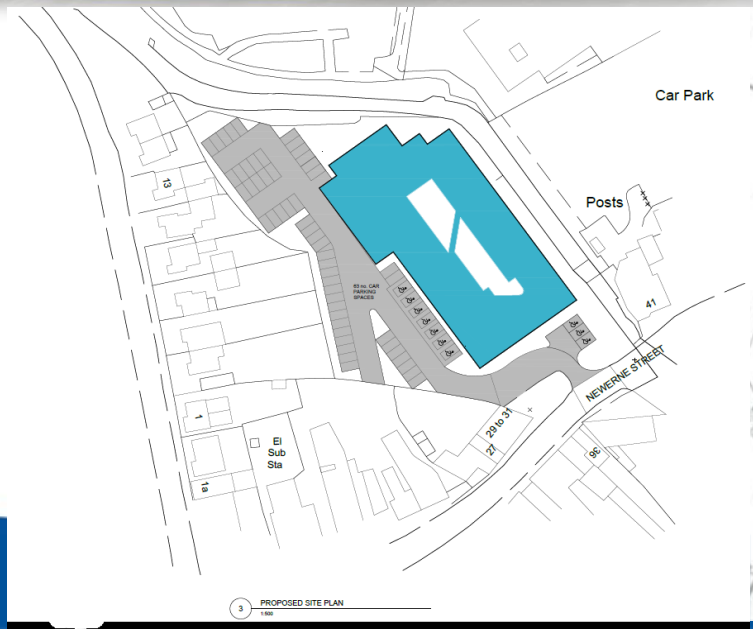
Delivery of a Lydney Health & Wellbeing Hub Scheme

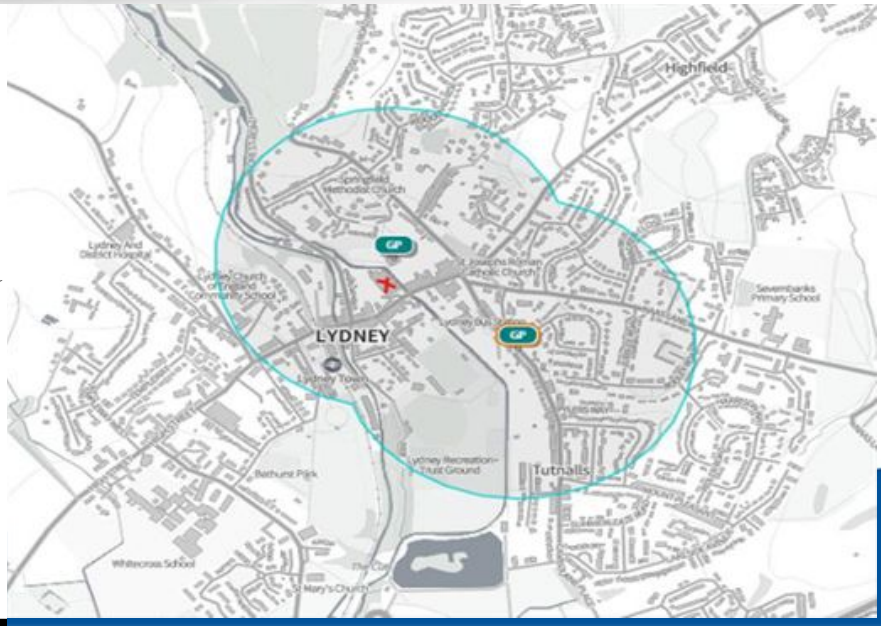
1

Summary

- Development of new Lydney Primary Care Centre key priority for local NHS.
- Co-location of current Lydney practice and Severnbank surgery and to be built for around 15,000 patients with expansion space of at least another 4,000 patients.
- Transformation of existing coop building
- 20 consultation, examination and treatment rooms
- GHC expected to colocate.
- £7.5m capital cost excluding GHC elements.
- Assura - Development Partner;
- Scheme also provides facilities support a large activity and wellbeing space
- New building expected to be open Spring of 2026.

Overarching design and location





One Gloucestershire
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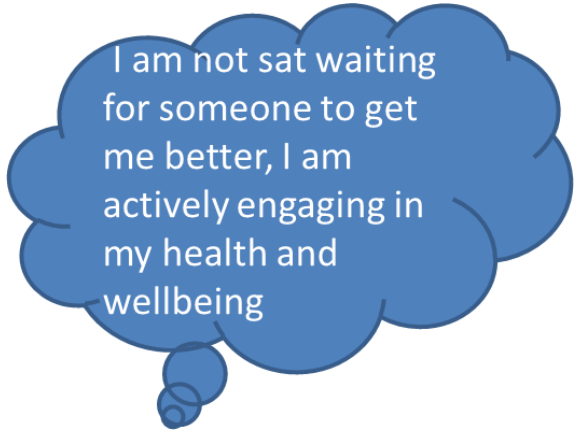
Schematic layout (subject to final refinement)

Focus on activity and wellbeing space: emerging design

Activity & wellbeing space-

- A multi-purpose space that can meet the requirements of many different wellbeing needs.
- Spaces that can cater for different cohorts and flex to deliver a range of activities and energy.
- Available in the day, the evening and the weekend.



One Gloucestershire
Transforming Care, Transforming Communities

A practical approach – designing around four core themes

Food: a Community Pantry or Long Table Freezer of Love onsite with access to healthy food for less; Community Kitchen to learn and make food together

Physical Activity: Walking for Health; Green Gym; Health promotion

Creativity: Creative health activities people can see – art from community on the walls; classes taking place

Connection: Make it work for human relationships – concierge instead of receptionist; social prescribers and volunteers walking around and introducing people; scheduled services drop in such as CAB; include digital inclusion – digital hubs

One Gloucestershire
Transforming Care, Transforming Communities

Delivery timeline

Action	Date
Primary Care & Direct Commissioning Committee (PCDC) approval.	6 June 2024
Legally exchange on Co-op site.	By end of August 2024
Change of Use approval / external alterations planning application	By end of August 2024
Completion of detailed technical design, VOA questionnaire and room data sheets	By end of August 2024
Tender for build contract	Commence August and completed November 2024
Agreement For Lease agreed.	By end of December 2024
Construction contract placed	By end of December 2024
Construction commences	By end of February 2025
Building completed and open	By end of February 2026

NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Health and Care NHS Foundation Trust

Output of Workshop Report: 16 June 2021

Accessing urgent care services from the south Forest

www.fodhealth.nhs.uk

Fit for the Future: Accessing urgent care services from the south Forest

1. Executive Summary

This report is intended to be used as a practical resource for NHS Glouestershire Clinical Commmissioning Group (CCG) in its consideration of access to urgent care services for people living, working or visiting the south of the Forest of Dean. It captures feedback shared through Get Involved in Gloucestershire and the online stakeholder workshop held on the 16 June 2021, which was facilitated by The Consultation Institute.

Following Consultation in late 2020, about services provided by the new hospital in the Forest of Dean, the CCG committed to explore whether it might be possible to develop an option to deliver urgent care services in the Lydney area, following the opening of the new Forest of Dean Community Hospital in Cinderford and subsequent closure of the Lydney and District Hospital. Whilst this work has been delayed beyond the original timeline, the commitment to explore local options remains.

This Report has been prepared by the CCG's Engagement Team and will be shared across the local health and care community. It is available to all on the Forest of Dean health website www.fodhealth.nhs.uk and on the new online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.net For details of how to obtain copies in other formats please turn to the back cover of this Report.

1.2 Summary of feedback

A detailed summary of the feedback received at the workshop can be found in Section 3.4 of this report. Additional feedback received from the Get Involved in Gloucestershire on-line community is also included.

Most workshop participants were supportive of the suggestion that a Minor Injury service could be incorporated into a new health centre in Lydney (solution 2). The rationale for this focussed on the projected rise in population and the difficulties with travel and transport from the south of the Forest to both Cinderford and Gloucester.

There was a call for provision of a significant urgent care service in Lydney that would provide equity for local residents in terms of access and availability.

1.3 Next steps

This report will be considered as part of the work to review access to urgent care from the south of the Forest and shared in full to inform the relevant decision making committees at NHS Gloucestershire CCG.

1.4 Appendices

This report and appendices is available on the FODhealth website at: www.fodhealth.nhs.uk and on the online participation community *Get Involved in Gloucestershire* https://getinvolved.glos.nhs.uk

Appendix 1: *Accessing urgent care services from the south Forest:* Presentation from online workshop held on Wednesday 16 June 2021.

2 Background

2.1 A new hospital for the Forest of Dean

Following a period of Consultation in 2017, the Board of Gloucestershire Care Services NHS Trust (now Gloucestershire Health and Care NHS Foundation Trust; GHC) and the Governing Body of NHS Gloucestershire Clinical Commissioning Group (CCG) approved the option to build a new community hospital in the Forest of Dean. This new hospital will replace The Dilke Memorial Hospital and Lydney and District Hospital.

A Citizens' Jury, made up of local people, met over four days in August 2018. Having reviewed extensive information, they recommended that the new hospital should be located in Cinderford. This recommendation was formally approved by the CCG and GHC.

Further engagement, followed by a period of Consultation with local people and staff during 2020 has informed the services for the new hospital. The site for the new hospital was announced in December 2019 as the Collingwood Skatepark and Lower High Street Playing Field in Steam Mills Road, Cinderford. The Board of GHC approved the Full Business Case for the new hospital in July 2021. The Trust is currently in the process of applying for full planning consent for the new hospital. Assuming that planning is granted, it is hoped work on site will begin in early 2022, with the new hospital opening in Summer 2023.

2.2 Urgent care in the Forest of Dean

During the last phase of engagement regarding the services for the new hospital, concerns were raised around the availability of urgent care in the southern areas of the Forest and the challenge for residents in terms of distance and accessibility to the new hospital in Cinderford.

Alongside the Consultation in late 2020, the CCG gave a public commitment to explore if it might be possible to develop other options for the provision of additional urgent care services in the Lydney area. Throughout the Consultation, people were given the opportunity to register an interest in being involved in this explorative work and consequently an online workshop was arranged for 16 June 2021. The workshop was independently facilitated by The Consultation Institute.

The workshop provided an opportunity to discuss ideas and take account of potential opportunities and constraints. It was not intended to reconsider the decision to build a new hospital in Cinderford, which will replace the two existing hospitals in the Forest of Dean.

3 Workshop

This section describes the approach taken in the organisation and delivery of the independently facilitiated workshop, including an overview of the attendees, content presented and feedback received.

3.1 Opportunity to participate

During the Consultation in late 2020, approx. 100 people expressed an interest in being involved in future discussions relating to access to urgent care. Following the CCG response to the Consultation, we contacted those who had expressed an interest to advise them of the short delay in this work and subsequently invited them to attend a workshop.

Due to the ongoing COVID-19 restrictions, the workshop had to be arranged online (via Zoom) and was scheduled for 4pm on Wednesday 16 June 2021. We recognise that this format and the timing of the on-line event may have restricted some people from taking part in the discussions. Consequently we invited people to share their views via our Get Involved in Gloucestershire on-line community and contact us if they were unable to access digital options so we could facilitate their participation.

Thirty-five people registered to attend the workshop. Most attendees were either resident in the south of the Forest of Dean and/or members of community organisations, Councillors, or healthcare partners supporting this community. This included representatives from Cinderford Town Council, County Councillors, Dilke Hospital League of Friends, Forest Health Forum, Forest Sensory Services, Forest Voluntary Action Forum, Friends of Lydney and District Hospital, HOLD, Lydney Dial-a-ride, Lydney Town Council and local GPs.

Sixteen people commented via the Get Involved in Gloucestershire on-line community and two people wrote to us requesting further information to enable their participation.

3.2 Workshop presentation

A copy of the full presentation is included in Appendix 1. In summary, the presentation aimed to ensure participants had a shared understanding of the local population, current urgent care services and the role of other health and care services in supporting the local community. The presentation covered the following key points:

3.2.1 Population demographics: to support the assessment of current and future need for urgent care services, we need to consider the current/projected population numbers; existing/projected GP practice populations and housing developments in the local area.

Facts & Figures:

- In 2019 population in the wards in the south of the Forest – approx. 41,000
- The Forest of Dean District Council, housing completions and availability trajectory report of July 2020 indicates that between 2020 and 2031, 2,207 homes will be built across wards in the south of the Forest
- GP practices: Blakeney Surgery, Lydney Health Centre, Severnbank Surgery, Yorkley & Bream Practice – approx 23,000 registered patients
- Hospital minor injury activity – Approx. 11,000 attendances (in 2018/19, Significantly reduced over last year due to COVID)
- There are significant developments in Chepstow planned, some people from these postcodes may access services in Lydney
- Analysis of flows shows us that people in the South Forest also attend services in the Bristol and South Wales areas.

3.2.2 Other health and care services in the Lydney area: before considering urgent care services, it is important to understand other health and care services that are accessible to the local community:

- New Lydney Primary Medical Centre (to include the Lydney Health Centre Practice and Severnbank Surgery with a combined list size of approx. 11,150 patients). The surgery will be designed to accommodate a minimum of 15,000 patients. To note:
    - The building will have space for community outpatients
    - Subject to Business Case processes and planning approval etc. building work expected to start late 2023 / building open early 2025
- Care at Home (including urgent care) is provided by a range of practitioners including District Nurses, Paramedics, Physios, OTs offering Rapid Response and Complex Care at Home.
- Specialist teams are offering care in the home for people who have both physical and mental health Long Term Conditions.
- Integrated Care Teams (health and social care working together) in the Forest are divided into 2 teams, the North and the South team and they are currently based across Cinderford, Coleford and Lydney Health Centres and several GP practices.
- A number of eye care services have been relocated out of hospital and into primary care, including Glaucoma follow-up care and treatment for minor eye emergencies. The Kear Optometry practice in Lydney is signed up to deliver this service.
- Pharmacies currently provide a range of self help advice for minor injuries and ailments.
- A Social Prescribing service to support people with a wide range of health and wellbeing needs is available from our practices across the district.

3.2.3 Urgent care: information shared included a definition of urgent care; the range or urgent care services available to people in any 24 hour period**;** the role of existing Minor Illness & Injury Units and who attends the units in the Forest of Dean.

Urgent Care – An illness or injury that requires urgent attention i.e. generally needs to be assessed and dealt with on the day, but is not a life threatening situation.

Emergency Care – When you have a life or limb threatening illness or injury which requires rapid and intensive treatment.

Urgent & emergency services in Gloucestershire are currently provided through the routes below. We understand that sometimes due to convenience / travel time people choose to attend services in other areas e.g. at The Grange University Hospital, Cwmbran.

- Community Pharmacies: offer assessment of minor ailments
- Online and telephone advice: National and local NHS websites and Apps as well as the 24/7 NHS 111 telephone and web-service. NHS 111 is able to book urgent appointments with GP practices and Minor Injury Units.
- GP surgeries: supporting people with their long term conditions as well as urgent ailments.
- Out of Hours GP service: 18.30 – 08.00 hours Monday to Friday and 24 hours a day at weekends and bank holidays. Accessed via NHS 111, providing urgent telephone advice, face-to-face appointments and a home mobile visiting service.
- Private and NHS dental practices: located throughout Gloucestershire with an urgent Out of Hours service based in Gloucester City.
- Minor Illness and Injury Units (MIIUs): Units support people with a variety of minor injuries such as sprains, broken bones and cuts. Currently provide support for minor illness including sore throats, rashes and headaches.
- Emergency Departments (A&E): Two Emergency Departments, in Gloucester and Cheltenham, which provide care for people who have a life threatening illness or serious injury such as heart attacks and or significant fractures. People with less serious (including minor) illness and injury can also ‘walk in’ to these services.
- Out of county A&E: The most complex ‘tertiary’ urgent care services are provided through regional networks at ‘out of county’ hospitals such as Southmead Hospital, Bristol. This would include care for major trauma, such as following a major road traffic accident or care for a patient with significant burns.

Our community hospital MIIU’s are nurse practitioner led units which specialise in treating things such as sprains, simple fractures and wounds, minor burns, skin problems and other minor illness. Whilst they have x-ray facilities available the opening hours do not always match the opening hours of the MIIU, meaning some patients have to attend a different location.
In considering minor illness and injury services for the south of the Forest, it is important to recognise that:

- Minor Illness is primarily the business of primary care and most people with a minor illness need on the day receive urgent care from their GP.
- The future plan is that all hospital based urgent care services in the county will focus on injuries, with illness redirected to primary care (care closer to home)
- Urgent care services will increasingly be pre-booked 'talk before you walk', this will support redirection of illness to primary care.
- Services currently operating during COVID 8am – 8pm, 365 days /year
- Approximately 6% of patients with an injury require an x-ray
- Some Primary Care Networks/GP Practices are already delivering injury care to their local population, e.g the 'Winchcombe' model.

3.3 Facilitated discussion

Before breaking into three smaller discussion groups, attendees were introduced to a Primary Care led model for minor injury services and asked to consider two potential solutions:

- **Solution 1:** The new hospital in Cinderford will provide the MIIU facility for the district. It will be open 8-8, 7 days a week and be supported by x-ray. The unit will provide dedicated space for children to meet national expected standards. As minor illness is increasingly redirected to GP practices it is expected this unit would be anticipated to serve approx. 11,000-17,000 patients per annum, depending on the size of the illness 'shift' to primary care. Moving illness to primary care could provide a 'care closer to home' benefit.
- **Solution 2:** Provide the hospital unit as per the above AND provide an injury service in Lydney for up to approx. 3,500 patients per annum. Forest Hospital takes all other injuries (approx. 7,500 -13,500 patients per annum) as urgent illness is increasingly seen in people's own GP practices. The Lydney practice service would be a weekday service, opening hours TBC.

Through facilitated discussion, participants were asked to consider each proposal against the 'case for change criteria' established during the development of the hospital services in the Forest of Dean:

Case for Change	Solution 1: Hospital Only	Solution 2: Hospital+Lydney
The existing healthcare estate is no longer fit-for-purpose, and does not efficiently support the provision of modern, effective, high-quality care	There will be a new hospital with fit for purpose facilities, with capacity for population growth accommodated, including dedicated space for children	There will be a new hospital in Cinderford and a new health centre in Lydney, both with sufficient capacity for population growth in place
The ability to maintain some essential services across two community hospital sites is becoming increasingly unsustainable	The staff can be consolidated into one team and we can make the best use of our resources	We will need to staff two units, and there will be a greater running cost having two units open The reduced workload per site may impact on staff experience and attractiveness of the roles – impact on retaining staff
The current healthcare system is fragmented and disjointed from both a service user and professional perspective	There will be one clear offer for the district, which will be easier to communicate where to attend, with x-ray available	Would this offer be more complex to communicate? - we would need to consider how to present what the Lydney offer would be?
There are significant needs within the Forest of Dean which are not being met effectively or equitably	The Citizens Jury selected the Cinderford site on a rationale of putting services closest to areas of highest deprivation. However moving to one site will extend the travel time for some people, especially those in the south of the Forest	There would be an option for people to attend a minor injury service closer to home – is there a clear rationale of the population needs for prioritising this offer for people in Lydney? Should we be considering other areas e.g. Coleford?

3.4 Feedback

Case for change: Estate

The existing healthcare estate is no longer fit-for-purpose, and does not efficiently support the provision of modern, effective, high-quality care.

There was significant support amongst workshop participants for solution 2, which proposed additional services in Lydney. The rationale for this focussed on the projected rise in population and the difficulties with transport from the south of the Forest to both Cinderford and Gloucester.

Concern was raised about the uncertainty regarding the new GP premises in the town as discussions are still in the early stages and there is no confirmed site for the new health centre. Many participants commented on the potential gap in provision with the closure of Lydney and District Hospital likely to come inbefore a new health centre is built in the town.

Whilst participants were interested in the Winchcombe Minor Injury service, it was noted the population in Lydney and surrounding areas would be significantly higher and a new build would need to be sized appropriately. Examples of comments noted below:

Definitely need a second site in the Lydney area. Public transport is a significant challenge and really difficult if you have a sensory impairment and/or disability.

The journey to Cinderford even by car is harder than just driving straight to Gloucester A&E or Southmead.

I think a projected list size of 15,000 for the new health centre is about right .

The old hospital site is dear to me, but I recognise that the service available is more important.

It works in Winchcombe but that's very different to Lydney. We would need it to be much bigger.

The Winchcombe model does seem to bring some value, but from the stats given for 2019 that only averages 3 people a day accessing the services, so is it too limited in its offer or operating hours?

Where will the new health centre be built? Could it be on the old hospital site or use the old hospital refurbished?

We need a service to cover the gap between the hospital closing and a new health centre opening its doors.

Case for change:Sustainability of services
The ability to maintain some essential services across two community hospital sites is becoming increasingly unsustainable.

Issues with recruitment and retention of staff to the existing MIIU were raised by some participants, whilst others asked about the potential impact on GP services in the town, which were already considered to be stretched. There was uncertainty about whether the GP services would be able to manage with the redirection of illness back to primary care. Some participants reflected on the variation in services between current GP practices and the impact of the COVID-19 pandemic on the range of appointments available.

A number of questions were raised about the staffing model:

- which organisation would employ staff to work in an urgent care service at the new health centre?
- would staff transfer from the existing MIIU at the hospital?
- how would staff retain their skills?

Whilst some questioned whether providing a minor injury service on two sites might dilute a good service, there was also recognition of potential benefits in bringing primary care teams together with other healthcare professionals. Examples of comments noted below:

Would staff be able to rotate between different sites so that they could maintain their skills? Training staff takes a long time.

Will GPs be able to maintain the service? Services are already reduced because of COVID. When will they be reinstated?

Continuity of care is really important. Services need to be linked to Primary Care and integrated with other healthcare professionals.

How will community services work out of the new health centre? Would it be GHC staff who would run the MIU?

Should we not be looking at recent data, especially with Covid as this is putting pressure on services?

I don't believe the figures for Lydney MIIU. I know of people who have waited over two hours recently because they were busy. Would a MIU in the new health centre be able to cope with demand?

Case for change – Joined up care

The current healthcare system is fragmented and disjointed from both a service user and professional perspective

Many participants felt that people don't understand the existing services and stressed that good communication about the availability and location of services is always really important. If there was a minor injury service at a new health centre in Lydney, people suggested clear messaging about who could use the service, what they should use it for and when it was open would be essential.

Due to the unplanned nature of urgent care services, there was recognition that it was difficult to target messaging in a timely way.

If there was a "gap" in the minor injury service in the town, between the hospital closing and a new health centre opening, it was suggested there would need to be communication campaign to avoid unnecessary attendance at Gloucestershire Royal Hospital. Examples of comments noted below:

If there isn't a MIU in Lydney people will be confused and just go to GRH, not Cinderford.

Communication needs to be really clear and simple. People need to know what to do otherwise they'll just call an ambulance.

People generally don't understand existing services and what is available, for example lots of people don't know about the hearing services at Lydney hospital.

Communication is absolutely key. You'll need to have some really clear messages if there is a "gap" in the services.

When you need urgent care you need it now – it's difficult to target messaging, you just need to keep repeating the messages.

There is no mixed message – the people of Lydney want a service in the town.

You need to think about communication with people living on the Welsh border. Lots of people from Chepstow use the service at Lydney hospital.

If you want people from Lydney to use the hospital in Cinderford you're going to have to make a good case. Most people will just go straight to Gloucester.

Case for change: Needs/Equity
There are significant needs within the Forest of Dean which are not being met effectively or equitably

There was much discussion about the topography of the Forest of Dean, road infrastructure and the lack of public transport between Cinderford an the south of the district.

The closure of Lydney and District Hospital was a significant concern raised by workshop participants considering the projected increase in housing in Lydney and the surrounding areas, particularly those near the Welsh border. The loss of outpatient services and access to mobile units such as the screening services that currently visit the hospital site was also raised.

Some participants reflected on the fact that there has only been one MIIU open in the Forest of Dean during the pandemic and questioned the impact of this change. Examples of comments noted below:

In poor weather road transport to Cinderford from Lydney is a real problem. Solution 2 would at least give some relief.

What has been the impact on GRH of only one MIIU in the Forest this year? The answer to this question should inform the decision about a service in the south of the Forest.

Lots of new houses and residents coming to the South Forest. Many are moving from Bristol and they have high expectations of access to NHS services.

The topography of the Forest of Dean means the south Forest needs an MIIU. Lydney residents are 'entitled' to an MIIU.

Lydney is roughly the size of Ross-on-Wye, which has many more NHS services

I know someone who is disabled finds travelling really difficult and uncomfortable. Having online services has helped, but when they need to travel it needs to be as short a distance as possible.

Lydney needs more than the Winchcombe offer. The MIU needs to be open 7 days a week

It's not just MIU. We need lots of outpatient services in the south of the Forest too.

Cost shouldn't be a factor. The money saved from closing Lydney hospital should be used to fund services in Lydney

4. Comments from *Get Involved in Gloucestershire*

The following comments were made via the Get Involved in Gloucestershire online community and related to access to urgent care from the south of the Forest.

- There is no logic in removing the minor injuries unit from Lydney , pressure on A & E at the GRH coupled with the travelling time makes smaller minor injury units sensible and economically viable and what is most important is that they provide a better and speedier service to the patients. We need this service in Lydney, a town which is expanding all of the time . Cinderford is relatively inaccessible to those who do not have a car so what will they do? call an ambulance and probably be taken to GRH. It may be less costly from an accountants stand point but considerably more expensive for the patient, in time, and worry (and probably financial as well).
- If anything the forest needs MORE MIUs with all the tourism and other sectors coming back to life and continuing to build, cannot see how having a single hospital unit is going to benefit the Forest.
- We definitely need to keep our minor injuries unit in Lydney it is vital for our residents who are unable to drive due to pain and discomfort as well as not being able to drive, we also need our outpatients services such as physio therapy, specialist consultations appointments ect as there are many people in the south end of the forest that are in pain before attending physio so a closer facility is vital for treatment and having to travel further away for treatment will cause more pain and discomfort and make the discomfort worse. Lydney is the largest town in the forest and is already having more housing development built aswell as other towns around the South end of the forest so we need a closer facility to accommodate all south end residents and provide closer accessible care which will provide less travelling time, reduce pain and discomfort and save finance.
- Lydney needs MIU. The town is expanding rapidly. This will put a large amount of strain on GRH. Not everyone drives and bus services stop early evening,which will mean people having to rely on the ambulance service for transport.
- We desperately need a Minor Injuries unit, medical centre in Lydney. It is not just Lydney having a housing explosion, Sedbury and Tutshill are as well plus, every likelihood that the Army camp could become a housing site.
- Any hospital needs to be 'fit for purpose but also needs to be futureproofed. With the amount of homes to be built within the Forest boundaries (potential new 4,000 home village off the A48 is just the tip of the iceberg) it would be a relatively short time before the new hospital mooted for Cinderford would be proved to be a total waste of time and money. Yes the current facilities are outdated and probably not cost efficient but surely that is where the energies should be directed. Make the most of what we already have, make them a model for other areas having the same problems.
- Lydney MIU is a crucial life line in the area, which, given our geography is a service that needs to stay. Over the years it's been extremely helpful to my family and countless others. It's out of the question for local people to travel to Cinderford, especially at

vulnerable times in their lives which is generally when you need a hospital. Public transport just isn't an option.

- Lydney needs MIU. The town is expanding rapidly. The people of Lydney deserve better than the options being proposed Use the money available to support existing facilities and stop wasting money on these so called consultations that so far seem to be ignored LISTEN

A small number of additional comments were received via Get Involved in Gloucestershire, but these did not relate to urgent care services and have therefore not been included in this report.

5. Next steps

This report will be considered as part of the work to review access to urgent care from the south of the Forest and shared in full to inform the relevant decision making committees at NHS Gloucestershire CCG.

5. Copies of this report

This report is available on the FODhealth website at: www.fodhealth.nhs.uk
and on the online participation platform Get Involved in Gloucestershire
https://getinvolved.glos.nhs.uk

Print copies of the report can be obtained from the Engagement and Experience Team by calling Freephone 0800 0151 548 or email: GLCCG.gig@nhs.net For information in alternative formats please see back cover.


To discuss receiving this information in large print or Braille, please ring **0800 0151 548**
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Accessing urgent care from the south Forest
5220 Valiant Court, Gloucester Business Park, Brockworth,

NHS Gloucestershire ICB Audit Committee Part 1 Meeting

Held at 09.30am on Thursday 7th March 2024
as
Hybrid Meeting via MS Teams and in ICB Canton Room, Shire Hall, Gloucester

Members Present:		
Julie Soutter	JS	Non-Executive Director, ICB (Chair)
Dr Jo Bayley	JB	Chief Executive, GDOC
Michael Napier	MN	Non-Executive Director, GHFT
Participants:		
Adam Spires	AS	Partner, BDO LLP
Christina Gradowski	CGi	Associate Director of Corporate Affairs, ICB
Cath Leech	CL	Chief Finance Officer, ICB
Julie Masci	JM	Director, Grant Thornton LLP
Justine Turner	JT	Audit Manager, BDO LLP
Paul Kerrod	PK	Deputy Head of Local Counter Fraud Service
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Jekaterina Sinakova	JSi	Finance Trainee, ICB
Ryan Brunsdon	RB	Board Secretary, ICB
Mark Golledge *(Agenda Item 8)*	MG	Programme Director, PMO & ICS Development, ICB
Kelly Matthews *(Agenda Item 8)*	KM	Programme Delivery Director, ICB
Tracey Cox *(Agenda Item 8)*	TC	Director of People, Culture & Engagement, ICB
Emma Savage *(Agenda Item 11)*	ES	Associate Director of Research & evaluation, ICB
Sarah Jeeves *(Agenda Item 11)*	SJ	Clinical Manager, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the Audit Committee.

2. Apologies for Absence

2.1 Apologies were received from Ayesha Janjua (AJ) and Marcia Gallagher (MG).

2.2 The Chair confirmed that the Audit Committee meeting was quorate.

3. Declarations of Interests

3.1 There were no Declarations of Interest (DOI) received other than those presented by way of Register.

4. Minutes of the Last Audit Committee Meeting Held on 7th December 2023

4.1 Minutes of the meeting held on 7th December 2023 were approved as an accurate record of the meeting.

5. Matters Arising & Action Log

5.1 **Action 21: 07.12.2023, Item 7.1.2,** Internal Audit Cyber Report. Members stated that waiting for 3 months to receive the cyber security report could be an inhibiting factor in the mitigation of risk. Members requested that the report be circulated to Audit Chairs of partner organisations for consideration, by January 2024. The reported was circulated. **Closed.**

5.2 **Action 22: 07.12.2023, Items 7.3.12 & 7.3.2,** POD Governance. 5 recommendations from internal auditors relating to POD were receiving attention and were awaiting further guidance from NHS England. It was agreed that the reports would be brought before the Committee in June 2024. **Item remains Open.**

5.3 **Action 23: 07.12.2023, Item 8.2,** Risk Development. It was recommended that Risk Leads and Risk Owners should receive further training to help them fully comprehend basics such as risk description, risk impact and risk controls. All Risk Leads have been met. **Closed**

5.4 **Action 24: 07.12.2023, Item 10.2,** Audit Committee Annual Review. Members requested that the new Annual review platform developed by Christina Gradowski be extended to the Board and the other committees in agreement with the Chair. Annual Committee Assessment Surveys have started to be extended to other committees. **Closed.**

5.5 **Action 25: 07.12.2023, Item 10.2,** Audit Committee Annual Review. It was agreed that Julie Soutter would meet Christina Gradowski to review the survey outcome and possibly create an action plan to address areas identified as requiring improvement. Recommendations from the review were being implemented. **Closed.**

5.6 **Action 26: 07.12.2023, Item 17.2,** POD Governance. It was agreed that reports on POD transition would be brought before the Committee in June 2024. **Item remains open.**

6. External Audit Plan for Year Ending 31stMarch 2024.

6.1 JM presented the External Audit Plan for approval. JM described the Gloucestershire Integrated Care Board (thereafter "the ICB") planning materiality of £20,098,000 as equating to 1.5% of annual expenditure budget for 2023-24. JM added that overall, the level of testing materiality would be enhanced. JM stated that during the audit, the auditors took into consideration contract variations and operational transactions taking place prior to year-end deadline. JM highlighted the increase in variable spend in the ICB.

6.2 JM mentioned inaccuracy of non-NHS expenditure as another potential risk requiring attention. JM described Value for Money (VFM) arrangements and stated that the auditors had not found any significant weaknesses in the previous years. JM explained that the Mental Health Investments Standard (MHIS) audit was completed in February and the auditors had

issued a certificate to the ICB. JM clarified that a compliance statement would formally be published after being signed off by NHS England. Members discussed the report and agreed an overall Green Assurance rating.

RESOLUTION: The Audit Committee approved the External Audit Plan for Year Ending 31st March 2024.

7. Internal Audit Report

7.1 Progress Update Report

7.1.1 AS presented and explained that work relating to Cyber Environment, Key Financial Systems and Personal Health Budget was complete and work on POD was progressing. AS stated that some adjustments were made to some sections of the Plan to accommodate in year changes. AS stated the reasons behind the slippage and the rescheduling of work relating to Primary HealthCare commissioning.

7.2 Internal Audit Follow-Up Report

7.2.1 AS confirmed the seven recommendations which had been implemented by the ICB, and he highlighted four recommendations whose implementation was progressing well. AS added that the recommendations which were being implemented would address the problems surrounding Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity. AS also cited the recommendation relating to the revisiting and the redefining of ICB and ICS vision, priorities and objectives as being overdue.

7.3 Draft Head of Internal Audit Opinion

7.3.1 AS explained that the report provided an overall opinion on adequacy and effectiveness of the ICB's risk management and governance processes. AS stated that audit opinion was based on:

- assessment of the design and operation of underpinning Board Assurance Framework;
- assessment of supporting process;
- management's diligence in addressing identified control weaknesses;
- level of reliance placed upon third party assurances.

7.3.2 AS clarified that the Head of Internal Audit Opinion was a draft report which could be amended, and he highlighted that the audit work so far covered pointed toward Moderate Assurance. Members discussed various possible ways of supporting the organisation toward substantial Assurance. AS suggested that consistency of standards would lead to a higher rating.

7.4 Draft Internal Audit Plan

7.4.1 JT presented the Internal Audit Plan and sought approval for the Plan. JT stated that in terms of internal controls the auditors took a risk-based approach. JS emphasised that considering that system risks for which committees of the Board were responsible fell within the realm of enterprise risks, committees of the Board could benefit from a joined-up approach to managing systems risks.

7.4.2 JT stated that planned risk controls should be embedded in both long term strategic plan and short-term operational plans. NM expressed a concern that Equality, Diversity and Inclusion (EDI) had been flagged a high-risk area but appeared to be excluded from the Audit Plan. CGi responded that an EDI maturity review was underway. Members requested to receive updates on progress of the review. **Action: CGi to update the Committee on progress.** JS suggested that committee Chairs charged with supporting the managing of risks should schedule meetings to share ideas on risk. **Action: CGi, RB and GN to engage committee Chair and facilitate meetings.**

CGi

GN

7.5 Key Financial Systems

7.5.1 JT presented and stated that the ICB was required to maintain sufficient controls over its key financial systems to support effective management of resources. JT explained that the auditors had conducted comparative analysis on controls in similar organisations. JT added that the areas reviewed and tested during process included access controls, control accounts reconciliation, journal entries, Board financial reporting and effectiveness of Cost Improvement Plans (CIP). JT highlighted that auditor issued Substantial Assurance for both design and effectiveness of ICB Key Financial Systems. Members commended the efforts of the finance team.

7.6 Personal Health Budget

7.6.1 JT described Personal Health Budget (PHB) as amount of money identified by the ICB as appropriate to support a person's health and wellbeing needs. JT explained that when funding was jointly provided by the ICB and local authority it would be referred to as Integrated Personal Budget (IPB). JT stated that BDO LLP and Local Counter Fraud Service (thereafter "Counter Fraud") conducted a joint audit on PHB transactions and processes.

7.6.2 JT cited notable improvement in Continuing Health Care (CHC) PHBs. JT cautioned that the PHB audit did not cover the complete spectrum of PHBs within the system and this limited the audit. JT clarified that there were PHBs which were outside the Terms of Reference of the auditors; these were managed by partner organisations. CL stated that the ICB contributed toward standardised system through sharing PHB best practice with partners.

7.7 POD Audit (Dental)

7.7.1 JT stated that the report was still incomplete and being finalised. The Chair directed that the report be subsequently circulated to members. **Action: GN, AS and JT to circulate the report to members.**

GN

7.8 Members noted the auditors' concerns and recommendations applying to PHBs but overall agreed a Green Assurance rating.

RESOLUTION: The Audit Committee:

- **Noted the Internal Audit Progress Report.**
- **Noted the Internal Audit Follow-Up Report.**
- **Noted the draft Head of Internal Audit Opinion.**
- **Noted the Key Financial Systems Report.**
- **Noted the PHB Report.**
- **Ordered that the POD report be circulated.**
- **Approved the Internal Audit Plan for 2024-25.**

8. Risk Management Report

8.1 Board Assurance Framework (BAF)

8.1.1 CGi presented the BAF and described how risk tools were embedded in the ICB strategic objectives and how they mitigated threats to the Pillars supporting the vision, mission and strategy of the ICB. CGi explained that the Governance team met with directorate Risk Leads and others to collaborateon applicable tools and promotion of BAF efficacy. CG also highlighted that the Governance team directly appraised each Executive Director of the risks impacting their respective directorates.

8.1.2 CGi added that all risks were taken to the Operational Executive meetings for collective scrutiny. Members commended the new BAF reporting. JS stated that collaborating with partners could standardise risk scoring regime across system. JS added that she was committed to working closely with relevant committee Chairs and feedback from them would be valuable on matters of improving risk Assurance.

8.2 Corporate Risk Register Report

8.2.1. RB stated that the ICB had 22 public facing risks and 7 sensitive risks which for practical considerations remained confidential. RB presented the risks aided by application of dashboard. The dashboard showed both high level and low-level risks through use of tables, bar graphs and circular heat maps (doughnut maps).

8.3 Risk Closure Report

8.3.1 RB requested approval to close four risks, namely:

- F&BI 6;
- Integration 1;
- Integration 24;
- SG4.

RB explained that requested for closure related to risks around the Sanger House lease, workforce pressures and maternity services pressures. RB stated that the matters giving rise to the risks had reversed or had been mitigated.

8.3.2 Members discussed the report on risks. Members noted some risks requiring extra focus but commended the commitment and pace of mitigating risks demonstrated by the Governance team. Members gave an overall Assurance rating of Amber.

8.4 Risk Management Deep-Dive

8.4.1 MG and KM presented the risks for the Strategy & Transformation directorate. KM described the measures the directorate was taking to mitigate such risks. MG explained that some of the risks in question were inherently cross directorate or cross system, and the Strategy & Transformation directorate was strengthening information sharing with other directorates, system partners, and Programme Groups. Members discussed the information presented and expressed a concern over some risks but agreed with the direction and measures being taken by the Strategy & Transformation directorate. Members gave a directorate Assurance rating of Amber.

RESOLUTION: The Audit Committee:

- **Noted the BAF report.**
- **Noted the CCR report.**
- **Noted the Deep-Diving report.**
- **Approved closure of 4 risks as per request.**

9. Conflicts of Interest

9.1 GN presented and stated that the ICB staff had complied with the requirement to declare interests. GN stated that the required compliance standard was 95%. GN explained that compliance level in the third Quarter (Q3) was 100% for members of the Board and the average compliance level for both the Board members and staff was 97%. GN further stated that compliance level in the fourth Quarter (Q4) was 100% for members of the Board and the average compliance level for both the Board members and staff was 98%. Members discussed the report and agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Conflict-of-Interest report.

10. Draft Annual Governance Statement

10.1 CGi presented the Statement and stated that the draft was complete except for a few updates which were not ready at the time of presenting the draft before members. CGi explained that the Annual Governance Statement would on completion be incorporated into the Annual Report. Members discussed the Statement and noted the outstanding data and information. Members agreed a Green rating for Assurance.

RESOLUTION: The Audit Committee noted the draft Annual Governance Statement.

11. Policy Approvals

11.1 Clinical Records Management Policy

11.1.1 SJ presented the draft Clinical Records Management policy. SJ clarified that this was an update of an existing policy. Members discussed the policy and identified areas requiring improvement. The policy was referred back for reconsideration. **Action: SJ and CGi to rework the policy and bring it back before the committee.** **SJ & CGi**

11.2 Intellectual Property Rights Policy

11.2.1 ES presented an updated draft Intellectual Property Rights policy Members discussed the policy and identified areas of improvement for the policy. MN expressed a need to revisit gains accruing from the policy review and beneficiaries from such gains. MN suggested that ideally the ICB should draft a policy which favoured the retention of benefits accruing from inventions instead of awarding such benefits to employees. **ES & CGi**

11.2.2 MN emphasised that the ICB was an enabler and sponsor of the policy, therefore favouring the ICB as the main beneficiary of Intellectual Property Rights policy made sense, and it was not an infringement of law. MN also cautioned that Intellectual Property Rights policy should be drafted with capacity to retain rights when engaging third parties in contracts. Members referred the policy back for reconsideration. **Action: ES and CGi to rework the policy and bring it back to the committee.**

RESOLUTION: The Audit Committee:

- **Referred back the Clinical Records policy for further amendment.**
- **Referred back the Intellectual Property Rights policy for further amendment.**

12. Counter Fraud Report

12.1 PK presented the Counter Fraud Report including cases being investigated by Counter Fraud and the actions being taken. PK presented the Counter Fraud Functional Standard Return ((CFFSR) 2023-24 proposed ratings and performance metrics. PK requested approval of the Counter Fraud, Bribery and Corruption 2024-2025 Workplan. PK reiterated that overall Counter Fraud performance standards had achieved Green Assurance overall, and across each individual category except for fraud, bribery and corruption risks which were rated Amber. PK reassured that Counter Fraud and Governance Risk Leads were continuing to work toward achieving a Green Assurance rating for this individual section and notable progress was had been made to move from Amber. Overall, members agreed a Green Assurance rating.

RESOLUTION: The Audit Committee:

- **Noted the progress report.**
- **Noted the Counter Fraud Functional Standard Return (CFFSR) proposed ratings- 2023/2024.**
- **Noted the Counter Fraud Metrics report.**
- **Approved the Counter Fraud, Bribery and Corruption 2024-2025 Workplan.**

13. Summaries of Procurement Decisions

13.1 CL presented procurement decisions relating to the following:

- Children and Young People's Autism Assessments;
- Implementation of the Provider Selection Regime (PSR) Regulations;
- TiC+ and Young Gloucestershire Contracting Arrangements for Mental Health Support (Children and Young People);
- West Cheltenham Medical Practice;
- Community Vasectomy Contract.

13.2 Members noted the significant sum totalling £3,264,958 which related to TiC+ and Young Gloucestershire Contracting Arrangements for Mental Health Support. CL reassured that the procurement decisions had followed process. She added that the decisions went through scrutiny of Operational Executive Committee and ultimately that of the Board. Members agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted contents of the Procurement Decisions report.

14. Register of Waiver of Standing Orders

14.1 CL presented 15 waivers of Standing Orders approved by the ICB Executive. Members examined the waivers and discussed their impact. Members requested to see a trend analysis of waivers and transactions across major suppliers, high value and volume for example. **Action: David Porter to prepare the report.** Members reviewed the Standing Orders and agreeed a Green Assurance rating. **DP**

RESOLUTION: The Audit Committee noted the Waivers of Standing Orders.

15. Draft Annual Accounts Timetable

15.1 CL presented an overview of the timetable for the ICB Annual Accounts for 2023-24. CL added that the 2023-24 timetable reflected that of the previous year. CL highlighted that draft Accounts would be submitted to the Department of Health and External Auditors by 9:00am on 24th April 2024, and the audited Accounts would be submitted to NHS England by 9:00am on 28th June 2024. CL further stated that the deadline for publishing the Annual Report and Accounts on the website was 30th September 2024. JS reiterated that members would hold an informal meeting on 9th May 2024 via MS Teams to be briefed on the draft Accounts and subsequently hold a formal meeting on 24th June 2024 to recommend approval of the final Accounts by the Board on 27th June 2024.

RESOLUTION: The Audit Committee noted the final Accounts Timetable and Plan.

16. Losses and Special Payments Report

16.1 CL presented two losses incurred by the ICB during year 2023-24. An overpayment of £78.74 made to an employee was written off and an amount of £668.31 owed to the ICB by Lloyds Pharmacy Ltd was also written off.

RESOLUTION: The Audit Committee noted the Losses and Special Payments report.

17. Debts Write-Offs

17.1 Nothing was reported under this item.

18. Aged Debtor Report

18.1 CL presented the outstanding debt report as at 27th February 2024; this showed total debt of £932,097 of which £587,190 was NHS and £344,907 was non-NHS. CL clarified that the debt had gone down, and the total debt had been reduced by about £400,000 at the time of presenting the report. Members discussed the individual items constituting the outstanding debt and the actions required to recover such debt. CL stated that all controls were in place and functioning well. Members expressed satisfaction with management action and the low level of risk. Members agreed a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Aged Debt report.

19. Any Other Business

19.1 The Chair presented the committee meeting schedule. JM noted that the External Audit Plan had been excluded from the schedule. The Chair directed that the Plan be included. **Action: RB and GN to include the Plan.**

The meeting ended at 11:15pm.

Date and Time of Next Meeting: 9th May 2024 at 09:30am (MS Teams).

Minutes Approved by the Audit Committee:

Signed (Chair): Julie Soutter
Date: Monday 24th June 2024

AUDIT COMMITTEE 24th June 2024

ASSURANCE REPORT

Part I

Area	Assurance	Notes
Annual Report and Accounts	**Green**	Going concern statement – confirmed Annual Report - recommended to Board for approval. Annual Accounts 23/24 – recommended to Board for approval. Service Auditor Reports (6) – no issues identified. Committee noted the significant effort required of staff to deliver the above and commended the results.
External Audit	**Green**	Year-end work completed. No significant issues raised. Unqualified audit opinion reported. Value for Money work completed with five improvement recommendations – all medium (MTFP updating and efficiency tracking; financial impact of risks in finance reports; strategic risk alignment across system, performance reporting). Management actions already in train. Relevant committees to be notified of recommendations in their area. General comments included: POD reporting and processes improved with further development proposed (applies to all ICBs); contract sign off timing could be improved.
Internal Audit	**Green**	Progress report and follow-up - reviewed and noted. No concerns over follow up of recommendations. IA Annual Report and HOIA opinion – overall moderate opinion. POD – Dental report: substantial for design and effectiveness EDI – advisory report: ICB stated to be at advanced stage compared to peers and noted broader role across system and OD workplan. Actions in train. Data Security and Protection Toolkit: One area awaiting completion. Confident of all requirements being met for submission 30/6/24 as required
Risk Management	**Amber**	Corporate Risk Register – Improvement work continuing on risk reporting and information presentation. Noted continuing dialogue with risk managers on improvements to risk register and reporting. Red risks reviewed and actions discussed including how challenge through discussion is adequately recorded in minutes to underpin assurance to Board (in addition to Chairs Reports). Assurance and risk assessment at system level discussed for inclusion in future Board workshop. BAF – discussed continuing work to improve BAF (using maternity as a case study to identify where improvements could be made to reporting and assurance pathways and hence governance infrastructure). More improvement in updating, system alignment and focus to come. Directorate discussion – People, Culture and Engagement. Top 6 risks and assurance discussed. Integration Directorate to present at Sept meeting Red – risks; Green – management action.

Conflicts of interest	**Green**	Noted compliance to date, expected achievement in next period and more frequent publishing of register when changes arise. Chair to attend a staff meeting as COI Guardian.
Counter Fraud	**Green**	Annual Report 23/24 – approved Counter Fraud Functional Standard Return – noted submitted on time. All indicators green with one amber. Investigations - noted Staff Survey Report – noted. Discussion on improving the % staff reporting suspected fraud directly to CF as required by policy. Hot desk working by CF commended and attendance at team meetings. New CF risks (linked to the 'amber' CFFS Return standard above) discussed with request to review scoring
Procurement	**Green**	Information on waivers reviewed. Agreed to progress 'annual' report for procurement function including further information on waivers and controls.
Financial Management	**Green**	Aged Debtor Report received. No Losses/Special payments or Debt Write off.

NHS Gloucestershire Primary Care & Direct Commissioning Committee, Public Session

Thursday 4th April 2024, 15.30-17.00pm
Board Room & Virtually at Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Ayesha Janjua (Chair)	AJ	Non-Executive Director, NHS Gloucestershire ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Prof Jane Cummings	JC	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MC	Chief Nursing Officer, NHS Gloucestershire ICB
Participants Present:		
Becky Parish	BP	Associate Director of Patient & Public Engagement, NHS Gloucestershire ICB
Carol Alloway Martin	CAM	Councillor, Gloucestershire County Council
Christina Gradowski	CGI	Associate Director Corporate Governance, NHS Gloucestershire ICB
Christina Worle	CW	Dental Strategy Clinical Lead
Julie Symonds	JS	Deputy Chief Nursing Officer, NHS Gloucestershire
Jo White	JW	Deputy Director of Primary Care & Place, NHS Gloucestershire ICB
In attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB

1. Introduction & Welcome

1.1 The Chair welcomed members to the public session of Primary Care & Direct Commissioning (PC&DC) Committee. The meeting was declared to be quorate.

1.2 There were no members of the public present during the meeting.

2. Apologies for Absence

2.1 Apologies were received from Ellen Rule, Andrew Hughes, Helen Edwards, Meryl Foster, Helen Goodey, Olesya Atkinson, Ryan Brunsdon.

3. Declarations of Interest

3.1 The Register of Integrated Care Board (ICB) Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)

3.2 LH declared that she worked out of Gloucestershire Health & Care NHS Foundation Trust (GHCNHSFT) in some of the community hospitals (see Item 7.17).

4. Minutes of the Previous Meeting held 1st February 2024

4.1 The minutes of the meeting held on 1st February 2024 were approved as a true and accurate recording of the meeting.

5. Matters Arising and Action Log

5.1 Action Log

Actions 4 and 19 remained Open.
Actions 15,16,17 and 18 were requested to be Closed.

6. Questions from Members of the Public

6.1 There were no questions received from members of the public.

7. Training Hub and Long Term Workforce Plan (LTWP) Update

7.1 LH presented on this topic and informed the Committee that some of the workforce data was based on that from December 2023. Since then, data had come in from February 2024 for workforce and further discussions regarding this would be taking place at a future board development session.

7.2 At the end of the financial year 2022/2023, an announcement from NHS England was made that the New to Partnership scheme was ending. Thanks to ICB funding, a pilot partnership, fellowship and partnership support offer in Gloucestershire commenced, with 17 GPs so far having signed up to the scheme. A number of those were prospective GPs and salaried posts, who were going into partnership roles as a result. There were also an existing number of partners who were joining the scheme to aid retention. Evaluations would be coming from that scheme as it progressed, with close liaison with the Local Medical Council (LMC) to deliver some of the training offers.

7.3 The Spark scheme was still ongoing for newly qualified GPs and for newly qualified and new-to-practice nurses in county. To date there had been over 113 GPs and nurses who had gone through the scheme since 2020. Sadly, there had been news from NHS England that this scheme of funding was also closing. A Business Case was being prepared for the ICB to see whether that scheme could be continued in some form, given how important it had been to help with both recruitment and retention of less experienced staff within general practice.

7.4 Other highlights included:

- The nursing lead, Sarah Rogers was in the final stages of delivering a Primary Care Nursing Strategy with further updates expected for the Committee in due course.
- A multi-professional educator conference was recently delivered to primary care bringing together a huge range of educators and a fantastic array of speakers across the day. There was an ambition to deliver similar conferences in future, bringing together that multi-professional team to consider education.

7.5 LH updated on workforce, informing about the reduction of qualified GPs with an ongoing reduction in GP partners in Gloucestershire. Despite this, the county remained above the regional and national averages. Gloucestershire still had the highest numbers of GP partners per 10,000 population across the South West and were the 8th highest in terms of overall GP numbers nationally per 10,000 population. A future deep dive would be undertaken around workforce issues.

7.6

- Just over 20% of GPs were over 55 and there were over a third of nurses within that age bracket, although there had been a fairly significant increase over baseline.
- Direct patient care roles were buoyant and included a fair amount of staff from the Additional Roles Reimbursement Scheme (ARRS).

- Clinical pharmacists made up the largest proportion of Direct Patient Care (DPC) roles closely followed by Care Co-ordinators and Social Prescribers.

7.7 The long term workforce plan was released by NHS England in 2023. The three main aims examined training, retaining and reforming staff experience within the NHS. A significant shortfall in the NHS workforce gap was predicted if nothing were to be done over the next 10 to 15 years.

7.8 Tackling this:

- The aim was to increase the number of GP trainees by 50%, to 6000 by 2031/2032.
- To increase the number of adult nursing training places to retain and reduce the number of staff leaving over the next 15 years.
- Strong focus on multi-disciplinary teams and emphasis on generalist core skills within general practice and across the system.
- Mapping indicated a predicted increase of 49% of consultants over the next 15 years but despite a doubling of placements for GP trainees, there was only a predicted increase of 4% for GPs, which was a disconnect considering there was an aim to bring care out from acute settings and into communities.
- Estates was considered to be outside the scope of the plan.

7.9 LH spoke about placement capacity in Gloucestershire based on data from 2023, explained on Slide 6 of the Workforce presentation.

7.10 There had been a number of regional sessions that had taken place to look at various elements of the LTWP. The first was around supply and retention:

- 10% population growth was expected in the South West, which will soon have the oldest population in England.
- 120k extra staff were needed in the South West to deliver 'more of the same approach'.
- International recruitment (IR) was currently 30% of all clinical recruitment (40% nurses), with an aim to decrease this to 10%.
- Placement capacity was a limiting factor (approx. 5% nurses were trained in the South West but this needed to 10%). A large number leave the South West upon qualification.
- Data revealed that only 21% of the health and care workforce was male.

7.11 LTWP – Retention:

- There was an aim to reduce reliance on international nursing recruitment within the LTWP, as there was uncertainty around the continuing funding situation.
- Staff turnover rates had reduced since the pandemic and were currently at around 8.3% across the South West with the LTWP's ambition to bring that down to 7%.
- Much of the data from Primary Care was missing which was an ongoing challenge.

7.12 LTWP – Apprenticeships:

- There was a big aim from the Training Hub to increase the number of clinical and non-clinical apprenticeships across Primary Care, with an increase seen in nursing associate apprenticeships, associate apprenticeships, advanced practice apprenticeships and a large number of non-clinical placements. There was a requirement for apprentices to have some basic maths skills which was not always easy for people to evidence if they were later on in their career, but it was intended for dedicated support to be provided.

7.13 LTWP - Medical Expansion and Reform:

- Nationally there were around 4000 GP trainees but by 2031, this would need to be around 6000. Regionally the number was planned to go from 344 trainees, to 516.
- GHFT was a pilot site for 'Enhance', a national programme to develop a generalist approach. The first cohort was on Homelessness within Gloucestershire and the second cohort was on Frailty within Gloucestershire. It was a good model but the Hub only became aware of it within Primary Care when the second cohort on Frailty started. It had since been more widely advertised with great uptake from Primary Care.
- International Medical Graduate (IMG) trainees were mostly from an international medical graduate background. A number of extensions to placements were being required due to a slightly higher failure rate around GP exams, particularly for this cohort of graduates who might need further support once entering Primary Care as a qualified GP.

7.14 Next Steps:

- Allocation of numbers was still awaited for the LTWP. Detail would be coming down from a regional level and disseminated to a Gloucestershire ICS footprint. The numbers would not be allocated on a fair shares basis but would be dependent upon workforce and population need.
- All regional LTWP events were to be summarised and operationalised.
- Discussions were already underway about training/placement capacity, educator capacity and estates. Although the ARRS scheme was very welcome, it was placing additional pressures on estates and in order to be able to deliver the extra placement capacity, this would be an important area to address.
- The Primary Care Education and Training Strategy had been drafted
- System discussions:
  Housing hub/social prescribing, rotational models, nursing Terms and Conditions in order to retain and support those colleagues, together with workforce mapping and training needs.

7.15 AJ recognised that although estates was not within the scope of the LTWP, locally it had been recognised that in order to be successful, estate capacity would need to be in place.

7.16 JCu queried whether anything could be done in the shorter term to address the imbalance around the number of GP trainee clinical placements that Gloucestershire received, compared to that of other areas.

LH said based on the size of Gloucestershire, there were expectations of receiving slightly more placements than those current as the county were already struggling with the numbers available. The Vocational Training Scheme (VTS) had worked hard to develop some GP hybrid training placements and there were GP trainees in some of the community hospitals. LH stated that she herself worked out of GHC in some of the community hospitals. Due to insufficient capacity, there had been GP placement delays in Gloucestershire and across the South West recently, of six months.

LH said that Gloucestershire needed to be ambitious because GPs were being lost and despite doubling the numbers of GP trainees, only a 4% increase of qualified GPs would be seen due to the retention risk being so high at the moment. There was a need to think smarter about training delivery, making better use of technology going forward.

JCu also mentioned nursing Terms and Conditions and pay being at very different levels, which had been flagged 6-7 years ago.

LH said the Nurse Lead was looking at the survey with Tracey Cox at how support could be given in Gloucestershire. Pay could not be examined yet, but Parental Leave would be the focus for Terms and Conditions as a first step.

JCu also queried whether there was any concern about the position in Gloucestershire around physician associates and whether there were concerns also around clinical care or outcomes and lack or support for that role. Some of the physician associates were not always used appropriately.

LH said there were slightly lower numbers of physician associates in Gloucestershire. resulting in a number of patient safety concerns which was an area being monitored. Registration with the General Medical Council would provide greater visibility around levels of qualifications but supervision was a concern, particularly in Primary Care when dealing with undifferentiated patients.

AR spoke about the Educator Workforce Strategy with which he had been involved in nationally. The issue was beyond medical supervision as there was a finite amount of supervisor capacity across the country. The South West was conducting pilot work around this and there had been discussions about ICB involvement. AR had offered his services in this area.

AR mentioned differential attainment which was complex and it was likely that some of this was around induction, buddying and embedding it into the system. Understanding how exams worked (particularly the patient facing aspect), was also something to consider. The Deanery was continuing to support the International Medical Graduates (IMGs) around this.

AR said care was needed around physician associates and the scope of practice which was being examined by the Royal College of Physicians (RCP) national working group of which AR was part. A Scope of Practice could be written for someone coming out of training, but further on, this would need to recognise career progression. In the meantime, there was no regulation around certain aspects of their roles such as prescriptions and ionising radiation and there was national around mission creep occurring even before regulation. Conversations had taken place with national colleagues due to concern about how this could be addressed and monitored post-registration. The ICB would have a role in examining supervision around scope of practice from Primary Care and other providers.

AR said there had been some extremely vitriolic comments on social media which had affected the physician associates and trainees. A letter had been sent out jointly by senior managers in GHFT about appropriate respect for colleagues. AR wanted to get the message across that civility mattered and although it was important to keep colleagues safe, ultimately it was a priority to keep patients safe, thus the scope of practice and supervision levels were key.

LH informed members that NHSE and the PCN contract had now just specified a little more around supervision for physician associates which was unhelpful. There was still a slight disconnect in the fact that the PCN contract was still mentioning physician associates seeing undifferentiated patients but the British Medical Association (BMA) stated that they should see differentiated patients. There was funding available for a preceptorship scheme for newly qualified physician associates within Primary Care which was currently being promoted.

LH said that all non-medical staff (not just physician associates) were prevented from requesting radiology in Gloucestershire which was a huge problem. MH said she would be happy to put this on a list of actions for this Committee if that would help, with an answer in

four months' time. JCu said this was wider than primary care and AJ requested that this action should be as below.

Action: To find out where the requests for radiology should be directed and to inform the appropriate Committee chair so that this action could be followed up and reported back to this Committee. **AR**

Resolution: The Committee noted the content of the Training Hub and Long Term Workforce Plan Update.

8. Dental Recovery Plan

8.1 CW demonstrated slides on the Dental Recovery Plan:

- An increase of the minimum Unit of Dental Activity (UDA) value from £25 to £28 had been proposed. This recurrent payment would help retain dental practices who were undertaking NHS care. There were 23 contracts in Gloucestershire which was 36% of NHS dental practices who would be involved and the Hub had already started to examine contract variations which had been due to start on 1st April 2024.
- The new patient premium incentive would incentivise NHS dentists to see new patients that had not been seen by a practice for two years. The dentists would receive an extra UDA value dependent on the type of treatment needed by the patient which would last for a year, until March 2025.
- Dental van allocations had not yet been fully decided; Gloucestershire was one area of allocation but a series of workshops and discussions were still underway to address issues and actions.

Workforce:

- To support practices in areas where recruitment was particularly challenging, it was proposed to launch a new 'golden hello' scheme. £20,000 would be phased over three years, requiring a commitment from the dentist to stay in that area, delivering NHS work for at least three years. The ICB were planning to align this scheme to a Health Inequalities incentive or Fellowship, currently being scoped.
- The NHS LTWP would be increasing training places for dentists by 40% and for dental therapists. There would also be a big increase in training for dental nurses.

8.2 Prevention:

- The Smile4Life government programme was being pushed forward which included the Supervised Toothbrushing incentive, already underway in Gloucestershire.
- Mobile dental teams would be visiting state schools to provide advice and fluoride varnish to 165,000 children in underserved areas.
- The UK Chief Medical Officers had concluded there was strong scientific evidence that water fluoridation was effective but this was currently limited to the North East.

8.3 AJ recognised the strong Gloucestershire response to this to ensure that the county were meeting national objectives. The positive and ongoing work around this was much appreciated and acknowledged by AJ.

Resolution: The Committee noted the content of the Dental Recovery Plan.

9. Highlight Reports

9.1 Primary Care Network (PCN, General Practice and Pharmacy, Optometry and Dentistry (POD) Highlight Report – March 2024

9.2 Learning Disabilities (LD) and Serious Mental Illness (SMI) figures had not been finalised but were looking favourable in comparison to last year, where both of these targets had been met.

The Primary Care Recovery Plan (PCARP) had just been taken to the ICB Board to demonstrate progress.

All locally Commissioned Enhanced Services (CES) were being reviewed for 2024/25 by the Primary Care Team, Commissioning and Clinical Leads, and the Enhanced Service Review Group. The Primary Care Offer for 2024/2025 was currently being discussed.

The Home Office had now confirmed that Regency Halls Hotel would be closing in April 2024, leaving three hotels available for the county's migrant population.

FootFall had released their Foundation website and Rosebank Health had moved from a pilot to a live site with interest from 29 other practices who wished to also move over to this new website.

As part of PCARP, the ICB and Procurement hub were supporting a number of practices with the digital telephony requests from NHSE and had received good feedback from patients.

The 20 week spring booster programme for Covid was due to commence on 15th of April 2024 in care homes with other eligible cohorts coming online for 22nd of April 2024 onwards, delivering 75k vaccinations in total.

An internal audit report rated the ICB work as substantial on pharmacy, optometry and dentistry, confirming a successful transition around the five year strategy, particularly relating to dental and the embedding of new ways of working.

Work was ongoing around Pharmacy First, with a focus on the relationships between community pharmacies and general practice. Software that pharmacies intended to use would be coming online later in April 2024.

AJ mentioned potential problems around the public not knowing where to go with health problems, maintaining public trust and putting in mitigations. JW thought a lot of this was very much down to trust and relationships between the practices and the community pharmacies. It was expected that local and national communications would support patient understanding.

***Resolution*: The Committee noted the content of the Highlight Report.**

10. Performance Reports

10.1 JW informed the Committee that a variety of PC indicators were reported in the Performance report. Total appointments were around 25% more than for pre-Covid. Data comparisons to last year showed there was about an 11% increase and of that only 1.1% related to list size.

Appointments up to 14 days was not so healthy and there did appear to be a strong correlation with the activity being much higher for appointments in Gloucestershire. This was being examined and further reporting would follow.

10.2 There was a conversation about reporting and data :

- Consideration on reporting to this Committee should examine what was being reported, what assurance was being sought, and how it could bring added value.
- Data could potentially reveal where pressures were and what this might mean for patient outcomes and the impacts on patients and staff.
- Input could be made into future Quality and Performance reporting from the Clinical Programme Groups who often had very detailed reporting to hand.
- The new PSIRF system could examine how data could feed into Primary Care and examine how the new approach could be making differences and improvements from the quality aspect.

***Resolution:* The Committee noted the content of the Performance Reports.**

11. Primary Care and Direct Commissioning (PC&DC) Risk Report

11.1 The main focus for the Committee to note was a risk around general practice financial position in terms of expenditure to meet the demands of delivering core services to patients. Close working was continuing with a number of practices that were struggling and a Standard Operating Procedure (SOP) was in place to ensure that this was being managed fairly, factoring in due process and governance. Regular reviews linking into the Primary Care Strategy were also being undertaken. Financial training would also be available for GP partners and practice managers (or those dealing with accounts) working closely with the Finance team and an independent accountant with Primary Care experience. A provider had been identified and it was hoped to roll this approach out as quickly as possible.

***Resolution*: The Committee members noted the content of the PC&DC Risk Report.**

12. Primary Care Quality Report

12.1 JS informed members that new reporting would have a focus on pathways across Primary Care to bring in the work of Clinical Programme Groups, from the whole patient journey as opposed to isolated incidents. This would be picked up following the Board Development session and would add value to the discussions around what was being represented in future from a quality perspective.

12.2 Beachley Barracks was still very busy looking after migrants and the health model with GDoc was working extremely well. This extra contract had been put in place to support those at the Barracks but did not cover contingency hotels. There was a health visit once a week and good GP engagement with four sessions a week running alongside the work of the lead nurse. This had taken the strain successfully away from colleagues at the Lydney practices.

12.3 Regency Hall Hotel in Cheltenham would be closing on 11th of April 2024, so that would leave three hotels for the migrant population. The length of stay had been halved in the last four months probably due to the large scale disposal accommodation reviewed by County Council colleagues. New arrivals needed to be registered with a GP, so it meant keeping up with the demand on new registrations for Primary Care.

12.4 AJ said things had felt more positive and JS said this was down to working with an experienced team enabling things to run efficiently without impacting too much on local services, whilst maintaining expectations not only of the MOD but also of the Entitled Persons residing there.

12.5 BP said that benchmarking had been done across similar ICSs that Gloucestershire compared with around results from the GP Patient Survey last year. ICS comparisons could be done where data was available.

12.6 Data had been produced around enquiries for the last quarter coming through the PALS team. There are a lot of dental enquiries, but the majority were related to people's experiences of GP medical services. Shared care with respect to ADHD continued to be a theme and issues with registration and communication continued to be issues. Registration was a frustration for some patients living in rural areas where there was little choice offered to them.

12.7 The new Hub arrangement around complaints was working well with the quality of work being very good and amenable responses for suggested amendments. A lot of prior planning had gone into this and it was certainly reaping rewards.

12.8 Thanks and compliments were recorded and three had been received for the PALS team which were shared with Tracey Cox so that she was aware of positive compliments from those people that the team were trying to help. Complaints had unfortunately been received around the Continuing Health Care process which was not something discussed at PC&DC.

12.9 BP highlighted the People's Panel with a second survey about to go out on Social Prescribing which could yield some useful data for colleagues across Primary Care.

12.10 BP spoke about the Accessible Information Standard where Primary Care had a responsibility to ensure that due regard was paid to information requirements. Some interesting and innovative work had been done in collaboration with the voluntary sector to produce some guidance for colleagues, including a short video which was on the ICB's intranet (not yet in the public domain) to encourage people to pay attention to accessibility needs within Primary Care. Information was available on the G-Care intranet.

12.11 BP hoped that the new Interpretation and Translation contract arrangements would yield some positive developments as this moved forward.

Action: BP to send round the GP Patient Survey and the link to the video on Accessible Information to members of the Committee. **BP**

Resolution: The Committee members noted the content of the Primary Care Quality Report.

13. Financial Report

13.1 The finance report started with the delegated GP and financial position as of January 2024. It showed an overspend year to date of just under £500k. The forecast remained at an overspend of £750k. The majority of payments were contractually designated, meaning discretionary spend was limited. The main overspends for primary care remained.

13.2 As previously reported, the Investment and Impact Fund (IIF) contract showed an overspend as the 2022/2023 spend was much higher when the actual results came through. This had continued and there were some additional overspends within enhanced access. Small underspends were offsetting other overspends. The recurrent impact of the overspends would be brought into the 2024/2025 budget setting. This was based on the contractual position at the moment, but there were some assumptions within that due to numbers requiring finalisation.

13.3 In terms of the dentistry contracts, there was a significant underspend on dentistry of just under £4 million. That was due to under delivery and clawback. There were some small under and overspends on the pharmacy and optometry services.

13.4 CL explained that the commitments within the Primary Care budget tended to exceed the delegated allocation received and the programme allocation would be used to support those.

13.5 LH mentioned the overpayment in relation to sickness pay and was surprised to see how much it had been for GPs, stating that as a number of GP retention schemes were ending, was worried that the burden could increase as spend was already at a maximum. LH queried as to how this compared to historic data. CL said that locums covered maternity and sickness and payments could be quite variable. **Action: CL to examine and compare last year's figures for GP sickness pay.** **CL**

***Resolution*: the Committee members noted the content of the Financial Report.**

14. ICS Transformation Programme & ILPs Highlight Report

14.1 This set of slides were much the same seen by the ICS strategic executives. Given the time of year, this would be a look back and a look forward on the position. The second slide contained information on what some of the impacts had been and what had been achieved in the previous financial year across the six partnerships in the county. Great opportunities had been achieved with some small pots of funding that had been really valuable in terms of working with voluntary sector organisations and communities and in linking to the Integrated Locality Partnerships (ILPs) with a focus on the wider determinants of health.

14.2 Successful working had been achieved with the colleagues in the voluntary sector as well as with the ILPs and all the other partners from District Councils in housing and in other partner organisations. There had also been many opportunities to bring in some of the Health and Wellbeing Partnership exemplar themes, around blood pressure, smoking and employment which had given real focus on some of the work around health promotion and linking in some of the funding that had been available through the strength in local communities.

14.3 The 2024/2025 commitments had been put forward the Joint Forward Plan and other documentation. There was much stronger governance relating to reporting arrangements for the programme which had been a really important step to get to, in terms of the maturity of both the programme and the partnerships.
Plans were to:

- Complete programme of Community Health and Wellbeing Hubs in Core20 areas in Gloucester, Cheltenham and the Forest of Dean, leveraging the opportunity for outreach in communities where access to services may be more difficult in future years and linked to their respective ILP.
- Finalise reporting arrangements to Enabling Active Communities and Individuals Board with a dotted line to the Gloucestershire Neighbourhood Transformation Group for the Proactive Care priorities of the ILP with interventions for cohorts of people in the pre-frail and mildly frail cohorts, and children's mental health and wellbeing.
- Complete rollout of annual ILP member surveys to collect feedback to inform development of each partnership.
- Finalise 2024/2025 workplans for each ILP to collectively set direction in each partnership for the year ahead.

14.4 There had been growing maturity in conversations with the ILPs and a couple of weeks ago, a PCN had been invited to present on the challenges of a practice in an inner city where it had become apparent that people felt safe around sharing experiences and raised the perspective and understanding of system partners and to offer support. It had started a lot of different conversations around support and understanding and was a good example to the approach around sharing and moving forwards with a system approach.

14.5 AJ said it would be good over time to obtain feedback and to see what impacts on various people had been. This was something for the future and BB said this was something that could be addressed.

***Resolution*: The Committee members noted the contents of the ICS Transformation Programme & ILPs Highlight Report.**

15. Any Other Business or Items of Escalation

15.1 There were no items of Any Other Business to discuss.

The meeting formally closed at 17.05pm

Date and Time of next meeting: Thursday 6th June 2024, 15.30-17.00, at Shire Hall, Westgate Street, Gloucester GL1 2TG

Withdrawal of the press and public

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

(Commercial in confidence discussions)

Minutes Approved by: PCDC Committee

Signed (Chair): Ayesha Janjua Date: Thursday 6th June 2024

NHS Gloucestershire System Quality Committee Meeting

Wednesday 3rd April 2024, 2.00–5.00pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Prof Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Ananthakrishnan Raghurum	AR	Chief Medical Officer, GICB
Hannah Williams	HW	Acting Director of Nursing, Therapy and Quality, GHNHSFT
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marie Crofts	MC	Executive Nurse & Director for Quality, GICB
Matt Holdaway	MHo	Director of Quality & Chief Nurse, GHNHSFT
Participants Present:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Becky Parish	BP	Associate Director Engagement and Experience, GICB
Christina Gradowski	CG	Associate Director of Corporate Affairs, GICB
Jan Marriott	JM	Non-Executive Director and Chair of Quality Committee, GHC
Julie Symonds	JS	Deputy Chief Nurse, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Sarah Morton	SM	Chief Professional Lead for Allied Health Professionals, GHC
Trudi Pigott	TP	Deputy Director of Clinical Quality, GICB
In Attendance:		
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Gerald Nyamhondoro	GN	Corporate Governance Officer
Steve Shelley-King (Item 10)	SSK	One Gloucestershire Clinical Lead for Dementia, GHC
Jo Bridgeman (Item 12)	JB	Specialist Nurse for Safeguarding and Freedom to Speak Up Guardian, GICB
Helen Ford (Item 13)	HF	Deputy Director – Integrated Commissioning, GICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the meeting.

2. Apologies for Absence

2.1 Apologies were received from Alison Moon (now left) Sarah Scott, Karl Gluck, Katie Hopgood, Olesya Atkinson, Ryan Brunsdon and Emily White. It was noted that Sam Foster would be replacing Alison Moon at future meetings.

3. Declarations of Interest

3.1 The Register of ICB Board members is publicly available on the ICB website: Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk).

JCu declared that she had now stepped down from her role with the Department of Health & Social Care (DHSC).

4. Minutes of the last meeting held 15th February 2024

The minutes from the last meeting held on 15th February 2024 contained some typos and some rewording was required around documentation and mortality, which DC corrected following the meeting. Otherwise, the minutes were approved.

5. Matters Arising & Action Log

5.1 **Action 4 - Self-harm in Children and Young People.** Rob Mauler (RM) and Trudi Pigott (TP) to collate information on self-harm in Children and Young People and bring back to a future meeting. **Action to remain Open.**

Action 14: Quality in SLA's: The CNO had reviewed current processes which were ad-hoc in nature and will establish a method of ensuring quality expectations were laid out as part of any SLA going forward. An internal quality meeting would be set up to bring together quality improvements across all commissioned providers. **Action to be Closed.**

Action 50 - BAF Update: The BAF had been updated and action assigned to the People Committee. **Action to be Closed.**

Action 51 - 2WW Breast Cancer Referrals. MH updated that the sudden decline in performance had been due to staffing in breast services and a recovery plan had been developed and supported by the ICB. There had been a slow improvement since December 2023. The latest data showed that there had been further improvement to 30.5% in February 2024.
Action: Deep dive on Breast Services to come back to a future meeting. Action to remain Open.

Action 52 - RTT Deadlines: JSo had linked in with Contract Manager. **Action to be Closed.**

Action 53 - ICB Quality Report. Julie Symonds (JS) and Olesya Atkinson (OA) to provide further insight and suggestions around what to include in future reports from Primary Care. **Action to remain Open.**

Action 54 - Children's Social Care Julie Miles (JMi) to share the Ambitions plan with Committee members**. Action to remain Open.**

Action 55 - Children's Social Care. Julie Miles (JMi) to collate data on numbers of children excluded from school or not receiving schooling to inform a report to be brought back to the next System Quality Committee meeting. **Action to remain Open.**

Action 56 - Health Inequalities. Katie Hopgood (KH) to bring information from Power BI dashboard around health inequalities to a future meeting. **Action to remain Open.**

Action 57 - PSIRF Paper: RM now completed this action. **Action to be Closed.**

Action 58 - PSIRF Policy. Paper subsequently circulated. **Action to be Closed.**

Action 59 - Learning from Deaths. Dr AR and Suzie Cro (SC) to examine data mortality reporting and processes and bring findings back to a future Committee meeting. **Action to remain Open.**

Workshop Actions – July 2023
ToR to be reviewed. JCu said this could be closed. All other actions to be closed unless still relevant.

6. Risk Report and Board Assurance Framework (BAF) Update

6.1 CG talked through a summary report which included the appropriate BAF strategic risks. There were currently 20 assigned risks to the System Quality Committee that scored 12 or above.

The Committee were appreciative of the summary report worked on by RB and GN whereby a great deal of work had been undertaken and was still ongoing but asked for some key changes to be undertaken prior to the next meeting in May 2024. JSo had emailed CGi to say that the Corporate Risk Register (CRR) should have been included, which would need to follow the standard framework going forward.

The following needed to be changed, included or examined for future meetings:

- Assurances and state if positive, negative or neutral
- Examine gaps in Assurances and streamline the actions
- Place the current risks after the risk mitigation plans in place
- Compare the movement in the risk to the previous reporting period. (The Committee saw arrows going down in Green when the risk was going up, compared to the inherent risk.

It was recommended that in addition to the summary report, a cut be taken from the CRR relating to Quality which should be reported in the conventional manner and repeated for all future System Quality Committee meetings. This would focus on the key quality risks to demonstrate how effectively these joined up with those of system partners.

Discussion

JCu said It was important to recognise that the Committee provided assurance to the Board that all risks were being addressed. System partners could think how they might highlight any risks requiring system oversight or further system partner input, to this Committee.

CGi explained that directorates had received risk training around placing those risks with a higher score than 12 on to the CRR. The most recent papers had all been taken to Operational Executive for discussion and should be regularly discussed at directorate meetings. GN was working on a summarised "bird's eye" version to flag risks, enabling those higher scoring risks to be given priority.

JCu said UEC, boarding of patients and excess deaths in ED were all quality risks where offers of support should be being extended to system partners. JCu was keen to get to the heart of very difficult decisions in order to take them forward at these Committee meetings.

JM said that the raising of risks and the process of doing so was the most important aspect in shaping the agenda for this Committee. JCu said the forward plan should be examined in terms of subject matter for discussion but partners should also be asked what issues they would like to bring to the Agendas with data and reasoning behind those items of importance.

MH agreed with this and said that at the end of the Acute's Committee meetings, members were formally asked whether any issues discussed at that meeting needed to be raised to the system. The was relatively new but was the chosen route for which risks would be raised that required outside input.

AR spoke about weekend and long wait mortality and thought that discussions should take place at this Committee. **Action: Excess Mortality to be brought to a future Committee meeting by GHFT's Mortality Committee.** **AR**

MCr said that KM had raised BAF 4 at the last ICB Board meeting where the score had been moved from 15 to 10 and drew attention to the current challenges in maternity and UEC and suggested a review of this risk score. MCr and JSo agreed with this. These scores could be compared with those in other parts of the system.

Primary Care dental risks were mentioned where Strategy and Transformation were involved in this around performance.

JSo would take the valuable feedback to the Audit Committee along with any work conducted with the Governance Team and any of the Executives on specific risks. It would be useful to cross reference risks with other Committees and to keep a written record of a risk moving through the system. This could also apply to partners who wished to cross refer something from one of their Committees.

Health Inequality wording on the BAF - some of this needed to be less about process and should incorporate equity.

BAF 1 – go to System Resources
BAF 2 – go to PCDC
BAF 4 – quality but needs to be reviewed by MCr and AR
BAF 7 - To be referred to Tracey Cox. Workforce risk to be placed on BAF. Narrative to reflect that staff were supported, valued and working hard. Quality should still be involved. Joint oversight.

Actions:

- **CGi to work with RB regarding changes required in the CRR and BAF.**
- **CGi to talk to TC around Workforce risk being placed on BAF.**
- **CGi to contact Mel Munday regarding safeguarding risk scores.**
- **MCr, AR, TP and CGi to examine which of their risks should come to SQC.**
- **CGi to ensure that Agenda planning meetings afforded dedicated time for the examination and mitigation of all risks including those from partners.**

<u>Resolution</u>: The Committee noted the Risk Report and BAF update having recommended that changes should be made to these papers prior to the next Committee meeting.

7. <u>Future Reporting</u>

7.1 MCr said she had been working with various colleagues, Chief Medical Officers and other ICB's across the South West and in other areas, on what they reported and their processes around that. As the ICB currently had a good deal of duplication around papers, it was hoped to organise a meeting with colleagues before the next Committee in May. MCr would then be liaising with AR and JCu to discuss and take future reporting forward.
Action: MCr to work with colleagues on the streamlining of documentation for reporting to this Committee at the May meeting. **MCr**

JCu noted that the reporting from GHFT had changed and it had been useful to read the oversight report similar to what GHC had put forward to their Board.

8. System Partner Highlight Assurance Reports

8.1 GHFT including Maternity/LMNS

8.1.1 MH said that GHFT would be applying to take part in the pilot for Martha's Rule and had sent in an Expression of Interest. More information here NHS England » Martha's Rule

8.1.2 MH said that main escalation from the Quality and Performance Committee was around excess deaths, overcrowding and waiting in ED. More reporting in relation to this would come through and this would be going to the Trust's Board in May 2024.

8.1.3
- The Trust had been highly rated in some areas of the CQC's Maternity Survey of 2023 and although there were some areas of improvement noted, overall, maternity services feedback in Gloucestershire were very positive. Full survey results here.
- The CQC checked progress on Section 29A warning notices on training and staffing, last week in an unannounced inspection, with indications that they would be looking closely at the Well Led domain. There was positive feedback around culture and learning opportunities which had not happened at previous inspections. There were no immediate safety actions and things had felt much more positive. The Committee would be updated when the final report was received.
- The previous CQC actions associated with Surgery would be closed off in May 2024.
- The draft report for factual accuracy had been received back for the Children's and Young People Services inspection and was returned on 2nd April. Considerations for representations would take time and updates to the Committee would follow.
- Urgent and Emergency Care CQC required actions were undertaken very quickly following inspection. CQC colleagues were invited in to review progress against actions with the local team which was well regarded. Due to industrial action, this meeting had been postponed but would be taking place shortly.
- The Stroud Maternity Report was received following the inspection on 12th December 2023 and was rated as "Requires Improvement". The inspection last week was conducted under the auspices of the new inspection regime.
- Following the Panorama programme, two sets of Terms of Reference had been shared with outside agencies so colleagues in the Maternity and New-born Safety Investigations (MNSI) team will be undertaking an internal maternal death review and colleagues in another Local Maternity and Neonatal System (LMNS) outside the South West will be supporting the Trust with a review of neonatal mortality. Thanks were given to MCr for assisting with the development of the Terms of Reference.
- MH drew attention to water safety in the Assurance Report. A lot of work had been done by GMS and it was important to strengthen the governance around water safety and also more broadly with GMS partners.
- The Trust's Picture Archiving and Communication System (PACS) had been upgraded and had impacted backlog. Business as usual would commence when a further planned upgrade was brought in in an effort to tackle the backlog in radiology.

8.1.4 JSo noted that the Assurance Reports from GHFT's Quality Committee were very helpful and indicated that those should be kept in the reporting pack. There was not a similar report for GHC.

8.1.5 JSo raised the January 2024 report on the Review of the Paediatric Audiology Services which was rated as Red, being a serious risk. MH said that there had been a national audit where GHFT had not fared well in management of key issues and governance which had been flagged as an area of concern prior to plans being shared. The Action Plan had

gone through the Quality and Performance Committee this month and assurance would be provided to the Committee by sharing this at the System Quality meeting in May **MHo**

Action: MHo to bring the Action Plan for the Paediatric Audiology Services to the Committee meeting in June 2024.

8.1.6 MCr fed back from the recent LMNS that appeared really enthused following the CQC inspection that things had improved. The GHFT's Risk Register stated that the risk of colleagues identifying with certain minority protected characteristics were continuing to report a worse experience around high levels of discrimination. MCr wondered whether there was something across the system that could be done for supporting staff and recognised that this was probably being tacked in the People Committee.

8.1.7 CGi informed the Committee that Karen Clements the new Non-Executive Director for the People Committee had examined the data from various reporting from all organisations and recommended that a sub-group could look at Equality, Diversity and Inclusion (ED&I) in more detail and look at key things that could be done, systemwide, that would drive things forward on this.

- Recruiting from those with protected characteristics from a minority background into jobs that were not always at the lower levels
- Career progression
- Dealing with bullying and harassment from the public and colleagues and managers in the workplace

There are Charters and policies around the culture that organisations wanted to create within the workplace and how bullying and harassment would dealt with both for potential victims and bullies themselves. There was also a Special Assessment Scheme (SAS) in the NHS for violent patients.

Action: CGi to bring new plans for ED&I to a future Committee meeting. **CGi**

8.1.8 SM mentioned that a dashboard had been developed that would feed into wider system working but the Allied Health Professionals (AHP) data was not very visible which was something that had been picked up by the national team. It would be good to see some of the wider work having been done within the partner organisations across the system which had been presented at region with recognition that AHPs needed to have more of a presence from a quality dashboard and quality agenda perspective.

8.1.9 MH agreed with SM and said work was being done on AHP data but more would be coming through from them and the Acute Trust, with colleagues having a focus on food and nutrition over the next six months.

8.1.10 MH recognised that the recent positive comments reflected in the LMNS meeting had been due to changes in and the managerial and day to day leadership two years ago following the CQC inspection which had greatly improved quality and care and was great to see.

Resolution: The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).

8.2 Gloucestershire Health and Care Trust (GHC) Quality Report

8.2.1 HW said she would be following up with MH and MCr in terms of how GHC could align the presentation of their future reports to those of partner organisations.

Action: HW to link with MHo and MCr on GHC's future reporting to the System Quality Committee. **HW**

8.2.2 HW said the February data had been shared in the dashboard and had been to GHC's public Board last week. HW highlighted:

- The great work that Charlton Lane had done around falls is to be rolled out across community hospitals.
- Learning in hotspot areas about pressure ulcers had resulted in earlier referrals resulting in earlier referrals meaning ulcers were much more likely to heal. Extra time had been allocated to District Nurses to ensure assessments were accurate and to identify any healing devices that might be required.
- Operational pressures often made it difficult for colleagues to receive group supervision for adults and children in community, mental health and hospital settings, meaning that numbers of contacts to the internal safeguarding line had increased. BDO is to examine Children's safeguarding compliance around group safeguarding supervision as part of their internal audit for GHC.
- Closed Culture work was continuing and recent slides had been refined which revealed the areas of risk within this space with good feedback from Quality Committee and Board colleagues which can be found in the dashboard. Wotton Lawn colleagues had identified that they felt confident and safe to speak up about any patient safety concerns in a recently published Healthwatch report.
- Wotton Lawn was also mentioned in a CQC national report in the last few weeks as having good evidence around application of the Mental Health Act Assessment where the person was at the centre of that process with the care being wrapped around it which had been very pleasing to read.
- GHC were issued with a Prevention of Future Death (PFD) notice from the Coroner in March which related to the tragic death of a patient whereupon an Action Plan was commenced at the point of that incident. Some further actions had been requested by the Coroner for which there was a completion date of 18th April to submit this information. The report would be shared with ICB colleagues.
- The Berkeley House Quality Improvement Group is to hold a meeting next Friday. Enhanced Surveillance continued with the latest Action Plan being submitted with updates to the CQC who continued to be satisfied with the assurance given to them that actions were being addressed.

8.2.3 MCr noted that the Clinical Supervision rate was very low at 39.7% and said that Professional Nurse Advocates (PNAs) was a good way of delivering group clinical supervision. HW said the actual clinical supervision rate was higher than the figure reported with a newly ratified Clinical Supervision policy in place. Work was ongoing to upload clinical supervision onto the Electronic Staff Record (ESR) system but due to operational and workforce pressures in some areas, this had not been satisfactory and was being addressed.

MCr raised a potential safeguarding risk around the uploading of the Multi-Agency Risk Assessment Conferences (MARAC) plans. HW explained that some plans were uploaded purely as a precaution should people become future patients, with further discussion required following the meeting.

Action: Further discussion to be held between MCr and HW around MARAC plans. **MCr/HW**

8.2.4 TP raised eating disorder waiting times where figures had dropped for adolescents but not for adults. HW explained that some of this had been down to the voluntary sector colleagues having signposted large numbers of young people elsewhere to a more appropriate service. As sickness issues had been resolved, the adult waiting list would be expected to improve and it was also subject to a Service Development Improvement Programme being run in the Operational Directorate.

***Resolution**: The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Health and Care NHS Foundation Trust (GHCNHSFT).*

8.3 ICB Quality Report

8.3.1 JS said that the same ICB Quality Report would be presented to the Primary Care and Direct Commissioning meeting to be held tomorrow, and JS would meeting with Olesya Atkinson and Jo White in order to focus in on Highlight Reports with a quality care perspective in order to reduce duplication for future reporting to the Committee.

8.3.2 JS highlighted areas from the Quality Report:

- A contract commissioned with GDoc around health provision being provided on site at Beachley Barracks had proved successful enabling some burden of care being removed from local practices. By the end of April there would be 104 properties which could take larger families without increasing numbers on the base.
- A contingency hotel in Cheltenham was scheduled for closure on 11th April 2024 leaving two hotels functioning in Gloucestershire. Arrivals through these two remaining estates had increased significantly in February with approximately 60 new arrivals in month to date requiring Primary Care registration. There had been the equivalent number of service users moving on from the hotels with a drop in the average length of stay overall.
- The Nurse on Tour programme supporting Primary Care had identified a concern around inaccurate blood pressure readings from devices. Work would continue in this area which would link into New to Work and the Working as One programmes.

8.3.3 AR said he would like the Clinical Programme Boards to think about pathway working and then to work backwards from there to address the pressures in Primary Care. AR and Mark Pietroni (CMO GHFT) were working hard on this realising that closer collaboration and communication would be needed between primary and secondary care services.

8.3.4 JCu recognised that there was a lot of data from secondary care providers but very little from primary care. Reporting would need to be examined to see how it could add value to the Committee. Reporting could potentially come from Clinical Programme Groups (CPGs) and Pharmacy First examining demand, impact and outcomes. JSo would be interested to see dashboards with the Primary Care Networks (PCN) high level summaries. AR suggested linking in with CPGs would also be of benefit.

***Resolution**: The Committee members noted the verbal update on the Integrated Care Board (ICB) Quality Report.*

8.4 Adult Social Care Update – March 2024

8.4.1 It was noted that there was no representation from Adult Social Care and that any queries should be flagged outside the meeting and then be fed back to SS.

***Resolution**: The Committee members noted the Adult Social Care update from March 2024.*

8.5 Verbal update from System Quality Group (SQG)

8.5.1 TP noted the presentation from the CQC on their new framework. **Action: TP to circulate the CQC presentation from the latest SQG meeting.** **TP**

***Resolution**: The Committee members noted the verbal update from the System Quality Group.*

9. Infection, Prevention and Control

9.1 During Covid19 and following, monthly ICS Infection Prevention and Control (IPC) meetings were held to monitor and discuss IPC situations and agree a system approach. These meetings were, and still are, attended by all system partners and many other representatives from other organisations. There was also a system wide group that supported the delivery of the Anti-Microbial Resistance (AMR) action plan.

At the end of 2023/2024, the NHSE regional strategy was published and in preparation the ICS IPC reviewed the following:

- The Governance arrangements
- Training needs analysis
- Scoped improvement projects

Following this exercise to enhance the Governance arrangements an Infection Prevention & Management (IPM) Group was set up to help with writing a Gloucestershire Strategy which was in line with those of the national and regional teams. TP informed the Committee that Gloucestershire ICB was one of the best performing ICBs in the country around IPC.

Considerations for the Committee today were:

- Did the committee approve of the governance structure?
- The IPM group requested that once the Strategy was finalised, that be brought to the Committee for final sign off
- What reporting and frequency would the Quality committee like from the IPM group from a Gloucestershire point of view?

A Public Health Registrar would be supporting with the writing of the Strategy which would cover a two year period to consider the rapid changes in IPC.

JSo queried membership of the IPM which TP said would be different. Some of the same people would be on the IPM but the IPS would be a much wider group of all system colleagues. The aim was to ensure that senior leadership would looking at what needed to be prioritised in Gloucestershire over the next year and to link things in with the anti-microbial work to bring the groups together and to examine what could be done to support each other's groups.

TP explained to JSo that these meetings would be operational monthly meetings rather than a Committee meeting and senior leaders had requested these meetings be held in order to facilitate some of the important discussions that were required.

MHo said in terms of the request to sign off the governance structure, he would prefer to have sight of the governance structure first, before approving sign off. JCu agreed, saying she would also like to see the Terms of Reference and membership.

After discussion it was agreed that it would be more beneficial to produce the Strategy before considering the reporting route. HW thought the IPC was as important as safeguarding and did not have a preference around where it should report to. HW recognised the amount of work that TP had produced to bring the ICB to its current position.

Action: TP to circulate the draft Terms of Reference and relevant slides around IPC governance structure to Committee members following the meeting. **TP**

Action: IPC to be placed on a future Committee meeting agenda. **RB**

Resolution: ***The Committee members approved ongoing work with the Gloucestershire IPC Strategy and requested sight of further relevant papers before making any further decisions on the governance structure.***

10. Dementia Strategy 2023-2028

10.1 SSK informed the Committee that the Strategy had been in development for over three years with engagement having taken place with many and varied stakeholders across the whole of Gloucestershire particularly those living with dementia and Experts by Experience. The Strategy had been taken to various groups and Boards and most recently was signed off by Gloucestershire County Council in March 2024.

10.2 A programme of public engagement sessions had commenced across the county with groups being held in libraries where there had been capacity attendance, enabling people to connect back to dementia services or to signpost people appropriately, demonstrating already the benefits to communities.

10.3 SSK spoke about the five pillars contained in the Strategy and the various activities and education being set up across the county around dementia with local people and communities being at the heart of this. This had proved invaluable in strengthening relationships across the system and was teaching people about dementia and how they could be helped through various agencies to learn more about it.

10.4 SSK spoke about the importance of dying well and to get more people to complete advance care planning and to have those conversations as early as possible along with completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document across the county.

10.5 Gloucestershire had its own dedicated Dementia Education team that delivered training across the system to health and social care staff, Tesco workers, the fire service, police carers of people living with dementia and those living with dementia. Pro-active care was important for all pillars within the Strategy which was intertwined with personalised care and in getting people to complete Me at my Best forms to better support decision-making, which was especially important out of hours when there was a reduction in services.

10.6 Dementia of course linked in with other programmes of work such as Frailty and End of Life and the next steps would be to develop and finalise a Communications Plan to promote the Strategy across communities in Gloucestershire.

10.7 The Chair said it had been for her a good read; she loved the quotes and photos and it had been clear what the forward plan was. The amount of detail in the Quality and Impact Assessment and the background to this showed the amount of work and effort that had gone into something that was really good. SSK was also commended on the compelling real-life stories and the data. MCr mentioned doing something across the system around risk factors saying she would be happy to support in any way.

10.8 SSK said conversations with Public Health had taken place to influence mentioning dementia more locally and consistently. Dementia Action Week (13th-19th May) would be highlighting risk reduction and there were plans to meet the public to draw attention to

ways in which they could lower their risks of being diagnosed with dementia. SSK would be producing a webinar for GCC and ICB staff at the beginning of May on reducing the risk of dementia.

10.9 CGi mentioned the Health Checks taken up by staff recently and asked whether dementia questions could be included if appropriate. SSK said it was appropriate to draw to someone's attention for example, that if they stopped smoking then this would reduce the chances of them developing dementia in the future, so adding that in could be beneficial.

10.10 JS offered to support any communications from a nursing perspective for Primary Care and SSK was welcome to share updates in the monthly newsletter sent to all practice nurses. SSK could also contact JS offline around wider education and training opportunities within primary care so enabling other routes in. SSK said that during Dementia Action Week, a dementia education primary care event was being held in Cheltenham but the more inroads that could be made to support colleagues, the better.

10.11 JCu mentioned delirium and how more could be done around that particularly with patients who had received an injury, had gone through an acute illness or been harmed by anaesthetic to distinguish the difference between dementia and delirium. SSK said this would be something that this could be thought about in future.

10.12 HW congratulated SSK on the Dementia Strategy and said that it had been one of the most uplifting documents she had read for a long time. It reflected SSK's dedication, commitment and hard work which had shone through and was what the patients, families and carers saw every day. The Committee members thanked SSK for his sterling work.

Resolution: The Committee members unanimously approved the final Dementia Strategy for publication.

11. PCN Mortality Update

11.1 AR said that inner city Gloucester mortality was still of concern. The South West Critical Thinking Unit recently presented the latest data which suggested that there were issues in four Primary Care Networks (PCNs). The issues identified linked to other mortality indicators and were being addressed across the system. Particular focus was being given to Core20PLUS5 factors including smoking cessation, early cancer diagnosis and hypertension monitoring. SMI and LD were also areas of high mortality. **Action: RM/AR to prepare a paper on Mortality to be brought to the August meeting.** **RM/AR**

Resolution: *The Committee members noted the verbal update regarding PCN Mortality.*

12. Policies for Approval

12.1 Safeguarding Children Policy

12.2 JB explained that this Policy had been updated following a review of the original Policy last year. JSo mentioned that on Pages 7 and 8 of the Policy referred to Lay Members which was not a term currently used and needed to be changed. JCu said the Policy made mention of "Ensure there is a GP lead for safeguarding on the Board of the ICB." MCr had now taken this role as Chief Nurse so this needed to be revised. **Action: CGi to check the Safeguarding Children Policy against the terms of the ICB's Constitution.**

Resolution: ***The Committee noted and approved the Safeguarding Childrens Policy subject to the necessary amendments being made.***

12.3 Continuing Health Care Policy

This was not approved and the Committee asked for the following changes:

- Document to be checked for references to the CCG and updated with ICB and with the appropriate links on the website
- Check the inclusion of PoWER as the advocacy agency for CHC – this is the case but a more formal arrangement was needed rather than a spot purchase as the ICB was looking to have a proper contract with them
- Policy to be updated to reflect any new guidance
- A check to see if the policy should include the timeliness of assessments for Fast-track.

Once updated CGi would circulate the policy and ask for Chair's approval to avoid delay between the next Committee meeting in June 2024.

The Committee requested the Continuing Health Care policy have changes made to it prior to circulation before the next Committee meeting in June 2024.

13. Attention Deficit Hyperactivity Disorder (ADHD) Discussion

13.1 MCr wanted this to be logged here as a potential patient safety issue due to the increasing number of people presenting to services and subsequently being diagnosed, resulting in longer waiting lists. GHC provided a diagnostic service for under 18s and there was also a very small adult ADHD service with a substantial amount of funding being provided this year (phased) to further enhance this service. There had been recent complaints to the ICB around medication having been stopped once the service users had reached the age of 18. Children's service users are not currently being handed over to the adult service and there was no shared care protocol in place with GPs, who had said that they needed support.

13.2 MCr recognised the impact of having medication ceased as one young person may have to stop his apprenticeship because of this issue and wanted to bring this to people's attention and to ensure that the increased funding needed to be going into the 'right' places for these young people. If the Service Specification did not include prescribing of medication, then this needed to be addressed. **Action: MCr has arranged a meeting with GHC and PC colleagues and will bring ADHD concerns back to a future Committee meeting.** **MCr**

HW said she and colleagues at GHC were grateful for MCr having raised this and from an adult perspective, it had needed traction for a while, so was very supportive and looked forward to those future conversations.

13.3 HF said that people had the opportunity to go to different providers to obtain an ADHD assessment and was done on a national framework basis. People being diagnosed were then having to go onto a waiting list for a prescription for medication which was an issue relating to that topic.
Resolution: ***The Committee noted the verbal update on ADHD.***

14. Meeting Review, Items for Escalation to the Risk Register and Any Other Business

14.1 CGi informed the Committee about the forthcoming Committee Effectiveness Survey which would be coming out mid-April. The survey information would result in data being collated into a preliminary report, which together with improvement actions would be included in the next Quality Committee papers for the meeting in June 2024.
Action: RB to add Committee Effectiveness Survey to the Agenda for June 2024. **RB**

14.2 High Risk Breast Screening Programme

14.2.1 MCr said that notification had been received that 10 women had been affected but TP stated that they had all been subsequently followed up.

The meeting formally closed at 17.05pm.

Time and date of the next meeting:

Wednesday 5th June – 2.00-5.00pm
Shire Hall, Westgate Street, Gloucester GL1 2TG

Withdrawal of the press and public

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

(Commercial in confidence discussions)

NHS Gloucestershire ICB System Resources Committee

Meeting Held at 2.00pm on Thursday 2nd May 2024 as Hybrid Meeting via MS Teams and in ICB Board Room, Shire Hall Gloucester

Members Present		
Prof. Jo Coast	JC	Non-Executive Director, Chair
Ayesha Janjua	AJ	Non-Executive Director, Member
Cath Leech	CL	Chief Finance Officer, ICB
Ellen Rule	ER	Deputy Chief Executive and Director of Strategy & Transformation, ICB
Julie Soutter	JS	Non-Executive Director, Member
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Participants Present:		
Angela Potter	AP	Director of Strategy & Partnership, GHC
Emma Peace	EP	ICS Programme Director, ICB
Graham Russell	GR	Chair of the Board, GHC
Kat Doherty	KD	Senior Performance Management Lead, ICB
Karen Johnson	KJ	Director of Finance, GHFT
Tom Hewish	TH	System Operational Planning Lead, ICB
Sandra Betney	SB	Deputy Chief Executive & Director of Finance, GHC
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon	RB	Board Secretary, ICB
Paul Atkinson *(Agenda Item 7)*	PA	Chief Clinical Information Officer, ICB
Una Rice *(Agenda Item 7)*	UR	Associate Director Digital Transformation, ICB
Kelly Matthews *(Agenda Item 9)*	KM	Programme Delivery Director, ICB
Haydn Jones *(Agenda Item 9)*	HJ	Associate Director Business Intelligence, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the System Resources Committee meeting. The Chair welcomed Julie Soutter who will serve, ex officio, as a member of the Committee. Julie Soutter is Chair of the Audit Committee. The Chair welcomed Ayesha Janjua as a new member of the Committee. Ayesha Janjua is a Non-Executive Director in the ICB Board of Directors.

2. Apologies for Absence

2.1 Apologies were received from Mary Hutton, Jaki Meekings-Davis and Ian Quinnell.

2.2 The Chair confirmed that the System Resources Committee meeting was quorate.

3. Declarations of Interest

3.1 There were no Declarations of Interest (DOI) received other than those presented by way of the Register.

3.2 There was a request that the DOI log be reviewed and updated accordingly. **GN**

4. Minutes of the System Resources Committee Meeting Held on 7th March 2024

4.1 The minutes of the meeting held on 7th March 2024 were approved as an accurate record of the proceedings.

5. Action Log & Matters Arising

5.1 Action Log

5.1.1 **16/01/2024, Action 28.** Shared Outcomes Framework. It was agreed that a further update would be brought back before the Committee. This was included in the agenda of the 2ndMay 2024 meeting. **Item closed.**

5.1.2 **16/01/2024, Action 30.** Investments & Benefits Review. A small set of strategic schemes to consider the impact of investments. The proposed list should be brought back to the System Resources Committee, and criteria should be developed on what schemes would be considered. The arrangements for monitoring scheme delivery still not finalised. **Item remains open.**

5.1.3 **16/01/2024, Action 31.** UEC Benefits Plan**.** Members requested more detailed discussion on Working as One/UEC benefits realisation. This was included in the agenda of the 2ndMay 2024 meeting. **Item closed.**

5.1.4 **07/03/2024, Action 33.** Resources Committee Risk. Members asked that arrangements be made to deep dive into system risks. The Digital team had been invited to the System Resources Committee and more deep diving sessions would follow. **Item closed.**

5.1.5 **07/03/2024, Action 34.** System Resource Committee workshop. Members proposed a System Resource workshop themed "What do we spend our money on". Plans for the workshop were still to be finalised.
Item remains open.

The Chair directed that for practical considerations, meeting items would not necessarily follow the order set in the agenda.

6. Terms of Reference (TOR) Review

6.1 MG presented an updated draft of TOR. AJ proposed a few more amendments. AJ identified minor typographical errors and requested more clarity to distinguish the Integrated Care Board (ICB) from the Integrated Care System (ICS). The inclusion of Primary Care was also requested and agreed. Amendments were noted and members agreed to take the TOR to the ICB Board. **Action: MG to facilitate submission of TOR before the ICB Board.** **MG**

RESOLUTION: The System Resource Committee resolved that:

- **The Terms of Reference presented before the Committee be and are hereby approved.**

7. System Resources Committee Risk Register Review

7.1 RB presented the report and reassured members that the Corporate Governance team continued to meet with Risk Leads across the ICB to ensure risk was being updated and given appropriate review. RB further reassured members that the heads of directorates also received monthly dashboards showing their assigned risks. RB added that monthly reports on risk management and prevailing risk landscape were taken to the Operational Executive Committee.

7.2 JS stated that the Audit Committee provided oversight on the remodelling of the risk management system. JS added that members were working with Ryan Brunsdon (RB) on redesigning the Corporate Risk Register and they were also working with Christina Gradowski (CGi) on redesigning the Board Assurance Framework (BAF).

7.3 Deep Dive – Digital Risks

7.3.1 PA and UR presented and outlined the developing and remodelling of digital technology aimed at not only meeting current needs but also future needs of the local population. UR explained that the scope of planned joined-up digitisation work extended to various workstreams, and this included Social Care services. UR emphasised that this, together with other efforts, required the Digital team to commit to supporting joined-up data driven HealthCare services. PA added that the risk to data driven Health Care services was exacerbated by budgetary and workforce pressures.

7.3.2 PA highlighted that digital workforce pressures extended beyond local boundaries, and this increased competition for skilled workforce. JS sought further clarification on methods employed to develop sustainable infrastructure deemed able to proactively mitigate risks impacting the digital environment. PA stated that the Digital team was increasing focus on this matter. PA added that the development of sustainable infrastructure with capacity to proactively contain risks depended on availability of funding and the capacity to develop and retain workforce.

7.3.3 PA added that closer engagement between the Digital team and those charged with drafting Plans was a critical factor to success. PA cautioned that the funding of public

health services was to a great extent informed by political factors, and these were beyond control of the ICB and its partners. PA reassured members that they would receive consistent updates on digital technology upgrades and plans.

RESOLUTION: The System Resource Committee noted the Risk Review report.

8. Operational Planning Submission – Plans for 2024/25

This was a confidential section of the meeting, and it is captured on separate record.

9. Working As One Programme (Urgent & Emergency Care)

9.1 KM presented the programme timeline and governance aspects of the programme. KM stated that the programme aimed to deliver integrated and quality HealthCare outcomes in Urgent & Emergency Care services. KM described this work as transformational. KM added that the programme capitalised on core competencies inherent in current workstreams to create benefits such as:

- improving patient experience;
- promoting patient independence;
- supporting recovery;
- reducing health inequality;
- delivering sustainability and better Value for Money;
- encouraging staff empowerment and delivering work flexibility;
- promoting joined-up work;
- delivering savings.

9.2 AJ suggested that the programme would benefit from benchmarking against neighbouring and/or other systems to create improved work and patient flow outcomes. CL stated that there was factoring of critical elements of this programme during the developing of financial plans. Members discussed risks which could affect the programme outcome and they shared possible mitigations. KM explained that a half day workshop was being held in May to review hospital flow. **Action: KM added that she would share the output of the workshop with the Committee.** **KM**

9.3 EH highlighted a need to guard against slippage emanating from organisation centred priorities not aligning with Working as One Programme's integrated approach. ER also spoke of a need for transparency and improved communication between partners to limit dissonance and to create awareness of transformation benefits. AJ concurred and stated that employing common metrics for transformation programmes could promote a gravitation toward an integrated system.

RESOLUTION: The System Resource Committee noted the Working as One Programme (Urgent & Emergency Care) report.

10. Shared Outcome Framework

10.1 KD presented the report and emphasised the importance of Shared Outcomes Frameworks. KD stated that Shared Outcome Framework sought evidence-based solutions and it incorporated factors informing a wide range of workstreams.

10.2 KD described the Shared Outcome Framework (SOF) as a vehicle for:

- measuring performance which supports reduction of inequalities in health delivery for the local population;
- identifying gaps which posed a risk to long-term HealthCare outcomes;
- aiding the joined-up process and bringing partners together to achieve shared ambitions;
- enabling system partners to target specific population groups or geographies in delivering health HealthCare;
- demonstrating transparency to the local communities.

10.3 KD clarified that although SOF addressed local needs it was part of national driven programmes and was subject to Care Quality Commission (CQC) scrutiny. KD explained that SOF would not result in derogating from local principles, or from use of local tools, metrics and platforms. Local tools were in congruence with the SOF.

10. <u>RESOLUTION</u>: The System Resource Committee noted the Shared Outcome Framework report.

The Chair proposed a five-minute break and members welcomed the break.
The meeting adjourned at 3:40pm and reconvened at 3:45pm

11. Any Other Items for Escalation from System Partners

11.1 There were no items for escalation from system partners.

Graham Russell, Angela Potter and Karen Johnson exited the meeting at 4:35pm

12. Performance Report

12.1 MW, KD and CL presented the report and MW stated that NHSE commended the county health system's efforts to reduce long waiting periods in Elective Care, and to improve performance in the Emergency Department 4-hour standard. MW highlighted that Elective Recovery performance continued to meet national target. MW added that health checks for people with Learning Disabilities or Serious Mental illness recorded increased uptake.

12.2 MW stated that demand for Primary Care services remained high and endoscopy performance remained an area of concern. MW explained that the local system expected to clear the 78-hour performance backlog by June 2024. MW stated that regarding matters of Urgent Care, Category 1 & 2 ambulance performance remained of concern and such area was receiving appropriate focus. MW highlighted that virtual wards were operational and supporting Urgent Care.

12.3 KD stated that Urology remained an area requiring focus. KD added that endoscopy remained an area of concern too, but evidence of reduction in slippage brought an element of optimism. KD stated that although overall Emergency Department performance was below target, the system performance continued to move toward the required target. KD reiterated that Mental Health performance had achieved national target.

12.4 CL presented the financial aspect of the performance report and stated that in year 2023-24 the system had a surplus of £541,000; and she highlighted this as a commendable achievement considering the pressures experienced during the year. CL described the performance of Saving Schemes within the local system and stated that whilst two partners had achieved target, one partner underperformed because of factors beyond control. CL added that inflationary factors contributed to pressures faced in Capital and Savings planning within the local system. Members discussed the report and suggested mitigations.

RESOLUTION: The System Resources Committee noted the Performance report.

13. Month 12 Finance Report Inc. Savings Plan

13.1 This was covered in the above discussions.

14. Any Other Business

14.1 The Chair introduced the subject of a planned Systems Resources Committee workshop to be held on 5th September 2024. Members discussed how they wanted the workshop to run and what they wanted the workshop to cover, and they agreed on following issues:

1. mapping how the ICB employs its financial resources and exploring optimal ways of resource use;
2. exploring optimal use of human resource;
3. exploring how to make best use of fixed assets owned or leased;
4. employing segmentation approach to address local health needs and reducing health inequality in the Gloucestershire population.

14.2 Members proposed who could be invited to the workshop and agreed that invites be extended to the Chair of the ICB Board. The Chair requested MG, RB & GN prepare for the workshop. (incorporated in action no.34) **Action: MG, RB and GN to prepare for the workshop.** **MG, RB & GN**

The meeting ended at 5:00pm

Date and Time of Next Meeting: 4th July 2024

Minutes Approved by: Signed (Chair): Jo Coast Date: Thursday 4th July 2024

NHS Gloucestershire ICB People Committee

Thursday 16th May 2024, 14.00 – 17.00pm

Virtually via MS Teams and in the Board Room at Shire Hall, Westgate Street, Gloucester, GL1 2TG

Members Present:		
Karen Clements (Chair)	KC	Non-Executive Director, Committee Chair
Deborah Evans	DE	Chair, GHFT
Emily White *(deputising for Sarah Scott)*	EW	Director of Quality, Performance and Strategy, GCC
Marie Crofts	MC	Chief Nursing Officer, ICB
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Tracey Cox	TC	Director of People, Culture and Engagement, ICB
Participants Present:		
Christina Gradowski	CG	Associate Director of Corporate Affairs, ICB
Claire Radley	CR	Director of People & OD, GHFT
Neil Savage	NS	Director of HR & OD, GHC
Sophie Atkins	SA	People Programme Manager, ICS
Zack Pandor	ZP	Strategic Workforce Transformation Programme Manager, ICS
In attendance:		
Cindy Miu *(shadowing Zack Pandor)*	CM	PA, University Hospitals Bristol NHS Foundation Trust (UBHT)
Ryan Brunsdon	RB	Board Secretary, ICB

1 Introduction & Welcome

1.1 KC welcomed members to the People Committee and acknowledged all of the hard work that had been undertaken and continued to be worked upon since the previous People Committee in February 2024.

2 Apologies for Absence

2.1 Apologies were received from Mary Hutton (MH), Sarah Scott (SS) and Jane Cummings (JC).

2.2 It was confirmed that the meeting was quorate with the members present and in attendance.

3 Declarations of Interest

3.1 No declarations of interest were received prior or during the meeting.

4 Minutes of the Previous Meeting

4.1 The minutes of the previous meeting held on Thursday 8th February 2024 were approved as an accurate record of the meeting.

5 Action Log & Matters Arising

5.1 Action Log

5.1.1 **08.02.2024, Item 7.1** – Workforce Intelligence Report. This action was requesting closure. Information sent via email by ZP. **Action Closed.**

5.1.2 **08.02.2024, Item 7.3** – Workforce Intelligence Report. This action was requesting closure. Information sent via email by ZP. **Action Closed.**

5.1.3 **08.02.2024, Item 7.13** – Workforce Intelligence Report. TC highlighted that further conversations were required around this action and was not to be closed at this point. **Action to remain open.**

5.1.4 **08.02.2024, Item 8.10** – Staff Survey Results. This action was requesting closure. There are currently no ICS level staff survey platforms available on the market. **Action Closed.**

5.1.5 **08.02.2024, Item 9.16** – ED&I and WRES. This action was requesting closure. Invite sent and session held on 16th February 2024. **Action Closed.**

5.2 ZP provided the Committee with a brief update on Digital Staff Passports which was noted to be a Core element of wider 'Enabling Staff Movements' programme. Locally this programme was called workforce agility.

5.3 A baseline assessment been conducted which two areas highlighted as amber and one as red. The red rated requirement around project implementation resources had yet to had been scoped.

5.4 It was reported that this had been discussed at both the Workforce Steering Groups (WSG) and Education and Training Groups. A task and finish group was due to be set up and arranged when national timescales became clearer for wave four sites.

5.5 ZP mentioned that a demo of the product was to be held on 28th May 2024 and colleagues had been circulated the invitation to attend.

5.6 CGi reported that organisations were required to sign-up to the same statutory and mandatory training modules. But acknowledged that there were different levels dependant on job role. The timescale had not been fully released.

6 Integrated Care System (ICS) People Function Summary Report

6.1 TC highlighted there had been a number of national legislative changes which took effect from 1st April 2024. This included; holiday pay, flexible working, statutory carers leave act & protection from redundancy. Organisations were updating local policies to reflect any national changes.

6.2 TC explained that more work was underway to collate volunteering data for the system. A new mandatory NHS volunteers data collection process was introduced for all NHS Trusts and foundation trusts at the beginning of April with the first return date due July 2024 for the previous quarter's data.TC explained that the NHS Long Term Workforce Plan assumed volunteering as a route into employment within the NHS. Volunteering numbers would be included in future workforce dashboards for the Committee.

6.3 TC referenced the Volunteers into Careers Project pilot which was progressing with GHFT to identify potential areas of placements for volunteers. Early ideas included Therapy Services and some non-clinical areas. TC confirmed that the volunteer period would be between three to six months and volunteers would be supported and mentored to apply for a permanent position if necessary.

6.4 TC provided an overview of the national and regional vacancy positions which continued to demonstrate a positive trend. This was to be discussed later within the agenda. It was noted that the national position for Social Care had also improved.

6.5 The Committee discussed the use of Artificial Intelligence (AI) within candidate applications for vacancies and noted the national advice on policy development. NS advised that an AI app had been tested in Gloucestershire Health & Care NHS Foundation Trust (GHC) which supported the application of jobs. Guidance was being reviewed with regards to screening for jobs with advice that candidates should not use AI. There was evidence around its use in some applications.

6.6 TC reminded members a bid for the national Working Well initiative had been submitted but unfortunately the ICS had been unsuccessful. The ICB had been allocated an earlier grant of approximately £90k to develop capacity and capability and to better linkages with the employment and skills hub. It was added than a role was being scoped which looked at better alignment between the organisations supporting individuals into work and with health care support.

RESOLUTION: The People Committee noted the content of the ICS People Function – Summary Report.

7 Workforce Intelligence & Programme Highlight Report

7.1 SA first presented the key achievements and recent developments. Key points noted to the Committee included;

- Final Operational Plan was submitted on Thursday 2nd May 2024. The workforce element was described as non-compliant as at this point we reported a planned deficit, and the indicative cap was not met. As of 14th May, the plan was now financially balanced.
- The Arts Health & Wellbeing Centre had issued a small grants application process for research and evaluation projects. 40 applications had been received with 16 shortlisted for further review.
- System Thinking Masterclass - cohort five was half way through the programme and due to finish in July 2024.
- An ICS coaching conference was held on 25th April. 35 coaches across the system attended.
- The fixed term We Want You project team was transitioning into a new service arrangement with the commencement of two system careers engagement officers who had recently started.

7.2 SA agreed to circulate the narrative document as part of the operational planning submission return for workforce and would circulate the numerical return if specifically requested. **SA**

7.3 SA confirmed that both Peoples Promise Managers had been appointed within GHC and Gloucestershire Hospitals NHS Foundation Trust (GHFT). GHC's lead role had started and GHFT's was due to start on 28th May 2024.

7.4 The apprenticeship strategy was in its final stages of development and SA anticipated that this would be brough to the People Committee in July for ratification. RB to add to the forward planner. **RB**

7.5 SA reported that eight people had been confirmed for the upcoming health and social care careers awareness conference being held at University Of Gloucestershire (UOG) on 17th May which had a designated Care Leavers workstream. Incentives had been put in place to encourage attendance. The Committee also discussed attendance levels in general and what could be done to increase the numbers of attendance across conferences and training. SA acknowledged that attendance via virtual online training had seen a reduction.

KC requested that this be discussed outside of the Committee to try and support the reduction of cost and waste for the Integrated Care System (ICS).

7.6 SA reported that within the Operational Plan submission, a sexual safety charter had been introduced. GHC and the ICB had already signed up and e-learning was available for staff. GHFT were in the process of signing up and anticipated e-learning would be made available by end of May 2024.

7.7 SA informed the Committee that a Leadership Conference Series had been planned targeted at all partners across the ICS. Two conferences were planned in June and October 2024. As of 15th May, 160 out of 250 paces had been allocated for the June conference focusing on health inequalities.

7.8 SA progressed onto the ICS workforce performance dashboard. Key points noted included;

- Workforce Race Equality Standard (WRES) had been included.
- Primary Care (PC) data had been excluded from this iteration of the report as we are re-confirming reporting metrics with Training hub leads.
- With the exception of the leavers rates, SA described the data trends to be positive.
- Vacancy rates for the ICS were at 11.7%. Trust positions were 8.2% and 15.2% for Adult Social Care (ASC).The goal was to reach 6.6% by the end of 2024/25 for the provider Trusts.
- Sickness rates had improved to 4.1%
- There was a reduction in agency usage to 181 Whole Time Equivalent (WTE) for the provider Trusts and 155 for ASC. Plans were in place for 2024/25 to support continued reduction in agency spend.
- In terms of 2023/24 for temporary staffing, supported by the pension calculation, the system had achieved a position of £25.9m against a target of £25.6m and this was the second-best performing system in the Southwest.
- GHT were leading on the tender for medics E-rostering with GHC needing to be involved sooner than anticipated. This was following the award of the new Integrated Urgent & Emergency Care contract. (UEC).
- There was an improvement in likelihood of being recruited for candidates with a disability.

7.9 KC queried the leavers rates regarding those with less than one year service and if this had been distorted by those with short-term contracts. SA agreed to share deep-dive paper which demonstrated the impact of the increase in fixed-term contracts coming to an end and which had affected the data. Both NS and CR confirmed that fixed-term contract data was included within their organisational reports. **SA**

7.10 TC commented that the operational plan had a number of implied assumptions on sickness and vacancy rates and agreed to continue to work on the dashboard to illustrate demonstrate performance and variance against the operational plan assumptions.

RESOLUTION: The People Committee noted the content of the Workforce Intelligence & Programme Highlight Report.

8 People Work Programme for 2024/25 (Plans on a Page – POAP)

8.1 TC contextualised that the People Committee had been presented with the People Work Programme for 2024-25 which had been developed by the three Steering Groups and delivery groups. The plans reflected a shared system view of priorities for the coming year, the continuation of some workstreams from 2023/24 and workforce related priorities as set out in the 2024-25 Operational Planning guidance.

8.2 TC confirmed that it had been highlighted within the programmes where there may be resource implications.

8.3 KC commented on the work programme and acknowledged the amount of work that was to be undertaken, but queried what the absolute must-dos and priorities were and if these priorities were aligned across the ICS organisations.

8.4 NS explained that there may be additional pieces of work or projects that will need to be undertaken throughout the year which will result in a potential change of priorities. For example, an issue that recently arose was the reduction in Adult Nursing university applications, noting a reduction of 30% for UOG, and felt that there was an immediate piece of work to be undertaken by the Education & Training Group and WSG. TC said connectivity with UOG could be improved and exploration of how we could work together to improve the number of applicants. This was to be potentially added to the risk register.

8.5 MC queried if UOG offered a dual qualification course for nursing, and also provided an example of another University offering psychology graduates into a fast-track mental health nursing course and suggested that UOG may need to be more innovative in its approaches. ZP added that a better understanding of how UOG were outreaching to attract potential applicants was required.

8.6 SA flagged the risk within the operational plan with regards to national and local workforce caps and noted that if there were national communications around workforce caps, this would have an effect on student numbers and applications. The committee further discussed the marketing campaigns, local opportunities and open days. Further conversations were agreed to be taken outside of the Committee.

8.7 CR felt that there was a good combination of strategic development and tangibility across the plans. Some of the activities within the plans had already commenced and that it would be easier to manage the plans because of this.

8.8 MC asked whether new roles such Mental Health Wellbeing Practitioners were being used within the system. NS confirmed they were and added that new roles within Eating Disorders Services had been created using psychology graduates.

8.9 KC felt that it would have been helpful to have this presented again that demonstrated what the clear joined up priorities were. This would help with full engagement across the system. TC agreed with this approach and proposed that HRDs review the top three for each area and present back. **TC, NS & CR**

8.11 TC commended the work from the We Want You Team and highlighted a promotional video they had produced and suggested that this was presented at the next Committee meeting. **TC**

RESOLUTION: The People Committee noted the People Work Programme for 2024/25

9 Retention Focus

9.1 ZP presented the retention presentation to the Committee. The report had been circulated to members as part of the papers. ZP initially discussed the leavers rates across NHS and Social Care. There were lower rates during the Covid pandemic with peak leaver rates being noted at Summer 2022. It was added that the graph on slide two did discuss specific rates within staffing groups

9.2 ZP advised that there was not 100% accurate data as to why staff leave the NHS, but there was an ongoing effort to try and improve this. Work-life balance was described as being one of the most common categories.

9.3 ZP discussed the four priority focus areas for retention work. These included;

1. Improving understanding why staff leave
2. Support staff at all stages within their careers
3. Flexible working
4. Support for international staff.

9.4 NS discussed the driver diagram that had presented as part of the GHC retention programme. This had been produced following previous and ongoing actions. NS explained that when the driver diagram was developed, it was unclear as to whether funding would be made available to support the People Promise and that was why this was not included.

9.5 TC reflected that a majority of retention work undertaken had focused on the Nursing workforce but noted the ongoing challenges with other roles such as Healthcare Sciences, Midwifery and Pharmacy trainees. NS confirmed that when the People Promise assessment was conducted, these services and roles were reviewed

9.6 KC questioned if members of the Committee would like to see a regular deeper dive into the metrics to obtain a better understanding around vacancy data and the challenges being faced.

9.7 MC queried what recognition and rewards were available to staff within the system and gave the example of the Daisy rewards. MC added that she had been able to purchase 27 spaces for a restorative justice and learning culture training course spaces that would be available for staff.

9.8 CR presented the GHFT focus on retention and described the key focus areas for the Trust including retention & culture and recruitment and attraction and these had been separated. CR outlined the activities and workstreams that had been identified and undertaken as part of the focus for retention. It was noted that a dedicated lead for colleague health and wellbeing had been recruited and this was a new role for the Trust.

9.9 CR described the three projects as part of the current priorities and improvement projects. These included;

- Exit/Leaver process

- Flexible retirement / retire and return
- Substantive leavers to bank

9.10 Turnover data for GHFT was presented and it was reported that turnover had seen a 0.11% increase from Feb-24 to Mar-24, but this was the first increase since April 2023.

9.11 TC acknowledged the difficulties for staff who tried to understand the flexible retirement and retire and return schemes and queried what had been done to better support staff. NS confirmed that the Pensions Manager for GHC attends pension programmes to advise staff and better discuss alternative options. CR felt that this was more specific to different staff groups within the Trust and suggested that more work was needed with Consultants and said split contracts were being reviewed at GHFT. CGi reported bespoke face to face pension workshops were going to be available for ICB staff.

9.12 KC queried the progress with E-rostering within GHFT. It had been mentioned that Ward 9A had been piloted for self-rostering, however this had been paused. SA commented that Ward 9A had low vacancy figures and annual leave had to be maximised and this made self-rostering difficult for staff. In terms of E-rostering, GHC approaches had been shared with GHFT. KC requested that the E-rostering pilot be discussed and taken forward outside of the Committee.

9.13 ZP highlighted that there was data regarding Adult Social Care within the presentation. It related more to turnover rater than leaver rate, and this was due to what had been available.

9.14 KC concluded the discussion and requested that more granular retention data be presented back to the Committee every six months.

RESOLUTION: The People Committee noted the retention presentation and requested a six-monthly update at the Committee.

10 People Committee Risk Register Update and Board Assurance Framework (BAF)

10.1 TC introduced the agenda item related to risk. The Board Assurance Framework (BAF) had been presented and the workforce risk had still been rated at a score of 20. This score was consistent with providers BAFs. The Committee debated the current score in light of some improving metrics. DE noted that there had been improvements within GHFT, but the Trust felt that risk remained at a score of 20 and that messaging around the workforce risk appetite, risk focus and workforce culture were still important.

10.2 CR said that with regards to the band 2-3 Healthcare Assistant (HCA) pay issue, there had been a positive outcome from the Unison ballot. This risk was expected to be downgraded or closed soon.

10.3 TC reviewed the remainder of the risk register as identified within the steering groups. The risk around industrial action was not to change due to the potential strike action with Primary Care. The risk around social work placement required needed further follow up and understanding. TC agreed to send EW more information regarding the social work placement risk. **TC**

10.4 KC questioned if there was a way of mitigation for the funding for legacy mentors that was due to run out. It was confirmed that no funding had been identified, and funding could be drawn from vacancy factors for individual departments or directorates to continue any positive impacts. CR suggested this risk should be upscaled to wider risk

around lack and clarity of funding. KC thought that it would be helpful to discuss or draw out risks which have a risk to delivering commitments within plans.

RESOLUTION: The People Committee noted the content of the risk register and BAF.

11 Freedom to Speak Up Update

11.1 ZP identified that there had been eight freedom to speak up enquiries into the ICB over the previous year. It was added that the policy had been refreshed based upon national guidance. The majority of cases were with regards to bullying and harassment.

11.2 Guidance for the ICB had been provided around how the ICB could support Primary Care with freedom to speak up.

11.3 ZP explained that freedom to speak up training was not mandatory, but this was something that was being reviewed. NS added that this was included within the GHC corporate induction. CR noted that GHFT had a freedom to speak up guardian who had been in post over a year.

CG informed the Committee that there was a recommendation from the BDO internal audit report on ED&I and inclusion that training provided through E-Learning should be made mandatory, and that this was going to be mandated when the ICB moved to Electronic Staff Records (ESR).

RESOLUTION: The People Committee noted the update on Freedom to Speak Up.

12 Policy Updates

12.1 CG presented the policies that had been presented for approval. These included;

- The Carers Policy was a new policy that was supported by the Staff Partnership Forum and Operational Exec.
- The Other Leave Policy had been reviewed in line with changes to other ICB policies. The changes made included reference to the new carers policy, updated disability leave, the National pregnancy and baby loss policy and leave for armed forces or reservist personnel.
- The Annual Leave policy had been reviewed due to the change in process for booking annual leave (now done via ESR). Whole policy reviewed and updated.
- The Career Break Policy was reviewed in line with the ICB standard review procedure. No major changes noted. This policy was taken to the Staff Partnership Forum and Operational Exec.
- The Working Time Policy was reviewed in line with the ICB standard review procedure. This policy was taken to the Staff Partnership Forum and Operational Exec.

RESOLUTION: The People Committee approved the;

1. ***Carers Policy***
2. ***Other Leave Policy***
3. ***Annual Leave Policy***
4. ***Career Break Policy***
5. ***Working Time Policy***

13 Any Other Business

13.1 TC highlighted the requests for a future meeting which included a deep dive on WRES data within the provider organisations and continue to ensure best practice is being shared. This session may benefit from external input.

The meeting closed at 17.02.

Date and Time of next meeting: Thursday 18th July 2024 at 2pm in Shire Hall.

Minutes Approved by: Signed (Chair):Karen Clements Date:18th July 2024